The Determinants of Maternal Mortality Under Restrictive Abortion Laws in High-Income Democracies: A Comparative Analysis of Poland and the United States

by

Ava Sofia Dale

BA International Relations, University of British Columbia, 2023

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

in the Department of Political Science

© Ava Dale, 2025
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part,
by photocopy or other means, without the permission of the author.

We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

The Determinants of Maternal Mortality Under Restrictive Abortion Laws in High-Income Democracies: A Comparative Analysis of Poland and the United States

by

Ava Sofia Dale

BA International Relations, University of British Columbia, 2023

SUPERVISORY COMMITTEE

Dr. Mara Marin, Co-Supervisor
Department of Political Science

Dr. Laura Parisi, Co-Supervisor
Department of Gender Studies

Dr. Amy Verdun, Member
Department of Political Science

ABSTRACT

This thesis examines abortion laws and maternal mortality ratios (MMRs) in Poland and the United States, which are the only two countries that have removed legal grounds for abortion since the establishment of the United Nations Sustainable Development Goals (SDGs) in 2015. Despite global trends toward abortion liberalization, both countries have implemented restrictive policies. Conventional theory suggests that restrictive abortion laws are associated with higher MMRs. However, Poland maintains one of the world's lowest MMRs at two deaths per 100,000 live births, while the US has one of the highest among high-income countries at 17.

This research addresses two questions: (1) What explains the abortion restrictions in Poland and the US? (2) What explains Poland's significantly lower MMR despite having more restrictive abortion laws historically? The conventional theory would suggest Poland's MMR should be higher than that of the US, yet the opposite is true. Explaining Poland's lower MMR allows for a separation of the legal impact on MMR from the effects of other factors, such as healthcare and education systems and broader socioeconomic factors.

The study identifies politically mobilized religion as a common variable that partially explains these abortion restrictions, despite significant differences in political systems, regional contexts, and demographics. Poland's lower MMR is attributable to its universal healthcare system, nationally standardized maternal care protocols, strong integration of midwives, and comprehensive parental leave policies. Through legal-historical analysis, SDG analysis, and intrinsic and comparative case study analyses, the research demonstrates that while similar religious and conservative political forces have influenced the legal restrictions in both countries, they differ in healthcare system design, access to care, social support policies, and inequalities across peoples and regions.

This research contributes to understanding how countries can achieve low maternal mortality even with restrictive abortion laws, challenging oversimplified understandings between abortion legality and maternal health outcomes. While most research on maternal mortality focuses on the Global South, these findings provide valuable insights for policymakers seeking to improve maternal health in high-income contexts where abortion liberalization faces barriers.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

LIST OF ABBREVIATIONS

AMA	American Medical Association
BMat	Bayesian Maternal Mortality Estimation Model
BMis	Bayesian Maternal Mortality Misclassification Model
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRR	Center for Reproductive Rights
CRVS	Civil Registration Vital Systems
EU	European Union
GDP	Gross Domestic Product
ICD	International Classification of Diseases
ICJ	International Court of Justice
IUD	Intrauterine Device
IVF	In Vitro Fertilization
ICPD	International Conference on Population and Development
LAM	Lactational Amenorrhea Method
MDGs	Millennium Development Goals
MDSD	Most Different Systems Design
MMEIG	Maternal Mortality Estimation Inter-Agency Group
MMR	Maternal Mortality Ratio
MMRate	Maternal Mortality Rate
NFZ	National Health Fund (‘Narodowy Fundusz Zdrowia’, Poland)
NPM	New Public Management
NVSS	National Vital Statistics System
OECD	Organisation for Economic Co-operation and Development
PiS	Law and Justice Party (Prawo i Sprawiedliwość, Poland)
PLN	Polish Złoty
RAMOS	Reproductive Age Mortality Study
SDG	Sustainable Development Goal
SRHR	Sexual and Reproductive Health and Rights
TRAP	Targeted Regulation of Abortion Providers
UHC	Universal Health Coverage
UK	United Kingdom
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNSD	United Nations Statistics Division
US	United States
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization

ACKNOWLEDGEMENTS

This thesis would not have been possible without the collective support of everyone who has touched my life academically and personally. I would like to extend my gratitude to my supervisory committee, Dr. Mara Marin, Dr. Laura Parisi, and Dr. Amy Verdun, for their invaluable guidance and feedback throughout the development of this thesis. Their expertise and encouragement have been instrumental to bringing this research to life. Special thanks to Dr. Claire Cutler and Dr. Oliver Schmidtke for the tools I gained from their courses and for their feedback on my earliest drafts.

The unwavering love and support from my family throughout this academic journey has made it possible for me to pursue this work. To my parents, Kirsty and Steve, my brother Griffin, my cousins Piper, Abrielle, Audrey, and Hendrick, my aunts and uncles, and my grandparents, Diane and Nigel, and Wendy and Rodney. Thank you for believing in me and for teaching me to believe in myself.

I am especially grateful for the encouragement from my friends every step of the way. To my closest friends, Kenya and Kaelin Stoodley, Ashlee Appel, Ava Bakala, and Taya Henderson, my partner Max McDonald, and the new friends I made in my cohort at the University of Victoria, Jasmine Ramsay, Annilea Purser, Sage Kraftcheck, and Monet Nobuso. Thank you for your patience, warmth, insight, and advice. Your enduring support has been a grounding source of strength. I am incredibly fortunate to have you all in my life.

Finally, I extend my sincere thanks to the reader. I ask for your patience and understanding for the length of this thesis being longer than customary. I hope that the depth of analysis offered here makes the time spent reading it worthwhile.

CHAPTER I: INTRODUCTION

Somewhere in the world, a woman dies from complications related to pregnancy and childbirth every two minutes, resulting in approximately 700 deaths each day (World Health Organization (WHO), 2025b, xv). Despite concerted international efforts, progress in reducing maternal mortality has been slow and uneven across countries and regions. A key factor in this critical global health issue is the legality of abortion, which is often subject to debate. The relationship between abortion laws and maternal mortality is intricate, involving not only legal frameworks but also healthcare and education systems, socioeconomic factors, and cultural norms. Globally, 6 out of 10 unintended pregnancies and 3 out of 10 of all pregnancies end in abortion (WHO, 2024a). However, around 40 percent of women of reproductive age, aged 15 to 49, live under restrictive abortion laws (Center for Reproductive Rights (CRR), 2025c). Approximately 73 million abortions take place worldwide each year, and around 45 percent of them are unsafe, yet there is no medical reason for abortions to be unsafe (WHO, 2024a). Estimates on abortion-related mortality vary widely due to misclassification of causes of death. Unsafe abortions performed by unqualified individuals in illegal contexts account for somewhere between 8 and 50 percent of all global maternal deaths (Ngo et al., 2024, 7; Ndyanabangi et al., 2021, 43). Comparatively, complications arising from safe abortions result in less than one death per 100,000 procedures (WHO, 2024a).

In 2015, the United Nations (UN) established the Sustainable Development Goals (SDGs) to be met by 2030. SDG target 3.1 aims to reduce the global maternal mortality ratio (MMR) to less than 70 maternal deaths per 100,000 live births, while target 3.7 focuses on universal access to sexual and reproductive healthcare. The MMR is defined as the number of maternal deaths during a given period per 100,000 live births in the same period. Despite these

targets, the 2023 global MMR is 197, and at the current rate of progress, it will only decrease to 177 by 2030, far above the target of 70 (WHO, 2025b, xv).

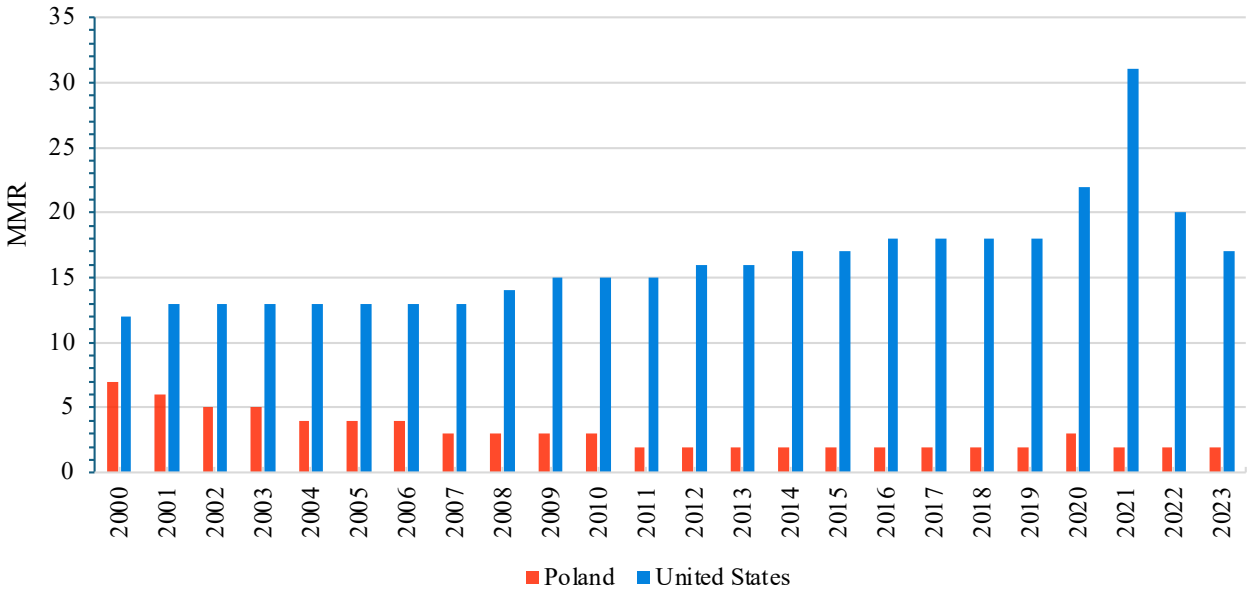
The average MMR is three times higher in countries with more restrictive abortion laws compared to countries with more liberal laws (Johnson et al., 2017, 542). The emerging theory from the literature review in Chapter Two is that countries with stricter abortion laws have higher MMRs, and those with more liberal abortion laws have lower MMRs. Numerous studies provide examples of countries where maternal mortality decreased significantly following the legalization of abortion and improved access to safe procedures, including Bangladesh, Cambodia, Colombia, Ethiopia, Guyana, Mexico, Nepal, Romania, South Africa, and Uruguay (Benson et al., 2011, 10; Latt et al., 2019; Mutua et al., 2018, 2; Darney et al., 2020, 1363; Gebrehiwot and Liabsuetrakul, 2008, 86; Briozzo, 2016). However, there are notable exceptions, such as Chile and Poland, where strict abortion laws coexist with low MMRs, challenging the theory's universality.

In the past 30 years, more than 60 countries have liberalized their abortion laws, while only four countries – El Salvador (1998), Nicaragua (2006), Poland (2020), and the United States (US) (2022) – have rescinded legal grounds for abortion (CRR, 2025c). This global trend toward liberalization, supported by international frameworks and agreements, creates an expectation that countries will expand rather than restrict reproductive rights. Since the SDGs were established in 2015, only Poland and the US have removed legal grounds for abortion, contrary to the global trend. In 2020, Poland's Constitutional Tribunal removed the clause permitting abortion due to severe fetal abnormalities, which had been the grounds for 98 percent of all legal abortions performed annually (Eska-Mikołajewska, 2021, 8) (see section 4.1 below). This restriction is especially concerning from a maternal health perspective, as pregnancies involving severe fetal

abnormalities often carry elevated risks of complications that can contribute to maternal mortality. In 2022, the US Supreme Court overturned its 1973 decision in *Roe v. Wade*, which had constitutionally protected abortion under the right to privacy, leaving its regulation entirely to the states (see section 4.2 below).

Although both Poland and the United States have recently restricted abortion laws, they report notably different MMRs. Poland has one of the lowest MMRs globally at two deaths per 100,000 live births, whereas the United States reports one of the highest among high-income countries at 17. The contrast in MMR is surprising because, under the conventional theory that restrictive abortion laws are correlated with higher maternal mortality, one would expect Poland's MMR to be significantly higher, not lower. The selection of the US as a comparative case is compelling not only because it meets the core criterion of having enacted post-SDG abortion restrictions, but also because, as a wealthy country with advanced medical infrastructure, it would theoretically be expected to have a lower MMR than Poland. This contrast challenges conventional assumptions that greater economic resources and legal access to abortion necessarily correlate with better maternal health outcomes. The paradox invites deeper investigation into how factors such as healthcare system design, social protections, and structural inequality interact with legal frameworks to influence maternal mortality. The latest WHO (2025b) report on maternal mortality provides the most accurate MMR estimations to date for the 2000 to 2023 period (see Figure 1 below).

Figure 1: MMR in Poland and the US (2000-2023)



Source: Created by author based on data from WHO, 2025b.

Poland consistently maintains a lower MMR than the US, despite its history of stricter abortion laws. According to the conventional theory, this should result in higher, not lower, maternal mortality. Conversely, the US had broadly legal abortion access for nearly five decades before 2022, yet its MMR is among the highest in high-income countries. This paradox challenges the assumption that legal abortion access alone ensures better maternal health outcomes and suggests the need to examine additional explanatory factors beyond abortion legality. Therefore, the conventional theory is too simplistic to sufficiently encapsulate the relationship between abortion laws and maternal mortality and explain what accounts for MMRs. Understanding how Poland maintains a low MMR while simultaneously maintaining one of the strictest abortion laws in Europe provides an opportunity to isolate the factors making this possible, beyond the legality of abortion. Conversely, examining the persistent challenges in the

US despite its wealth illustrates how underlying structural inequalities can undermine maternal health in high-income democracies regardless of legal frameworks.

To reduce the global MMR effectively, there must be a strong understanding of what accounts for different levels of MMRs, particularly in countries with restricted abortion laws. The first step in developing this understanding is to explore what role, if any, abortion laws play in explaining MMRs. This step directly informs the first research question: What explains the abortion law restrictions in Poland and the US? This question examines the driving forces behind the restrictions in the two countries that have removed legal grounds for abortion during a period when most countries were expanding reproductive rights. Understanding these forces provides insights into the mechanisms through which abortion laws are shaped in countries with different MMR levels. These mechanisms operate differently in each country, such as cultural, political and religious influences on law. However, understanding where abortion laws and maternal health outcomes intersect in the context of these mechanisms is essential for identifying whether high MMRs are a symptom of broader institutional weaknesses. Furthermore, answering the first research question establishes the sociopolitical contexts within which maternal healthcare systems operate.

The second step is to identify which additional factors, such as healthcare systems, education, or social protections, explain differences in MMRs beyond legal frameworks. The second step aligns with the second research question: What factors explain why Poland's MMR (2) is considerably lower than that of the US (17) despite its history of stricter abortion laws? The conventional theory would suggest Poland's MMR should be higher than that of the US, yet the opposite is true. Explaining why Poland has a lower MMR than the US despite historically stricter abortion laws allows for a separation of the legal impact on MMR from the effects of

other factors, such as healthcare and education systems and broader socioeconomic factors. Countries with liberal abortion laws and attitudes towards reproductive rights tend to have a stronger integration of other key factors that improve MMR, such as access to contraceptives. However, Poland's low MMR provides an opportunity to study the impact of other key variables in the absence of the effects of liberal abortion laws.

Together, these two research questions fundamentally connect the analysis of how institutional, political, religious, and social forces translate into healthcare policies, social support systems, and approaches to maternal care that produce different MMRs. Researching these questions through a comparative analysis of Poland and the US presents an opportunity to isolate factors beyond abortion legality that protect maternal health, offering valuable insights for improving MMR, particularly in contexts where abortion access remains limited.

Most studies on maternal mortality are focused on Global South case studies, where the most maternal deaths occur. However, effectively reducing the global MMR is the responsibility of all countries. This study addresses an under-researched area that is essential to understand to combat the issue. Understanding why Poland has substantially less maternal deaths than the US helps to isolate the external factors of maternal mortality that countries with restrictive abortion laws should be prioritizing to reduce these preventable deaths. Examining these high-income outlier cases offers insights into the value of the different approaches used to address MMR. Furthermore, the US is rarely compared in international analyses. Most research on maternal mortality in the US focuses on the domestic variation between states, given that several important factors are decided at the state-level, including abortion laws. Therefore, this study contributes to shrinking a significant research gap in understanding what accounts for the high MMR in the US and how its institutional structures impact the ability to reduce MMR.

The structure of the thesis is as follows. Chapter Two is a literature review on global maternal mortality, focusing on identifying the key variables that influence MMRs and examining how abortion laws intersect with maternal health. Variables identified in the literature are treated as hypotheses, which are tested in subsequent chapters to assess their association with MMRs in the case studies. The literature review outlines the leading causes of global maternal mortality and explores the relationship between maternal mortality, unsafe abortion practices, and the legal status of abortion. The purpose of the literature review is to examine evidence for the theory that restrictive abortion laws are generally associated with higher MMRs, to find any exceptions to the theory, and to examine the factors beyond legal frameworks that play a role in reducing MMRs in contexts with restrictive abortion laws.

Chapter Three outlines the study's methodological approaches, research design, and limitations. This research employs a Most Different Systems Design (MDSD), a comparative methodology for selecting cases that differ in most respects but share a similar outcome variable: post-2015 restriction of abortion laws. The MDSD begins addressing the first research question: what explains the abortion law restrictions in Poland and the United States?

Chapter Four further addresses the first research question by identifying the key forces influencing abortion law restrictions in Poland and the US. The legal histories of abortion are traced in each case, drawing attention to influential factors such as political, religious, social, and cultural forces. The analyses of legal histories reveal the factors that explain why abortion restrictions occur across different contexts. This analysis builds a foundation for exploring how different systems impact maternal health.

Chapter Five addresses the second research question: What factors explain why Poland's MMR is considerably lower than that of the US despite its history of stricter abortion laws? This

chapter analyzes progress on relevant SDG indicators associated with key variables identified in the literature review. This SDG analysis helps direct the subsequent case studies by identifying which maternal mortality-related indicators Poland scores worse on than the US, thereby narrowing the study's focus. For example, one SDG target assesses contraceptive access, an essential maternal health factor. If Poland scores worse on the contraceptive target than the US, this finding eliminates the possibility of contraceptive access providing a reasonable explanation for why Poland's MMR is lower than that of the US. This analysis aims to rule out some of maternal mortality-related variables identified in the literature review as significant explanations for the differences in MMRs between the two cases. This higher-level data trend analysis allows for a more intersectional approach in the within-case analyses in the subsequent chapter.

Chapter Six presents the within-case analyses, assessing the strength and quality of systems associated with MMR, according to the findings from the literature, including healthcare systems, access to contraception, midwife integration, sex education, and socioeconomic disparities. These within-case analyses are guided by the legal history analyses, which establish an understanding of these cases' institutional, cultural and sociopolitical structures and how they contribute to different maternal health outcomes. Furthermore, the baseline understanding of how these countries compare on maternal health-related SDG indicators establishes an informed direction for exploring which within-case systems explain why Poland's MMR is lower than the US ratio. Given recent restrictions, this chapter also examines the risk of MMRs worsening in the coming years. Because maternal deaths often vary regionally and demographically, the analyses incorporate region-specific and demographic micro-studies where relevant.

Chapter Seven presents the comparative analyses and concludes the study by summarizing the results. The comparative analysis offers an explanation of the different MMRs

in Poland and the US by comparing the key influences on maternal health to provide a model for countries with similar characteristics. The conclusion proposes future research directions and policy suggestions based on the findings, offering final reflections on the broader reproductive health and rights issue. While the present study does not contain an exhaustive analysis, it aims to provide a foundation for future researchers to explore the matter in further depth especially as more data becomes available. Understanding how maternal mortality is impacted in these high-income cases can guide policymakers and future research in minimizing the effects of restrictive laws.

CHAPTER II: LITERATURE REVIEW

In Chichewa, a language Indigenous to Malawi that is also spoken in parts of Zambia, Zimbabwe, and Mozambique, the word for pregnancy is *pakati*, which translates to "the place between life and death" (Jackson et al., 2011, 133). This powerful association between pregnancy and death reflects the high risk of maternal death in sub-Saharan Africa, where a woman's lifetime risk is 1 in 36, and the region accounts for nearly two-thirds of global maternal deaths (Doyle, 2021, 106; Bhalotra et al., 2023, 2173). Studies show that unsafe, illegal abortions are a leading cause of maternal deaths, particularly in countries with restrictive abortion laws (WHO, 2024a). The prevalence of unsafe abortion as a cause of maternal mortality depends on four elements: the legal and health-related aspects of unwanted pregnancy, women's access to contraception, government education policies, and cultural and religious beliefs. This literature review examines global maternal mortality through three interconnected claims. First, substantial evidence supports the theory that restrictive abortion laws are associated with high MMRs, while liberal abortion laws are associated with lower MMRs. Second, notable exceptions to this theory provide reason to believe that the relationship is not universally applicable. Third, other factors, in addition to and combined with legal frameworks, may explain MMR levels.

The chapter begins by establishing key terminology, measurements, and common causes of maternal mortality to provide a foundation for understanding subsequent analyses. Section 2.2 provides an overview of the global commitments to address maternal mortality. Section 2.3 presents evidence supporting the association between restrictive abortion laws and high MMRs, examining cases where liberalization led to significant maternal mortality reductions. Section 2.4 explores counterevidence to this theory, highlighting instances where countries with restrictive abortion laws achieved remarkable decreases in maternal mortality. Section 2.5 investigates

additional factors that influence maternal mortality beyond legal frameworks, examining how religious and cultural contexts, healthcare accessibility, education, and socioeconomic disparities complicate maternal health outcomes. The literature review findings inform the theoretical and methodological variables for this study.

2.1 Definitions, Measurements, and Causes of Maternal Mortality

The International Classification of Diseases (ICD) provides the official global standard for recording and analyzing health data. The WHO defines *maternal death* as: "The death of a woman while pregnant or within forty-two days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from unintentional or incidental causes" (WHO, 2025b, 10). This definition has been used since the ICD's eleventh revision in 2019. The forty-two days are considered the puerperium period, approximately six weeks after childbirth.

The two primary maternal mortality indicators are the maternal mortality ratio (MMR) and the maternal mortality rate (MMRate), which are conceptually and empirically different. The *maternal mortality ratio* is defined as the number of maternal deaths during a given period per 100,000 live births in the same period. MMRs are calculated by dividing the number of recorded or estimated maternal deaths by the number of recorded or estimated live births in the same period and multiplying by 100,000, indicating the risk of maternal death once a woman becomes pregnant relative to the number of live births in the same period.

Comparatively, *maternal mortality rates* are calculated by dividing the number of maternal deaths by the number of women of reproductive age alive that year, usually 15 to 49 years old. MMRates reflect not only the risk of maternal death per pregnancy but also the level

of fertility in the population. The *fertility rate* refers to the average number of children a woman is expected to have over her lifetime. The MMR is the preferred indicator for this research because it explicitly measures deaths during pregnancy, childbirth, and the early postpartum period, which are directly relevant to the investigation of abortion laws and maternal health.

For international recording, ICD-11 specifies that only deaths occurring within forty-two days since the termination of the pregnancy should be included in MMR and MMRate calculations. However, countries are encouraged to record later deaths for national analytical purposes. Unfortunately, many countries have inadequate information on maternal mortality due to poor vital registration systems and certification of death causes, particularly those in the Global South (Manyeh et al., 2018, 3). *Late maternal deaths* result from direct or indirect obstetric causes more than forty-two days but less than one year after termination of pregnancy (MacDorman et al., 2016, 488). Chen et al. (2025, 4) found that 30 percent of pregnancy-related deaths in the US between 2018 and 2022 were late maternal deaths. Poland does not have publicly available data on late maternal deaths. *Maternal morbidity* refers to any short- or long-term health problems resulting from pregnancy-related complications that are not immediately life-threatening. *Maternal suicide* is the death of a woman by suicide while pregnant or within one year postpartum. Suicide is a leading cause of maternal mortality, particularly in the late maternal death period. Late maternal deaths, maternal morbidity, and maternal suicide are not included in MMRs

Despite its exclusion from MMR calculations, suicide is a leading cause of maternal mortality, accounting for 13 to 36 percent of maternal deaths in high-income countries, although few countries systematically collect this data (Lommerse et al., 2024, 2). Maternal suicides typically occur in the later postpartum period, often linked to postpartum depression (Chin et al.,

2022, 241). Information about maternal suicides is often not reported and the numbers are staggering. The Netherlands Society of Obstetrics and Gynecology estimates that as many as 82 percent of maternal suicides in the Netherlands between 1996 and 2025 were underreported (Lommerse et al., 2024, 2). To address global underreporting and misclassification, the WHO recommends classifying maternal suicides within one year postpartum as direct obstetric deaths. France and the United Kingdom (UK) have improved data collection by implementing enhanced surveillance systems, which reveal suicide as the leading cause of death among women in the year following childbirth (Lommerse et al., 2024, 2). In the UK, suicide accounts for an estimated 18 percent of deaths among women between six weeks and one year postpartum (Knight et al., 2018, 14).

Maternal deaths are typically categorized as either direct or indirect obstetric deaths. *Direct obstetric deaths* include the deaths resulting from "obstetric complications of the pregnancy state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above" (Jones et al., 2022, 3). Common direct causes include hemorrhaging, sepsis, hypertensive disorders, eclampsia, prolonged or obstructed labour, and unsafe abortion (Makuei et al., 2020, 2). *Indirect obstetric deaths* result from "previous existing disease that developed during pregnancy, and which was not due to direct obstetric causes, but which was aggravated by physiological effects of pregnancy" (Jones et al., 2022, 3). Examples include anemia, malaria, hepatitis, heart disease, and HIV/AIDS (Makuei et al., 2020, 2).

The WHO (2024b) Mortality Database, which only includes data coded according to the ICD requirements, attributes 75 percent of global maternal mortality to direct obstetric deaths resulting from high blood pressure during pregnancy, childbirth complications, severe bleeding

and infections (mainly after childbirth), and unsafe abortion. Hemorrhaging is the most common cause of maternal death, accounting for approximately 30 percent and causing 127,000 deaths annually worldwide (Makuei et al., 2020, 2). However, it is difficult to differentiate the cause of hemorrhaging in data. Obstetric hemorrhage is any excessive bleeding during pregnancy, labour, or the postpartum period. Other leading causes include hypertensive disorders of pregnancy, sepsis, and complications of unsafe abortion (Lawrence et al., 2022, 2).

Safe abortions meet medical standards, including care by trained health providers, sanitary conditions with adequate sterilization, proper equipment, correct techniques, infection control, and pain management (Hegde et al., 2012, 990). *Unsafe abortions* are performed by individuals lacking the necessary skills or those that take place in environments that do not meet minimum medical standards (Hegde et al., 2012, 990). Unsafe abortions can cause incomplete abortion, sepsis, hemorrhage, seizures, uterine perforation, internal organ damage, psychological trauma, infertility, and death (WHO, 2024a).

When abortions are performed in a well-functioning health system that adheres to WHO standards, abortions rarely result in complications. According to the WHO (2024a), a well-functioning health system requires evidence-based policies, universal health coverage, affordable medical supplies, and enough trained providers who can offer abortion care within an accessible geographical reach. Healthcare professionals are protected from stigma and receive proper training to interpret laws and policies regulating abortion to support patients in safe, respectful and legally informed decision-making. Abortion services should be accessible through both in-person and digital self-managed options, and access to contraception is essential to prevent unintended pregnancies.

The true scope of unsafe abortion-related deaths remains unclear as they are often misclassified due to inadequate reporting systems, legal concerns, and cultural stigma. For example, many unsafe abortion deaths that result in hemorrhaging, either during the procedure or later, are reported as an obstetric hemorrhage as a cause of death. Estimates vary widely, with some research identifying abortion-related deaths as the leading cause of global maternal mortality at 17 percent, while other studies rank unsafe abortion as the fourth most common direct cause at 8 to 14.5 percent (Wong et al., 2022, 834; Ngo et al., 2024; Hall et al., 2023, 1182, Faúndes and Shah, 2015, S56-S57). Other researchers estimate that 30 to 50 percent of global maternal mortality is attributable to unsafe abortions and inadequate post-abortion care (Ndyanabangi et al., 2021, 43).

Although the percentage of unsafe abortions that cause maternal deaths varies across studies, it is a significant factor in the MMR issue. The association of complications arising from unsafe and/or illegal abortions and high maternal mortality is a global public health concern, and restrictive abortion laws do not reduce unsafe abortions (Hall et al., 2023, 1187). The WHO (2024a) states that the proportion of unsafe abortions is significantly higher in countries with highly restrictive abortion laws than in countries with less restrictive laws. Whether abortion is legal or not, women are prone to using all available means to terminate unwanted pregnancies. Therefore, ensuring access to safe abortion is a necessary component of protecting women's health and preventing avoidable maternal deaths.

2.2 International Frameworks Addressing Maternal Mortality

The latest WHO report on maternal mortality explains that when women's rights are protected and they have access to the services and information needed for controlling their own lives and

bodies, unintended pregnancies, unsafe abortions, and maternal deaths decrease, while educational and workforce opportunities increase (2025b, vii). Bodily integrity is a foundational component of Sexual and Reproductive Health and Rights (SRHR), protecting people's physical liberty from direct or indirect government violation (Ngo et al., 2024, 13). Women's rights were first codified into an international human rights treaty in 1979 through the United Nations (UN) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). While not explicitly using the terms abortion or reproductive rights, CEDAW includes ten provisions relating to reproductive health and agency, specifically concerning maternity and family planning, which are widely interpreted as guaranteeing reproductive rights (UN, 2025a). Maternal mortality received little global attention until the 1987 Safe Motherhood Conference in Nairobi, Kenya, marking the first significant international effort to address the issue (Bhalotra et al., 2023, 2177).

A pivotal shift occurred in 1994 at the first International Conference on Population and Development (ICPD) in Cairo, Egypt. The ICPD Programme of Action formally recognized the right to sexual and reproductive health free from coercion, discrimination and violence and formally recognized abortion as a dimension of reproductive rights that should be safely accessible where legal (Gilby et al. 2021, 2). The ICPD shifted global understandings of reproductive rights from CEDAW's focus on family planning and maternity to a more holistic understanding of individual rights and agency. The ICPD reframed abortion as a matter of reproductive rights rather than a moral or religious issue (Adinma, 2011, 246). However, the Programme repeatedly states that abortion should never be promoted as a method of family planning and that governments should help women prevent abortions and eliminate the need for abortions by implementing and expanding family planning services.

The conceptual shift in the understanding of SRHR in global frameworks was strengthened the following year at the 1995 Fourth World Conference on Women in Beijing, China. The Fourth World Conference on Women in Beijing is the largest gathering ever convened on women's issues and the largest attended UN conference to date (Levenstein, 2018, 340). The Beijing Platform for Action declared that it is a woman's right to control their sexuality and reproductive health, requiring countries to review punitive measures against women who undergo illegal abortions (UN General Assembly, 1995, 36). The CEDAW Committee has since reinforced this declaration by linking it to the Committee on Economic, Social and Cultural Rights (CESCR) through its General Comments No. 14 (2000) and No. 20 (2009). These comments interpret the right to the highest attainable standard of health and non-discrimination as requiring states to ensure access to reproductive care and eliminate criminal penalties that disproportionately harm women.

Despite these advancements, the Millennium Development Goals (MDGs) established by the UN in 2000 included only two goals directly addressing women's issues, both defined in limited terms. MDG 3 *Promote Gender Equality and Empower Women,* and MDG 5 *Improve Maternal Health.* MDG 3 had one target and three indicators. Target 3.A aimed to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The three indicators for the goal were the ratios of girls to boys in primary, secondary and tertiary education; the share of women in wage employment in the non-agricultural sector; and the proportion of seats held by women in national parliament.

The original MDG 5 contained only one target and two indicators. Target 5.A aimed to reduce by three quarters, between 1990 and 2015, the global MMR. This target was monitored by the MMR and the proportion of births attended by skilled health personnel, including doctors,

nurses and midwives. Notably, the initial MDG framework did not mention SRHR. After extensive criticism, MDG 5.B was added in 2005 to achieve universal access to reproductive health by 2015. Still, the four indicators for this target were narrow: contraceptive prevalence rate; adolescent birth rate; antenatal care coverage; and the percentage of the population with an unmet need for family planning.

The 2010 MDG Summit outcome document expressed "grave concern over the slow progress being made on reducing maternal mortality and reproductive health" (UN General Assembly, 2010, 4). Consequently, evidence shows that MDG 5 made the least progress out of the goals (Alkenbrack, 2015, 2). Furthermore, the MDGs only applied to Global South countries, reinforcing the misconception that maternal mortality and sustainability are not issues in or responsibilities of the Global North.

In 2015, the MDGs were replaced by the Sustainable Development Goals (SDGs) in the 2030 Agenda for Sustainable Development, which significantly expanded the scope of SRHR in the international framework. Unlike their predecessors, the SDGs apply to all countries and include more comprehensive maternal health and reproductive rights targets. SDG 3 aims to ensure good health and well-being, with target 3.1 focused on reducing the global maternal mortality ratio to less than 70 deaths per 100,000 live births and target 3.7 promoting universal access to sexual and reproductive healthcare. SDG 5 aims to achieve gender equality and empower women, with target 5.6 ensuring universal access to SRHR as agreed in the ICPD Programme of Action and the Beijing Platform for Action. The most recent SDG report explains that although the goals were initially set for the 2015 to 2030 period, following the 15-year MDG period, it is clear that most of the SDGs will not be achieved in the original time frame (Sachs et al., 2024, 4). This shortfall is largely attributed to the COVID-19 pandemic, which caused

significant setbacks across health, education, and gender equality indicators (Sachs et al., 2024, 4). However, additional factors such as armed conflicts, climate-related disasters, economic instability, and persistent global inequalities have also contributed to the lack of progress (Sachs et al., 2024, 4). Therefore, the SDG framework has been remodelled with a long-term planning approach to achieve highly ambitious objectives by 2050.

The goal of ending preventable maternal mortality is guided by a 2014 WHO consensus outlining five priorities: reduce inequities in care access and quality; ensure universal health coverage for reproductive and maternal care; address all causes of maternal mortality and related morbidities; strengthen health systems for women and girls; and enhance accountability to improve care and equity (WHO, 2025b, xiv, 3). Recent years have focused on external factors affecting population health and health system strength, such as the COVID-19 pandemic, climate change, economic and political upheaval, and armed conflicts (WHO, 2025b, xvii).

Despite target 3.1 aiming to reduce the global MMR to less than 70 by 2030, the 2023 global MMR is estimated to be 197. Notwithstanding the 40 percent reduction since 2000, continuing at this pace will only reduce the global MMR to 177 by 2030, far above the target of 70 (WHO, 2025b, xv). At the 77th World Health Assembly in 2024, a resolution was adopted to accelerate efforts toward SDG target 3.1 amid stalled progress. Concerningly, the US is among the four countries with the most significant increases in MMR between 2000 and 2023, alongside the Dominican Republic, Jamaica, and Venezuela. The inclusion of the US in this group suggests profound systemic issues, given that it is a high-income country with advanced healthcare capabilities.

Notably, this rise in MMR occurred well before the 2022 overturning of *Roe v. Wade*. This trend suggests that other structural factors were already contributing to worsening maternal

health outcomes. One plausible explanation is the significant variation in MMRs across US states, particularly given that several states had already implemented restrictive abortion laws or limited reproductive healthcare access during this period (see sections 4.2 and 6.2 below). If states with higher MMRs also had more restrictive abortion policies in place, this would offer an important counterpoint to interpreting MMR as a national average and underscore the need to disaggregate maternal mortality data in federal systems such as the US.

2.3 Abortion Laws and Maternal Mortality: Support for the Theory

This section focuses on establishing the claim that there is a substantial amount of supporting evidence for the theory that restrictive abortion laws are associated with high MMRs and that liberal abortion laws are associated with low MMRs. The case of Romania presents a strong example, where abortion was outlawed in 1966 by its last communist leader, Nicolae Ceaușescu. Within a few years of the criminalization, Romania's MMR increased from 15 to over 140, and reached 170 by 1989 (Faúndes and Shah, 2015, S57). Illegal and unsafe abortion-related complications accounted for 87 percent of these maternal deaths (Benson et al., 2011, 3). However, when Romania liberalized abortion in 1989, the MMR rapidly declined to 75 by 1991 (Faúndes and Shah, 2015, S57). In the 20 years following the liberalization, Romania went from having the highest recorded MMR in Europe at 170 in 1989 to 26 in 2008, which was one of the most substantial MMR declines in the world from 1990 to 2008, alongside Bangladesh, China, Egypt and India (Hogan et al., 2010, 1615, 1620). Other countries that have experienced a notable reduction in MMRs due to abortion legalization include Cambodia (1997), Colombia (2022), Ethiopia (2005), Guyana (1995), Mexico (2023), Nepal (2002), South Africa (1996), and Uruguay (2012) (Latt et al., 2019; Gebrehiwot and Liabsuetrakul, 2008, 86; Briozzo, 2016).

Another important factor to consider is the degree of a country's abortion law liberalization. Latt et al.'s (2019) analysis of 162 countries shows that maternal deaths decline most significantly in countries that move from highly restrictive to broadly legal abortion frameworks, particularly when accompanied by expanded access to safe abortion services and public education efforts. Less drastic liberalizations, such as allowing abortion only to save the woman's life, are associated with less reductions in maternal mortality (Latt et al., 2019, 5).

Briozzo (2016) provides a compelling case study on Uruguay's maternal mortality transition from abortion criminalization to full legalization, dividing 25 years into three distinct phases. The first phase, from 1990 to 2001, reflects the effects of full criminalization, during which the mean MMR was 25, and unsafe abortions accounted for 37 percent of maternal deaths (S5). In response to its commitment to the MDGs, Uruguay began developing a harm reduction model during the second phase (2002 to 2012), which included pre- and post-abortion counselling and medical oversight, even while abortion remained illegal. This period saw the mean MMR drop to 20. Recognizing the limitations of operating within a restrictive legal framework, the government ultimately moved to decriminalize abortion in 2012, marking the third phase. This reform allowed abortion on request during the first 12 weeks of pregnancy, provided certain procedural conditions were met, and led to a further reduction in MMR to 14 within two years. As of 2023, Uruguay reports the third-lowest MMR in the Americas at 15, behind Canada (12) and Chile (10) (WHO, 2025b). However, it is important to note that Chile's abortion law remains highly restrictive, permitting the procedure only in cases of life endangerment, fatal fetal anomalies, or rape. Unlike Uruguay and Canada, Chile's low MMR has been achieved despite minimal legal access to abortion, highlighting the need to examine broader systemic healthcare factors alongside legal frameworks.

Studies that associate increases in abortion access with decreases in maternal mortality are the most common finding in the literature on this relationship. Complementary evidence also demonstrates that reductions in abortion access are associated with increases in maternal mortality, reinforcing the same underlying theory from the opposite causal direction. For example, Hawkins et al. (2020) present a study using data from the US National Vital Statistics System (NVSS) from 2007 to 2015 to explore why the US MMRate is increasingly higher than other high-income countries. Although the present thesis focuses on maternal mortality ratios (MMRs), maternal mortality rates (MMRates) consider maternal deaths in relation to the entire population of women of reproductive age rather than live births, making it a valuable measure for understanding population-level risk. Hawkins et al. (2020, 165) find that states enacting legislation to restrict abortion experienced a 38 percent increase in MMRate. In other words, restricting state abortion laws increases a woman's risk of maternal mortality by nearly 40 percent. Similarly, they find that closing 20 percent of Planned Parenthood clinics, which provide safe abortion services, resulted in an 8 percent increase in MMRate (165). These findings support the argument that reducing the legality of abortion and accessibility of safe abortion service is associated with increases in maternal mortality.

2.4 Abortion Laws and Maternal Mortality: Contrary Cases

Despite rigorous evidence that maternal mortality is higher in places with more restrictive laws, the theory does not always hold (Koch et al. 2012; Songane, 2013). There is some evidence that improving maternal health and drastically decreasing MMR is possible, albeit rare, without legalizing abortion. For example, in 1989, the same year Romania liberalized abortion, Chile became one of the few countries to ban abortion entirely, meaning no legal exceptions. The

government was globally criticized for this decision, given the likely negative consequences for maternal health. However, the predicted impacts did not materialize. Koch et al.'s (2012) analysis reveals that Chile's MMR decreased by 69 percent in the 14 years following an abortion prohibition and 94 percent over a fifty-year period from 1957 to 2007 (1, 8). They argue that the rapid decline in Chile's MMR was primarily driven by improving women's education, access to healthcare facilities, clean water and sanitation infrastructure, and the slope of MMR seemed unaltered by the change in abortion law (Koch et al. 2012, 1).

Koch et al.'s (2012) study period ends before Chile decriminalized abortion in 2017. The decriminalization of abortion was made on three grounds: (i) if the pregnant person's life is at risk, (ii) fetal nonviability, and (iii) rape or incest. Despite the decriminalization, access to abortion remains limited, and the legislative change is estimated to provide a legal option for only 3 percent of the abortions annually (Suárez-Baquero et al., 2024, 190). However, the most recent data shows that Chile recorded the lowest MMR in the Americas at just 10 maternal deaths per 100,000 live births in 2023, outperforming Canada's MMR of 12 (WHO, 2025b). While Koch et al.'s (2012) study period ends in 2007, WHO data shows that Chile's MMR has declined steadily from 24 in 2008 to 10 in 2023. The decriminalization of abortion in 2017 did not lead to a significant MMR reduction, as the MMR was 12 that year (WHO, 2025b). This study provides counterevidence to the Latt et al.'s (2019) findings that more drastic liberalizations lead to greater reductions in MMR.

The contrasting evidence to the widely accepted theory in other studies indicates that improving maternal health and drastically decreasing MMR is possible, albeit rare, without legalizing abortion. Koch et al. (2012, 1, 7) explain that low-income Latin American countries, such as Bolivia, Ecuador, El Salvador, Guatemala, and Nicaragua, also made considerable

progress in reducing maternal mortality during this study period despite having some of the most restrictive abortion laws. At the time, countries with the lowest MMRs, such as Ireland, Malta, and Poland, also had highly restrictive abortion laws. Some of these legal landscapes have changed since 2012. For example, Ireland significantly liberalized its abortion laws in 2018 and maintains a low MMR of 4 in 2023, down from 5 in the year of legal reform (WHO, 2025b).

2.5 Beyond Legislative Explanations of MMR

While Koch et al. (2012, 6) acknowledge that liberalizing abortion is important for improving maternal health, they recognize that law reform must be accompanied by improved accessibility to services, a reduction in stigma towards the services, and public awareness of the law to reduce maternal mortality sufficiently. Other exceptions to the theory are found in the cases of Malaysia, Sri Lanka, and Thailand, where maternal mortality was reduced by 62 to 73 percent between 1960 and 1970 when abortion was criminalized (Songane, 2013, 7). Abortion has been criminalized since 1950 in Malaysia, since 1883 in Sri Lanka, and was illegal in Thailand from 1956 to 2021. The MMR reductions in these cases were made possible by addressing injustices against women, improving women's education, and implementing effective interventions focusing on training midwives to be skilled birth attendants (Songane, 2013, 9). The following section focuses on the additional variables that potentially impact MMRs aside from the legal status of abortion.

2.5.1 Knowledge, Education, Stigma and Access to Services

Even when abortion is legal, many women remain reluctant to seek care because of inadequate education about the law (Mutua et al., 2018, 2). Dibaba et al. (2017, 11) emphasize community

interventions that decrease abortion stigma and increase knowledge of service availability to increase utilization of safe abortion services in facilities and prevent unsafe abortion. Similarly, Briozzo (2016, S1, S5) attributes Uruguay's substantial decline in maternal mortality primarily to reduced abortion-related deaths, noting that societal perceptions and acceptance of abortion evolved alongside legal reform and policy implementation. Legal contradictions can create confusing barriers to accessing safe abortion. For example, although Kenya's 2010 Constitution permits abortion under specific circumstances, the procedure remains criminalized under the 1930 Penal Code inherited from British colonial rule. The Kenyan High Court of Malindi affirmed the Constitutional right to abortion in 2019 and 2022; however, the Penal Code has yet to be amended (CRR, 2023). This unresolved legal contradiction contributes to pregnancy-related mortality being the leading cause of death for women in Kenya (IPAS Africa Alliance, 2016, 14).

Offering the examples of India and Zambia's abortion liberalizations in the 1970s, Latt et al. (2019) argue that legalization alone may be insufficient for lasting change, as the lack of adequate services to supplement laws limits safe abortions. Research consistently shows that legal reform is most effective when paired with policy implementation and sexual and reproductive health education. Sex education covers human reproduction's physiological and psychological aspects (Warzecha et al., 2019), while the WHO (2024a) defines accessibility of information as the availability of evidence-based sex education and accurate, non-biased information on abortion and contraception. Faúndes and Shah (2015, S58) found that induced abortions can be reduced through education and access to effective contraception.

The case of Ethiopia underscores the importance of going beyond solely addressing legal reform; service delivery improvements and stigma reduction are also critical drivers for reducing

MMRs. Ethiopia had one of the world's highest MMRs, with unsafe abortion accounting for approximately one-third of maternal deaths between 1980 and 1999 (Dibaba et al., 2017, 2). In 2005, the Ethiopian Parliament expanded legal access to abortion beyond cases where the woman's life or health was at risk, adding exceptions for pregnancies resulting from rape or incest, cases of severe fetal impairment, and situations where the woman is a minor or has a physical or mental disability (CRR, 2014). Following this reform, abortion-related deaths fell from 32 percent to less than 10 percent within a decade (Feyssa and Gebru, 2022, 2).

However, the reduction was not immediate. Three years after Ethiopia's legal reform, in 2008, access to basic safe abortion care services varied greatly between healthcare facilities, and only 27 percent of abortions took place in health facilities (Dibaba et al., 2017, 5, 2). The number of health facilities providing safe abortion services rose from 25 percent in 2008 to 117 percent in 2014 (Dibaba et al., 2017, 1). By 2014, the percentage of safe abortions increased to 53 percent because of supplementary efforts to improve accessibility and provision of safe abortion care and post-abortion family planning (Dibaba et al., 2017, 2). More women were also informed about how to access safe and legal abortion than in 2008 (Dibaba et al., 2017, 7). However, the 47 percent of abortions that continued outside health facilities suggests that accessibility, limited knowledge of services and legality, and abortion-related stigma in communities remained significant barriers (Dibaba et al., 2017, 10).

2.5.2 Religion, Culture and Politics

Reproductive rights reflect religious beliefs, political ideologies, and socioeconomic backgrounds, with abortion laws typically viewed as political matters with religious overtones (Brandt and Maner, 2024, 111). Hogan et al. (2010, 990) explore how religion impacts abortion

access even when laws are progressive, explaining that despite Cambodia having one of Southeast Asia's most progressive abortion laws, many citizens, including healthcare providers, consider abortion both illegal and a Buddhist sin. In the early 2000s, Latin America and the Caribbean had the highest regional rate of unsafe abortion due to strong social stigma opposing women's rights, particularly the right to terminate pregnancies, resulting from the strong influence of Roman Catholic and Protestant Churches (Briozzo, 2016, S3). However, with recent decriminalization in some Latin American countries, including Argentina, Chile, Mexico, and Uruguay, as well as increased availability of medication abortions, the highest rate of unsafe abortions is now in Central, Western, and Eastern Africa (Ganatra et al., 2017, 2377-2378).

Many religious ideologies centre on the value of fetal life, arguing that fetuses should be afforded the same moral protection from conception as adults (McGee et al., 2018, 595). For example, the Catholic Church's position on the sanctity of life flows from the belief that God creates each person in His image, and each human life is "fearfully and wonderfully made" (Wolk and Snead, 2021, 51). The newly elected Pope Leo XIV expressed that his stance on abortion aligns with the traditional Catholic position, stating that the unborn have inherent dignity as creations of God (Loren, 2025). Religious convictions shape attitudes towards abortion and effectively influence legislation (Deflem, 1998, 797). Furthermore, political conservatism strongly correlates with negative attitudes toward abortion and mobilizes religious ideologies (Brandt and Maner, 2024, 113).

2.5.3 Risk Factors, Socioeconomic and Regional Disparities

The global distribution of maternal mortality remains highly unequal. The highest MMRs are in low-income countries with weak institutions, current or recent war or conflict, and those with

weak or inaccessible healthcare services and facilities. Globally, 94 percent of maternal deaths occur in low- and middle-income countries with inadequate and inaccessible healthcare systems and services (Lawrence et al., 2022, 2). In 2023, Sub-Saharan Africa alone accounted for 70 percent of global maternal deaths, with a regional MMR of 454. The same year, Nigeria accounted for over a quarter of global maternal deaths with an MMR of 993. Together, Nigeria, India, Pakistan, and the Democratic Republic of the Congo accounted for almost half (47 percent) of all maternal deaths in 2023. High-income countries show significant disparities in maternal mortality among socioeconomic groups. Geographic, transportation, and financial barriers to accessing quality reproductive healthcare services result in increased rates of maternal death (Kheyfets, 2023, 1). Mukuru et al. (2022, 2128) found that lack of transportation from home to healthcare facilities is one of the most frequent avoidable factors in maternal death, accounting for 37 percent of maternal deaths in Uganda in 2015 (Mukuru et al. 2022, 2125).

Age is another critical risk factor. Pregnancy and childbirth complications are among the leading causes of death for adolescent girls aged 15 to 19 globally (WHO, 2025b, 55). Adolescents have a higher risk of adverse health outcomes, including anemia, a leading cause of indirect maternal death (Ndyanabangi et al., 2021, 44). In Liberia, adolescents account for approximately 14 percent of maternal deaths (Ndyanabangi et al., 2021, 44). Adolescent pregnancies are closely linked to unsafe abortions, often resulting in maternal mortality (UN Department of Economic and Social Affairs (UNDESA), 2025a). Globally, 55 percent of unintended pregnancies among teenage girls aged 15 to 19 years end in abortions, which are usually unsafe (WHO, 2024b). Early marriage is a key driver of adolescent fertility, as it often initiates early childbearing due to sociocultural expectations surrounding reproduction within marriage. Girls who marry young are more likely to experience early pregnancy, which increases

the risk of maternal complications and mortality. Global efforts to reduce maternal deaths frequently focus on ending child marriage to delay first births and mitigate these health risks (WHO, 2024b).

Abortion access can also be limited by socioeconomic status, racial discrimination, and access to healthcare, including contraception (Kheyfets, 2023, 2). Nehme et al. (2023, 8) find that restrictive abortion state laws in the US result in economic inequity between individuals with the financial means to receive appropriate care (whether legal or illegal) and those of low socioeconomic status who likely resort to unsafe abortion. In the US, the MMR is over three times higher for Black women than for non-Hispanic white women (Wong et al., 2022, 833). Obstetric racism is shaped by the history of medical experimentation on enslaved women (Boakye et al., 2023, 2). The racist belief that Black women have high pain tolerance was used to justify experimental gynecological surgeries without anesthesia (Boakye et al., 2023, 2). In the UK, the risk of maternal death is five times higher for Black women and twice as high for Asian women compared to non-Hispanic white women (Knight et al., 2018, ii).

Unlike the US and UK, few Canadian health agencies collect racial data on women's health, reflecting a 'colour-blind' attitude that masks inequalities (Boakye et al., 2023, 2). While there is limited race-based data on Canadian births, one study finds that 8.9 percent of Black women gave birth to preterm babies, compared to 5.9 percent of non-Hispanic white women, from 2004 to 2006 (Maxwell et al., 2024, E343). Statistics Canada (2024) highlights that "the population with Registered or Treaty Indian status has one of the highest fertility rates among the population with Indigenous identity, estimated at 2.2 children per woman in 2016 compared with the 1.59 for the total Canadian population in the same year." An older systematic review on birth outcomes among Indigenous women, primarily focused on those in Australia, Canada, and the

US, find the factors associated with higher risk of adverse outcomes to be: reduced access to standard prenatal care; inaccurate estimation of gestational age and subsequent complications of post-term pregnancies; pre-existing medical conditions; high rates of multiparity; young maternal age; marital status; and low educational attainment (Shah et al., 2011). Furthermore, Sheppard et al. (2017, 11) explain that birth outcomes among Indigenous peoples are consistently worse than among the non-Indigenous population, yet there is little information at the national level for Indigenous peoples overall. The lack of attention to adverse maternal health outcomes in Canadian health data masks inequalities and limits the ability to address disparities.

Singh (2021, 38) categorizes US women into three socioeconomic groups to examine maternal mortality across demographics, finding that women in the highest socioeconomic status group had a 13.2 MMR, while those in the lowest group had a ratio of 29.1. Women in small rural towns had an 80 percent higher MMR than women in inner cities (33), and mothers in the most deprived areas had a 120 percent higher risk of maternal mortality than those in affluent areas (29). Higher educational attainment is associated with lower MMRs. Non-Hispanic white women with 12 or fewer years of education experience 4.8 times higher MMR than college graduates, while the educational disparity among women of colour ranges between 2.1- and 2.5-times higher risk (Singh, 2021, 32). However, within each educational category, Black women had significantly higher MMR than non-Hispanic white women, with racial disparity most pronounced among college graduates (Singh, 2021, 33).

Brandt and Maner (2024) analyze data from 50 US states, 202 world societies, and 147,260 respondents across the globe to examine whether laws and moral beliefs about abortion are linked to local mortality rates. The study presents evidence that lower levels of mortality risk overall are associated with more permissive laws and attitudes toward abortion (111). More

restrictive abortion attitudes and laws are predicted by higher local mortality rates (117). These associations persisted when controlling for religiosity, political ideology, wealth, education, and industrialization (111). They find a strong link between mortality and restrictive abortion laws when controlling for medium population-level wealth gross domestic product (GDP) per capita and socioeconomic status (117). Higher educational attainment also strongly predicts more positive attitudes toward abortion, directly related to socioeconomic status (Brandt and Maner, 2024, 113). Similarly, industrialization predicts abortion attitudes, as post-industrial countries tend toward more liberal views of sexual and reproductive norms (Brandt and Maner, 2024, 114). However, exceptions exist, as Poland and the US, both post-industrialized nations, have removed legal grounds for abortion in the past decade.

2.6 Literature Review Findings and Research Questions

The literature review reveals that the fundamental question of what explains MMRs cannot be answered through a simple correlation between abortion laws and maternal health outcomes. The findings present three key insights. First, substantial evidence supports the theory that restrictive abortion laws are generally associated with higher MMRs, as demonstrated by Romania's dramatic MMR decrease following liberalization and Uruguay's phased improvement through gradual policy reforms. Second, notable exceptions such as Chile challenge this theory, where MMR decreased significantly following the abortion prohibition. Third, multiple factors beyond legal frameworks, including healthcare system capacity, the availability and accessibility of contraceptives and sex education, socioeconomic conditions, cultural and religious contexts interact to determine maternal health outcomes. Healthcare system capacity plays a crucial role, evidenced by Malaysia, Sri Lanka, and Thailand, which reduced MMR significantly despite

restrictive abortion laws by improving women's education and training skilled birth attendants. Religious and cultural stigma can undermine even progressive abortion laws. Most maternal deaths occur in low and middle-income countries, yet socioeconomic inequities persist even within wealthy nations, highlighting how economic strength does not guarantee maternal health when systemic inequalities remain unaddressed.

The evolution of international frameworks creates a clear expectation that countries will work toward expanding reproductive rights and reducing maternal mortality. The contradiction between global commitments and national laws provides context for understanding the first research question: What explains the abortion law restrictions in Poland and the US? Rather than relying on reductive correlations between abortion laws and maternal health, this study seeks to uncover the underlying institutional and social mechanisms that explain MMR differences. The second question is: What explains Poland's significantly lower MMR (2) compared to the US (17), despite Poland having historically more restrictive abortion laws? Complications arising from unsafe abortion account for a significant portion of maternal deaths, and most unsafe abortions take place in countries with restrictive laws. However, Poland's low MMR, compared to the US, gives reason to explore what factors significantly reduce maternal deaths besides abortion laws. Poland's exceptional status as a country with both highly restrictive abortion laws and extremely low maternal mortality makes it a fascinating case for exploring how healthcare systems, social policies, and cultural contexts interact to protect maternal health even when reproductive rights are restricted. The literature review is referred to throughout the rest of this research to guide the examination of what factors explain Poland's ability to maintain a lower MMR than the US. The following chapter presents the methodological approaches employed in this study.

CHAPTER III: METHODOLOGY

The literature review established three key claims about the relationship between abortion laws and maternal mortality. First, substantial evidence supports the theory that restrictive abortion laws are generally associated with higher MMRs. Second, there are notable exceptions that challenge this theory, indicating that the relationship is not universally applicable. Third, multiple factors beyond legal frameworks interact to determine maternal health outcomes. Many studies identified that increasing women's education levels, reducing cultural and religious stigmas and improving access to quality reproductive healthcare are also key factors in addressing maternal mortality, sometimes even when restrictive abortion laws are in place. These findings motivate the methodological approach and the two interconnected research questions for this study: What explains the abortion restrictions in these cases and why is Poland's MMR lower? This chapter outlines a research design that is tailored to examine these questions through a comparative lens.

The next section provides more justification for the selection of Poland and the United States as case studies. Section 3.2 outlines the Most Different Research Design (MDSD), which further justifies the selection of cases and provides a guide for the legal history analysis in Chapter Four. Section 3.3 explains the analysis conducted in Chapter Five, which examines each case's progress on SDG indicators that related to the maternal mortality-related variables identified in the literature review. Section 3.5 describes how the within-case and comparative analyses in Chapter Six and Seven are informed by the combination of findings from the literature review, the legal history analysis, and the SDG analysis. Finally, section 3.5 highlights the methodological limitations of this study. The limitation section explains how these analyses

are not exhaustive, and the findings only partially explain a broader set of complicated interconnected factors that cannot be fully addressed in this study.

3.1 Case Study Selection and Justification

Poland and the United States are selected as cases for this comparative study for several key reasons. First, they are the only two countries that have removed legal grounds for abortion since the establishment of the SDGs in 2015, moving against the global trend toward liberalization. While there have been other decisions around the world driven by anti-abortion objectives, Poland and the US legally stand apart. Both cases enacted a significant legal mechanism to alter or solidify their abortion laws drastically. For example, in 2022, the Hungarian Parliament, led by Prime Minister Viktor Orbán's Fidesz party, passed a "heartbeat law" aimed at steering women away from abortions. The new Hungarian law requires that women listen to the fetal heartbeat through an ultrasound before continuing the process of obtaining an abortion (Palfi and Askew, 2022). Despite the additional procedural barrier, abortion remains legal in Hungary until the twelfth week of pregnancy, with an extension to twenty-four-weeks in some circumstances. In 2021, the National Congress of Honduras put a legal lock on abortion legalization by requiring that three-quarters of Congress must approve future attempts to legalize abortion. While the Constitutional amendment did not remove legal grounds for abortion, it further solidified the existing ban.

Second, most literature on maternal mortality focuses on low- and middle-income countries, where 94 percent of maternal deaths occur (Lawrence et al., 2022, 2). However, it is important that we learn from the failures of the MDGs, which only applied to countries in the Global South. Historically, the practice of excluding high-income countries in the Global North

from objectives that aim to address global issues has been proven to be insufficient. While the maternal mortality issue in the US MMR is incomparable with the maternal mortality issue in Nigeria, India, Pakistan, or the Democratic Republic of the Congo, each country should be aiming for an MMR of zero, in theory. Although the SDGs do not explicitly set a target of zero maternal deaths, they emphasize the importance of minimizing avoidable mortality. High-income countries, with ample resources and advanced healthcare infrastructure, must be held accountable when they fail to use all available means to meet these global goals. Furthermore, the lack of attention to the persistent maternal mortality issues in the Global North provides more justification for excluding Honduras and Nicaragua from the present study.

Understanding how Poland maintains a low MMR while simultaneously maintaining one of the strictest abortion laws in Europe provides an opportunity to isolate the factors making this possible, beyond the legality of abortion. For policymakers in contexts where abortion liberalization faces political barriers, understanding Poland's success provides a model for improving MMR. Conversely, examining the persistent challenges in the US despite its wealth illustrates how underlying structural inequalities can undermine maternal health regardless of legal frameworks. The selection of the US is particularly methodologically significant, as it is rarely compared in international analyses. By investigating these exceptional cases through a comparative approach, this research contributes to a more nuanced understanding of the relationship between abortion laws and maternal mortality that challenges oversimplified narratives

3.2 Most Different Systems Design

The study employs a Most Different Systems Design (MDSD) to begin addressing the first research question: What explains the abortion law restrictions in Poland and the US? The Most

Different Systems Design (MDSD) is a theory-driven approach to small-N research that serves as a quasi-experimental method (Mills et al., 2010, 3). This design compares cases that differ on most variables except for the one of interest (Y), which in this case is restricted abortion laws post-2015. Originating from John Stuart Mill's logic of causal inference, MDSD functions both as a strategy for case selection and as an analytical framework (Mills et al., 2010, 3). The key to an MDSD is controlling for theoretically important independent variables to test specific hypotheses. The differences in independent variables act as control factors to test whether a similarity (X) these cases share is associated with the dependent outcome variable (Y), post-2015 abortion law restrictions. The five independent variables are grounded in the literature review on maternal mortality and abortion laws, including region, political systems, abortion law category, MMRs and ratification of CEDAW. While the cases differ in numerous respects, truly independent variables in social science research are rare, and variables can intersect and inform one another. The MDSD does not aim to paint Poland and the US as the two most opposite countries possible, such a claim would be false. However, these high-income cases differ on enough major variables to support the claim that they are not entirely similar.

Variable A, geographic region, is the most apparent difference. Region is important because legal, cultural, and institutional norms surrounding reproductive rights vary significantly by geographic context. For example, Eastern Europe has historically exhibited more conservative attitudes toward abortion and gender rights than Western Europe, despite similar regional income levels. The literature also shows that post-industrial Western democracies generally exhibit more liberal abortion laws, though important exceptions, such as the United States and Poland, underscore the need for closer analysis. The histories of North America and Eastern Europe are distinct, and these unique backgrounds have shaped the cultures and societies differently.

Furthermore, Eastern Europe had the most significant regional MMR reduction between 2000 and 2023 (74 percent) (WHO, 2025b). The MMR reduction rate stagnated in most regions from 2016 to 2022 but rose in Latin America, North America, the Caribbean, and Western Europe (UN Children's Fund (UNICEF), 2023). Interestingly, Eastern Europe is more socially, politically and religiously conservative than Western Europe (Pew Research Center, 2018). The literature review reveals that political conservatism is strongly associated with more negative attitudes toward abortion, and restrictive abortion laws are associated with negative maternal health outcomes (Brandt and Maner, 2024, 113; Latt et al., 2019, 5). While abortion is generally legal in Eastern Europe, attitudes towards human rights issues such as abortion and same-sex marriage tend to be more conservative than attitudes in the West.

Variable B is political systems, which have evolved differently due to the unique regional, historical and cultural contexts in these cases. Democratic regimes are generally more responsive to public opinion and international human rights norms and thus more likely to liberalize abortion laws. However, the degree of liberalization often depends on the structure of the political system. The structure of the US political system helps explain why abortion laws can vary by state. For instance, centralized parliamentary systems may facilitate more uniform national policies, whereas federal systems like the United States allow for greater subnational divergence, which can enable state-level abortion restrictions. The United States is a constitutional federal republic characterized by a presidential system, a strong separation of powers between executive, legislative, and judicial branches, and political dominance by two major parties, the Democrats and Republicans. Comparatively, Poland is a parliamentary republic with a multi-party-political system, where executive power is shared between a

President (head of state) and a Prime Minister (head of government) accountable to a bicameral legislature.

Variable C is GDP per capita, from 2024 data represented in United States Dollars (USD) (World Bank, 2025). The literature review shows that a country's wealth is a significant determinant of maternal mortality and that post-industrialized countries tend to have more liberal views of sexual and reproductive norms (Brandt and Maner, 2024, 133, 114). The literature review informs the selection of GDP per capita, rather than GDP. For example, Brandt and Maner (2024) use GDP per capita because it standardizes the economic measure across countries with different population sizes. Since the US population of 340 million is much larger than Poland's population of 38 million, comparing total GDP would be misleading. Poland and the US are considered high-income countries; however, in terms of GDP per capita, Poland is significantly less wealthy than the United States. Poland's 2024 GDP per capita is $25,022.70 USD, while the US reported $85,809.90 USD in 2024 (World Bank, 2025).

The Purchasing Power Parity (PPP) calculation, which shows what the dollar buys in a country, illustrates this economic disparity in practical terms. While GDP per capita (in USD) reveals a 1:3 income gap between the US and Poland, PPP conversion indicates that the cost of living in Poland is significantly lower. For example, a US salary of $100,000 would have the same purchasing power as $50,575.40 in Poland (PPP Calculator, 2025). Despite being poorer on average, Polish citizens may have greater access to key social services, such as universal healthcare and maternal care. Income distribution also plays a critical role. Chapter Five discusses differences in income inequality in Poland and the US drawing from Gini coefficients and Palma ratios. The US experiences far greater inequality, meaning poorer populations are more likely to be underserved. In contrast, Poland's broader access to healthcare services may

help explain its better maternal outcomes, particularly for low-income populations. This significant economic difference is essential as the literature review revealed that economic factors often influence healthcare outcomes and the ability to access services due to financial and geographic barriers.

Variable D is abortion law category. Latt et al. (2019, 5) find that less drastic abortion law liberalizations, such as allowing abortion only to save the woman's life, are associated with less reductions in maternal mortality. The Center for Reproductive Rights (CRR), headquartered in New York City, distinguishes six levels of abortion law categories. They have ranked them from least to most restrictive: (1) On Request (gestational limits vary); (2) Socioeconomic Grounds; (3) To Preserve Health; (4) To Save the Pregnant Person's Life; (5) Prohibited Altogether; and (6) Varies at the State Level—a more ambiguous classification. Poland's abortion law has been in the third category (To Preserve Health) since 1993, and its categorization was unaltered by the 2020 restriction. The US law was in most liberal category (On Request) throughout the *Roe v. Wade* era from 1972 to 2022 and is now in Category 6 (Varies at the State Level). Further details on these legal changes are explored in Chapter Four.

Variable E reflects progress toward SDG target 3.1, which aims to reduce MMRs, a key benchmark of this research. The country-level target is an MMR of 3.4, which is the average of the lowest five members of the Organisation for Economic Co-operation and Development (OECD). According to the most recent SDG report, which uses 2020 data, the US MMR is 21 and progress is stagnating. In contrast, Poland has achieved the SDG target, with an MMR of 2. Poland and the US both fall within the WHO's "very low category" that comprises MMRs under 20 (WHO, 2025b, 35). While the US MMR is considered "very low" from a global perspective, the US has the highest MMR among high-income OECD members. Non-OECD members with

similar MMRs to the US in the 2020 report include Antigua and Barbuda (21), Egypt (17), Iran (22), Lebanon (21), Malaysia (21), Ukraine (17), Uruguay (19), and West Bank and Gaza (20). Comparatively, Poland has one of the lowest MMRs in the world at 2.

Variable F is whether the country has ratified CEDAW, the international bill of women's rights which has been ratified by 187 of the 193 UN member states. CEDAW includes ten provisions relating to reproductive health and agency, specifically concerning maternity and family planning. The US is one of the six UN member states that has not ratified CEDAW, alongside Iran, Palau, Somalia, Sudan and Tonga. Poland ratified CEDAW on July 30th, 1980. The People's Republic of Poland set one reservation upon ratification, which essentially serves as an exemption, to Article 29, paragraph 1, which concerns the settlement of disputes between state parties (UN Treaties, 2025). The People's Republic of Poland declared that it does not consider itself bound by the provision requiring disputes to be submitted to arbitration or, failing that, to the International Court of Justice (ICJ). However, the Government of Poland notified the Secretary-General that it had decided to withdraw its reservation in 1997 (UN Treaties, 2025).

Table 1: MDSD 1

VARIABLES	**UNITED STATES**	**POLAND**
A: Region	North America	Eastern Europe
B: Political system	Constitutional Federal Republic	Parliamentary Republic
C: GDP per capita (USD)	$85,809.90	$25,022.70
D: CRR Legal Change	Category 1 to 6 (2022)	Category 3 to 3 (2020)
E: MMR Progress	Stagnating (21.1)	Achieved (2)
F: CEDAW ratification	NO	YES
X: What explains the restriction?	**?**	**?**
Y: Restricted abortion laws	YES	YES

3.3 Legal History Analysis

The first research question is: What explains the abortion law restrictions in Poland and the US? To address this question fully, Chapter Four provides a legal history analysis of abortion legislation in each case to identify and analyze the cultural, religious, and political factors that have influenced abortion policies over time. Tracing the evolution of abortion laws in Poland and the United States allows for an examination of whether shared factors may account for the parallel trend toward more restrictive policies, despite considerable differences in other political, social, and economic variables. The legal history analysis examines key legislative and judicial decisions, the roles of religious institutions, political parties, and civil society organizations, and the broader sociopolitical contexts in which the restrictive decisions occurred. The common explanatory variable (X) in the MDSD table that explains the shared outcome of abortion restrictions is identified in the legal history analysis. After identifying an explanatory factor of abortion law restrictions, the methodological approaches shift to address the second research question. However, it is important to note that this study does not address every possible factor, and the explanatory variable (X) is only a partial explanatory factor.

3.4 SDG Analysis

Chapter Five employs an analysis of 16 SDG indicators to compare progress in each case as outlined in the SDG data explorer that draws from the 2024 SDG report (Sachs et al., 2024). The SDG analysis approach allows for a detailed examination of how specific aspects of healthcare and education systems in each country might contribute to their respective maternal mortality outcomes, despite both having implemented restrictive abortion policies. By examining indicators where one country significantly outperforms the other, this analysis identifies potential

explanatory factors for the differing maternal health outcomes, thereby guiding the within-case analyses. The selection of indicators is grounded in the literature review, focusing on those related to income inequality, reproductive and maternal health, education and clean water and sanitation.

The literature review finds that MMR disparities within high-income countries are characterized by socioeconomic inequalities, where marginalized populations and low-income women have higher MMRs (Wong et al., 2022, 833; Hoyert, 2025, 1). Furthermore, the literature review identified transportation as a barrier accessing to healthcare services, particularly among low-income populations (Kheyfets, 2023, 1; Mukuru et al. 2022, 2128). Therefore, four of the indicators explored in this analysis relate to income inequality: poverty rates, which assess the share of the population whose incomes fall below half the median disposable income; the Gini coefficient, which measures how income distribution deviates from perfect equality; the Palma ratio, which represents the share of income received by the top 10 percent divided by the share received by the bottom 40 percent; and access to public transportation, measured as the percentage of the population with convenient access to public transit.

Six indicators relate to reproductive and maternal health and healthcare service coverage. First, the maternal mortality ratio. Second, the proportion of births attended by skilled health personnel. Skilled birth attendance reduces MMR because trained health professionals can manage complications during delivery and provide life-saving interventions (Songane, 2013). Third, proportion of women of reproductive age, ages 15 to 49 years, who have their need for family planning satisfied with modern methods of contraceptives. Meeting the demand for family planning with modern methods reduces MMR by preventing unintended pregnancies, which are at higher risk for poor obstetrical outcomes (UNDESA, 2025a). Fourth, the adolescent

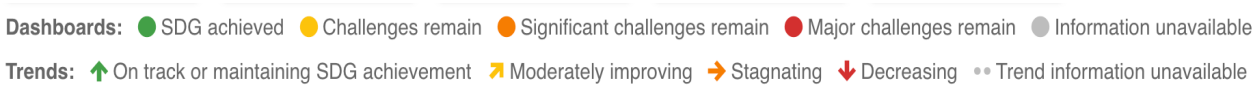
fertility rate, which reflects the number of births (ages 15 to 19) per 1,000 women in that age group, given that age is an MMR risk factor (WHO, 2025a; UNDESA, 2025a). Fifth, the Universal Health Coverage (UHC) index, which is essential to ensure equal access to safe, quality and affordable reproductive and maternal services. The UHC index measures the average coverage of essential health services across four areas: (1) reproductive, maternal, newborn, and child health; (2) infectious diseases; (3) non-communicable diseases; and (4) service capacity and access among both general and disadvantaged populations (WHO and World Bank, 2023). Finally, the percentage of GDP that the governments spend on health and education.

The next two indicators are related to education. As noted in the literature review, US MMRs are higher among women without college degrees (Singh, 2021). First, the percentage of the population, ages 25 to 34, who have completed tertiary education. Second, the percentage ratio of female-to-male mean years of education received is a metric to monitor this target. This percentage is calculated by dividing the mean years of education received by women aged 25 and older by the mean years of education received by men aged 25 and older. The final four indicators relate to clean water and sanitation. Koch et al. (2012, 1) note that clean water and sanitation infrastructure were key factors in Chile's MMR reduction during a total abortion ban. These first two are the percentages of the populations with access to clean drinking water and clean sanitary services. The last two are the percentages of the populations using safely managed drinking water and sanitation services.

The United Nations uses a combination of circle and arrow symbols to track SDG progress (see Figure 1 below). Green circles indicate achievement of a target, while yellow, orange, and red circles represent increasing levels of challenge. Arrows indicate trends, with green arrows showing progress at or above the required rate to achieve targets by 2030, yellow

arrows indicating moderate but insufficient progress, orange arrows indicating stagnating progress and red arrows show declining performance. By revealing the indicators with problematic symbols in either country, this analysis identifies priority areas that may explain maternal mortality differences and guides the direction of the subsequent within-case analyses.

Figure 2: SDG Symbols



Source: Saches et al., 2024

3.5 Intrinsic and Comparative Case Study Analyses

Mobilizing the guidance provided by the findings from the literature review, the legal history analysis, and the SDG analysis, the second research question is further addressed through intrinsic case studies in Chapter Six. These within-case studies focus on healthcare systems, healthcare accessibility and affordability, and socioeconomic determinants of health as key explanatory variables of MMR. The healthcare analysis examines access to safe and affordable reproductive services, such as contraceptives, maternal health policies, and the capacity and prevalence of healthcare providers and facilities. The education aspect of the analysis focuses on women's educational attainment, particularly concerning sex education policies and implementation. The legal history analysis findings reemerge as contextually valuable factors that may influence healthcare and education outcomes related to maternal mortality. Furthermore, the within-case studies take an intersectional approach by examining how the maternal mortality issue manifests through existing social inequalities.

Finally, Chapter Seven presents the comparative analysis of the case studies and offers a discussion that ties the answers to both research questions together. The comparative, controlled approach employed in this study isolates key factors contributing to MMRs in these cases. By identifying which factors most strongly differentiate the cases, this research challenges simplistic understandings of abortion legality and MMR in previous research by explaining how restrictive abortion legislation does not uniformly correlate with higher maternal mortality. The findings presented in the concluding chapters are also valuable for policymakers seeking to improve MMRs in contexts where abortion access is limited.

3.6 Methodological Limitations

Several limitations affect this research design. First, data availability and consistency issues arise from the nature of maternal mortality statistics, which are estimates rather than exact counts. Misclassification of maternal deaths is a significant barrier to obtaining accurate figures, occurring when the underlying cause of death is incorrectly classified due to errors in medical certification or coding (WHO, 2025b, 13). Many countries, primarily those in the Global South, have limited information on maternal mortality levels and causes "due to the lack of adequate vital registration systems and poor certification of causes of death" (Manyeh et al., 2018, 3).

The WHO publishes global estimates of MMR based on statistical models developed by the Maternal Mortality Estimation Inter-Agency Group (MMEIG), which was established in 2004 to standardize measurement methods that previously varied significantly by country and region. The MMEIG, led by the WHO, developed the Bayesian maternal mortality estimation model (BMat) to manage the uncertainty about the varying quality of nationally reported maternal mortality data. Using the BMat model, the MMEIG can adjust and standardize

nationally informed data to provide more accurate, refined assessments based on the quality of data each country provides. WHO MMR estimations are only available from 1985 to 2023, and the estimation methodology is still developing.

The latest WHO report on maternal mortality includes a revised methodology from the previous 2020 report and updated estimates for the years 2000 to 2023 (WHO, 2025b, 16). The updated method combines the Bayesian maternal mortality misclassification (BMis) model for civil registration and vital statistics (CRVS) adjustment and the MMEIG Bayesian maternal mortality estimation (BMat) model. The input datasets for the MMEIG estimates include empirical observations from CRVS, specialized studies such as reproductive age mortality studies (RAMOS), surveys, censuses and other miscellaneous data sources. This updated method provides the most accurate MMR estimations to date.

Another limitation is that MMRs only reflect maternal deaths occurring within forty-two days postpartum, whereas much of the literature suggests that maternal deaths should include those occurring up to one year postpartum. National reporting practices vary, and the ICD encourages countries to record late maternal deaths for national data purposes, though these are not included in international MMR calculations. The US Centers for Disease Control and Prevention (CDC) publishes state-level MMR data from 2022 on the National Vital Statistics System, which provides valuable information for the US case study. Statistics Poland also publishes MMR figures for 2021 and 2022, but without detailed information beyond the numerical values, such as demographic comparisons.

This study examines the 2024 SDG report, which draws from 2020 MMR data that slightly differs from the more accurate 2020 data in the new 2025 WHO MMR report using the improved estimation model. The 2020 MMR report estimated Poland's MMR to be two and the

US MMR to be 21, while the 2025 MMR report estimated Poland's 2020 MMR to be three and the US 2020 MMR to be 22. The new MMR report notes that "due to methodological modifications and data availability, differences between these and previous estimates should not be interpreted as representing time trends" (WHO, 2025b, 16). Most of the present thesis research was conducted before the release of the new MMR reports in April 2025. Therefore, the MMR data discussed in previous studies refers to data from older estimation methodologies. Nonetheless, the fact that the US has a higher MMR than Poland is consistent.

A shortcoming of the SDG analysis is that the data explorer only provides a single data point for each country on each indicator and does not include disaggregated data within country populations. A comprehensive understanding of indicators, such as access to clean water and sanitation, requires further information disaggregated by socioeconomic factors, including race, sex, and region. Additionally, the data explorer does not provide baseline scores for indicators involving population medians, such as the poverty rate. The reasoning is that each country defines its own poverty line, making it difficult to have comparable data. The SDG analysis serves primarily as a guiding baseline and reference for the within-case analyses rather than a systematic evaluation of the factors impacting these scores. While the present study does not contain an exhaustive analysis, it aims to provide a foundation for future researchers to explore the matter in further depth as more data becomes available.

CHAPTER IV LEGAL HISTORIES AND ANTI-ABORTION FORCES

Abortion is a highly emotive issue with multi-dimensional barriers, including social, legal, and physical ones. The contentiousness of the problem is reflected in legislation, the highly politicized morality debate, the monopolized pro-life versus pro-choice debate in the US, religious and cultural dimensions, overarching gender inequality, lack of adequate healthcare, geographic and discriminatory inequities in healthcare accessibility and more. The debate on the legality of abortion neglects the public health consequences and the universal right of women to healthcare and bodily integrity (Ngo et al., 2024, 6). This chapter examines the legal histories of abortion to identify the key forces driving restrictions in each case and answer the first research question: What explains the abortion law restrictions in Poland and the US? This chapter identifies the political, religious, social, and cultural forces that explain the abortion restrictions. The historical context established by tracing the evolution of abortion laws in these cases provides the foundation for understanding how these countries came to restrict abortion against global trends and how their different approaches to reproductive and maternal healthcare may also explain their different MMRs. Exploring the contentious issue of abortion laws over history and across unique political and cultural contexts reveals how the issue is not merely legislative but is deeply intertwined with national identity, religious beliefs, and ideological divisions.

4.1 Legal History of Abortion in Poland

Poland regained independence from the Union of Soviet Socialist Republics (USSR) (or Soviet Union, in short) in 1918 after World War I. At that time, the Polish government adopted laws that reflected a patchwork of foreign penal codes inherited from the Russian, Prussian, and Austro-Hungarian Empires. The first unified Polish abortion law was in the 1932 Penal Code,

which introduced two exceptions, making it one of the most liberal abortion laws in Europe at the time. First, when the pregnancy resulted from a criminal act, including rape, incest, and intercourse with a minor under 15-years-old, and second, if the woman's health or life was endangered. The law required abortion providers to have consent from two other physicians (UNDESA, 2004, 38). In 1939, Nazi Germany and the USSR signed the Molotov-Ribbentrop Pact, agreeing not to attack each other, but rather, divide the countries that lay between them. A few weeks later, the USSR invaded and annexed eastern Polish territories, occupying them until 1941 when Germany attacked the USSR. The only historical period when abortions were available to women on request was during the years of Nazi occupation from 1943 to 1945, given the regime's paradigm of "Social Darwinism" that aimed to exterminate the communities considered "inferior genetic stock" (Eska-Mikołajewska, 2021, 3).

Post-World War II, the USSR regained control of Poland and established a Communist regime that prevailed until the fall of Communism in 1989. The Communist era in Eastern Europe marked a pivotal transformation in political and economic structures, fundamentally reshaping state and societal functions under Soviet influence (Szelewa, 2019, 139). The Communist regime, influenced by the Soviet model of centrally planned social policies, promoted gender equality by creating conditions encouraging women's workforce participation. Among these changes included the introduction of paid maternity leave and establishing state-subsidized childcare facilities (Szelewa, 2019, 140).

Under Soviet influence, Poland's abortion law was further liberalized in 1956 for broader reasons, such as socioeconomic challenges faced by families. During this period, Poland, much as other Soviet bloc countries, provided state-subsidized childcare to support women's participation in the workforce. The *Conditions of Permissibility of Abortion* Act of April 27,

1956, allowed abortion on medical grounds when the pregnancy resulted from a criminal act and when women had “difficult living conditions.” Under this law, abortion was available on request if a woman submitted a statement concerning her life situation (Eska-Mikołajewska, 2021, 4). Although there was no explicit exception for fetal abnormalities, these cases often constituted “difficult living conditions,” which became the grounds for most abortions in Poland (United Nations Population, 2004, 38).

From 1947 to 1989, the Catholic Church positioned itself as a symbol of resistance against the Communist regime, representing hope for Polish independence and preservation of national identity. By maintaining its moral authority and institutional autonomy, the Church positioned itself as a counterweight to state-imposed ideological control, symbolizing the broader struggle for independence within an occupied polity. Beyond its central religious role, the Catholic Church became a central institution in Polish society, influencing culture, society, and politics (Kulczycki, 2023, 2). Although not formally embedded in the constitutional structure, the Church wielded significant informal influence over Polish politics, particularly since the democratic transition. The Church’s dominance among religious adherents enabled it to shape public discourse and policy, especially concerning morality and national identity.

With advice and support from the Catholic Church, the independent Solidarity trade union emerged in 1980. The union established a strong moral opposition to abortion and ‘artificial contraception’, which fostered the growth of several Church-affiliated anti-abortion groups (Kulczycki, 2023, 7). After the fall of Communism in 1989, the Catholic Church no longer monopolized religious and moral discourse in public life (Żuk and Żuk, 2019, 192). However, the Church’s anti-abortion stance continued to have a substantial influence over both public sentiment and government policy (Kulczycki, 2023, 5). The Church’s political influence

grew dramatically as it secured formal recognition in the *1993 Concordat* with the Polish state, which granted it privileges including religious education in public schools and significant impact in political affairs (Żuk and Żuk, 2019, 192; Kulczycki, 2023, 5). The *1993 Concordat* was a bilateral agreement signed between the Holy See (the Vatican) and Poland, laying the foundation for formal Church–State relations in post-Communist Poland. The newly independent Poland built a national identity constructed around notions of endangered exceptionality. The national identity centres on Poland's unique Catholic heritage and traditional values, positioning itself as a defender of these values against perceived secular threats from Western Europe and remnants of communist ideology. The Church fought the secularization of Polish society through political and legal means to solidify its position and has successfully influenced, directly or indirectly, the direction of Polish politics ever since (Żuk and Żuk, 2019, 191, 194).

After the fall of Communism, countries of Central and Eastern Europe generally adopted more tolerant and less punitive approaches to social issues during this transitional period (Fuszara, 1991, 171). However, abortion laws showed a contrary trend. The first free elections in the former Soviet Bloc countries of East–Central Europe were overwhelmingly won by candidates endorsed by the Solidarity Union (Kulczycki, 2023, 8). Therefore, Poland's political and social climate became increasingly influenced by the Catholic Church, which called the 1956 abortion law "criminal" and "Stalinist" (Eska-Mikołajewska, 2021, 5). The Ordinance of April 30, 1990, was issued by the Ministry of Health and Social Welfare, requiring abortion request approval by two gynecologists and a general practitioner, counselling by a State-approved psychologist, and a fee for non-therapeutic abortions (United Nations Population, 2004, 38).

The intensifying pressure for more restrictive regulation in the Solidarity-led government eventually led to the *Family Planning, Protection of the Human Fetus, and Conditions for the*

Permissibility of Abortion Act of January 7, 1993. This law excluded the socioeconomic grounds from the 1956 law that allowed abortion for cases constituting "difficult living conditions" and amended it to provide that "Every human being shall have a natural right to life from the time of his conception." It also granted a person who was damaged before birth the right to seek compensation, although it does not explicitly state from whom (United Nations Population, 2004, 38). Abortion became only permitted in three circumstances: (1) a threat to the woman's life or health, excluding mental health with no time limit; (2) a high probability of severe and irreversible damage to the fetus, which allows abortion up to twenty-four-weeks; and/or (3) if the pregnancy resulted from a crime, which allows abortion up to twelve-weeks. A physician who performed an abortion in violation of the law was subject to up to two years' imprisonment, but a pregnant woman was exempt from punishment (United Nations Population, 2004, 38). The 1993 law retained the requirements of the April 30, 1990, Ordinance requiring approval from multiple doctors.

In response to the increasingly restrictive abortion laws in Poland, abortion referral agencies both within Poland and in neighbouring countries began emerging to help Polish women gain access to services in other European countries (Kulczycki, 2023, 4). In the first year following the 1993 law going into effect, approximately 16,000 women received referrals for abortion services abroad (Kulczycki, 2023, 5). Higher-income women travelled west for better-quality services in Austria, Belgium, Germany, the Netherlands and Sweden, while women with fewer economic resources were referred to clinics in Belarus, the Czech Republic, Lithuania, Slovakia, Russia, or Ukraine (Kulczycki, 2023, 5).

The Catholic Church was a key force in shaping both anti-abortion discourse and the 1993 law. Proponents of the more restrictive law viewed it as a rejection of Communism and a

renewal of traditional Polish values (Koralewska and Zielińska, 2022, 675). The concept of fetal personhood was established through rhetorical shifts by the replacing "the words 'embryo,' 'fetus,' and 'pregnancy' with the new concepts of the 'unborn child,' 'conceived child,' and 'the child in the mother's womb in the rubric of the sharply restrictive 1993 law" (Kulczycki, 2023, 9). Meanwhile, religious instruction on family life education, including the value of conceived life, became mandatory in the Polish school system despite opposition from many secular and liberal groups (Kulczycki, 2023, 9).

The conservative religious ideologies dominating the media during this time made the abortion debate even more polarizing. A study conducted in 2005 found that public support for a more liberalized form of legal abortion between 1992 and 2002 was highest in 1993 after this legal but highly restrictive Act was passed (Jelen and Wilcox, 2005, 302), while simultaneously, anti-abortion protests became more common at hospitals (Kulczycki, 2023, 9). In 1995, Eastern Europe had the highest abortion rate globally. However, as contraception became more widely available and sex education improved following the liberalization of many post-Soviet states, the regional abortion rate dropped by 50 percent by 2008 (Faúndes and Shah, 2015, S57). The reduction in abortion rates demonstrates that liberalized abortion laws reduce abortions when accompanied by comprehensive reproductive healthcare (Faúndes and Shah, 2015, S57).

After leftist President Aleksander Kwaśniewski was elected in 1996, the Polish Parliament briefly reintroduced the condition for legal abortion under "difficult living conditions" until the twelfth week of pregnancy if the woman gave written consent, underwent counselling and then waited three days. The amendment also provided sex education and more affordable contraceptives (United Nations Population, 2004, 38). However, the 1996 law simultaneously set a twelve-week limit for abortions performed on the grounds of health, fetal

impairment or pregnancies resulting from rape or incest. The 1993 law did not specify a time limit for abortions performed to save the mother's health or life. Still, the 1996 liberalization set this at twelve-weeks, and reduced the limit for fetal impairment from twenty-four-weeks to twelve-weeks. Furthermore, the 1996 law heightened the hostility of anti-abortion legislators, religious leaders, and healthcare workers, leading the Constitutional Tribunal to revert the law a year later in 1997, ruling that the expansion was unconstitutional in Article 4a.1 (1-3).

Poland joined the European Union (EU) in 2004 and, three years later, acceded to the Schengen Agreement, which facilitates the free movement of people, goods, services, and capital within the EU. The Schengen framework simplifies access to abortion services abroad, while the increasing availability of affordable European airlines reduces travel costs to hospitals (Kulczycki, 2023, 9). However, anti-abortion religious leaders and legislators continued to emphasize that abortion rejects the traditional family values of the Polish national identity. As a result, public support for abortion rights decreased from 65 percent in 1997 to 45 percent in 2016 (Koralewska and Zielińska, 2022, 675).

In 2015, the conservative political party, Law and Justice Party (Prawo i Sprawiedliwość; PiS), gained control of the presidency and Parliament with 37.6 percent of the vote, which translated into an absolute majority of 242 seats in the 460-seat lower chamber of Parliament, called the Sejm (Parliamentary Elections in Poland, 2015, 1). This electoral success gave PiS unprecedented power to advance its agenda without coalition partners (Kulczycki, 2023, 2). The PiS began an overhaul of the judicial system, and Poland has been facing a rule-of-law crisis ever since (Jaraczewski, 2025). The Constitutional Tribunal comprises fifteen judges, appointed by the Sejm, the lower house of Polish parliament and is led by the president of the tribunal, who the President of Poland appoints from candidates proposed by the judges. After winning the 2015

elections, PiS began to fill the tribunal's bench with openly political appointments, compromising its independence. Two of the judges appointed to the tribunal were former PiS politicians, and its president, Julia Przyłębska, was a close associate of PiS leader Jarosław Kaczyński. Furthermore, three of the judges were appointed unlawfully, as the PiS-controlled parliament ignored the appointments made under the previous administration (Jaraczewski, 2025).

The party worked to restrict abortion further as part of its traditionalist agenda (Kulczycki, 2023, 2). With PiS in power, the emboldened anti-abortion movement started lobbying for a Parliamentary draft initiative to outlaw abortion entirely (Kulczycki, 2023, 11). In 2016, a near-total ban on abortion was proposed, leading to mass demonstrations nationwide known as the "Czarny Protest" (Black Protest), which included a one-day nationwide women's strike (Black Monday) with the marchers dressed in black to symbolize the death of choice and of their futures (Kulczycki, 2023, 11). As a result, the government ultimately decided not to adopt the ban and continued to uphold the 1993 law (Koralewska and Zielińska, 2022, 675).

Four years later, on October 22nd, 2020, Poland's Constitutional Tribunal further tightened the 1993 abortion law despite it already being among Europe's strictest. The European Commission (2023) announced that the Polish Constitutional Tribunal no longer meets the requirements of an independent and impartial tribunal previously established by law due to the irregularities in the appointment of three judges in 2015 and the selection of its President in 2016. The 2020 amendment ruled that the clause permitting abortion due to severe fetal abnormalities through the "difficult living conditions" exception is unconstitutional, which had been the grounds for 98 percent of all legal abortions performed each year (Eska-Mikołajewska, 2021, 8). This decision effectively banned nearly all abortions, leaving only exceptions for the

risk to a woman's life or health or pregnancies resulting from rape or incest, as amended on December 23rd, 1997. Despite 66 percent of surveyed Poles indicating they were in favour of abortion up to the twelfth week of pregnancy, and over 600 doctors nationwide signing a letter to the judges urging them not to ban abortion in cases of fetal impairment (Eska-Mikołajewska, 2021, 10), the ruling went into effect in January 2021. The decision further solidified Poland's status as having one of the strictest abortion regimes in Europe and as one of the two EU member states, alongside Malta, to have highly restrictive abortion laws.

After the 2020 ban, hundreds of thousands of protesters reemerged in the streets, and many "opposed the government's heavy-handed approach, the ruling coalition's domination of all three branches of government, and Church interference in what many perceived as private matters" (Kulczycki, 2023, 12). The ruling's backlash revealed a major gap between public opinion and the PiS's traditionalist agenda, prompting the party leader to state that he would defend churches at any cost and declare that the Church is the "repository of the only moral system commonly known in Poland' and that "rejection of it is nihilism" (13). While the ruling was not widely supported by the public, Polish societal attitudes are markedly less permissive than in much of Europe (1).

The population of Poland is currently around 38 million (World Population Review, 2025). Drawing from recent religious population data, 85 percent of Poles identify as Roman Catholic, 13 percent as unaffiliated, 1.3 percent as Orthodox Christian, and 0.4 percent as Protestant (Office of International Religious Freedom, 2023b; Central Intelligence Agency, 2025). Roughly 85 percent of Poles have been baptized Catholic, the highest percentage in any European country. However, the rates of traditional faith practice are decreasing substantially,

with regular Sunday mass attendance dropping from 50 percent in 1990 to 28 percent in 2021, despite most Poles identifying as Catholic (2, 14).

Some researchers suggest that the movement towards the individualization of religion does not necessarily mean secularization (Żuk and Żuk, 2019, 204). Although the Polish Constitution formally separates the Church and State, the Church's heavy influence on government policy continues through strong informal ties to the PiS and other conservative parties (Kulczycki, 2023, 15). The Church's role has been contested by large segments of Polish society, as evidenced by the widespread protests and survey data showing majority support for more liberalized abortion laws. Poland remains one of the last strongholds of institutional Catholicism in Europe, with the Church enjoying privileges such as tax exemptions, religious education in public schools, and significant political influence. While the process of moving towards an increasingly secularized society and moving away from institutionalized religion has been slow in Poland, these moves nevertheless weaken the Catholic Church's position in Poland (Żuk and Żuk, 2019, 204). However, Catholic moral beliefs continue to guide, directly or indirectly, the traditional family values of the political right that restrict abortion through legal tenets of fetal personhood.

Amid heightened tensions over abortion access, pro-abortion activists in Poland have demonstrated increased solidarity, strategically navigating legal grey areas to assist those seeking medication abortions (Kulczycki, 2023, 18). Medication abortion drugs like mifepristone and misoprostol can be ordered online from other EU countries and providing information on how to obtain and use abortifacients remains legal (Kulczycki, 2023, 18). Poland's current law criminalizes abortion providers but not individuals who self-manage their abortions (Kulczycki, 2023, 18). Underground networks and abortion referral programs have developed to help Polish

women access these medications despite the legal restrictions (Kulczycki, 2023, 16). In 2023, a co-founder of the Abortion Dream Team, an activist group helping women access drugs to facilitate terminations abroad, became the first person in Poland, and Europe, to be convicted for assisting in a medication abortion (Kulczycki, 2023, 18).

In 2019, the Ministry of Health reported 1,110 legal abortions (Kulczycki, 2023, 15). However, estimates continue to suggest that about 150,000 Polish women terminate pregnancies every year, and the actual number is now even more difficult to estimate due to the increased resort to medication abortion (Kulczycki, 2023, 15). The first reported death attributable to Poland's tightened abortion law occurred in 2021, when a pregnant woman died of septic shock after doctors delayed intervention during premature labour (Kulczycki, 2023, 17). Despite diagnosing a severe fetal anomaly and the absence of amniotic fluid weeks earlier, physicians withheld treatment until the fetus no longer showed signs of life, due to legal constraints. The woman's final text to her family warned, "My life is in danger. They cannot help if the fetus is alive thanks to the anti-abortion law. A woman is like an incubator" (Kulczycki, 2023, 17). Her death sparked nationwide protests. The hospital maintained that its staff acted within legal boundaries and did everything possible to save her (Kulczycki, 2023, 17).

4.2 Legal History of Abortion in the United States

In the United States, the first abortion criminalization campaign was launched shortly after the American Medical Association (AMA) was formed in 1847 by its 95 percent male members (Planned Parenthood, 2025). By 1880, all states had laws to restrict abortion, and by 1910, abortion was illegal in every state, with minimal to no exceptions. In 1930, unsafe, illegal abortions were the cause of nearly one in five maternal deaths (Gold, 2003, 8). In the 1950s and

1960s, estimates of the number of illegal abortions ranged from 200,000 to 1.2 million a year (Gold, 2003, 8). In 1966, nine doctors in California, known as the San Francisco Nine, were sued for performing abortions on women who had been exposed to rubella, a disease known to cause congenital disabilities (Planned Parenthood, 2025). Doctors, including the deans of 128 medical schools nationwide, came to their defence. As a result, California amended its prohibition to allow hospital committees to approve requests for abortion (Planned Parenthood, 2025). By 1973, Alaska, Hawaii, and Washington had included more exceptions for abortion, and New York had legalized it entirely, resulting in out-of-state women accounting for two-thirds of the abortions being performed in the first two years of legalization (Planned Parenthood, 2025). These states were part of a broader national reform movement between 1967 and 1973. Thirteen other states enacted laws expanding abortion exceptions to include threats to physical or mental health, fetal abnormalities, or cases of rape and incest (Planned Parenthood, 2025). Although the majority of states had not fully legalized abortion, by the early 1970s, nearly every state was engaged in efforts to liberalize or reform existing laws.

The case of *Roe v. Wade* began in 1970 when Plaintiff Norma McCorvey, protecting her identity with the name "Jane Roe," instituted federal action against the district attorney of Dallas County, Henry Wade. When *Roe* was prevented from obtaining an abortion due to Texas's abortion ban, she presented her case on the grounds of rights violation. On January 22nd, 1973, the US Supreme Court, consisting of all male justices, voted 7–2, ruling that the unduly restrictive state regulation of abortion is unconstitutional. Justice Harry Blackmun and the Court agreed that the Texas statutes that criminalized abortions violated women's constitutional rights to privacy. The Supreme Court recognized that the constitutional right to privacy was broad enough to encompass a woman's decision whether to terminate her pregnancy. The Court ruled

that abortion is a fundamental right for a woman's life and future, protected by the Constitution. During the first trimester, the decision was left entirely to the pregnant woman and her physician. In the second trimester, the state could regulate abortion procedures in ways reasonably related to maternal health. After fetal viability, which is estimated to occur near the end of the second trimester, the state could restrict or prohibit abortion, except when necessary to preserve the woman's life or health. This framework effectively guaranteed access to safe and legal abortion until around twenty-four-weeks of pregnancy, when a fetus might survive outside the womb.

In 1976, just three years after *Roe v. Wade* was decided, Representative Henry Hyde passed a restriction in Congress that eliminated the use of federal funding, specifically Medicaid funding, for abortion except in limited cases such as rape, incest, or when a woman's life was endangered by her pregnancy known as the "Hyde Amendment" (Ernst et al., 2004, 766). Since its introduction in 1976, the law has been annually renewed. The women most impacted by the Hyde Amendment are those of lower socioeconomic status and often marginalized racial groups who rely on Medicaid for their healthcare. The same year, the Supreme Court saw *Planned Parenthood of Central Missouri v. Danforth*, which challenged a Missouri abortion law requiring written consent from the pregnant woman, her husband, or her parents, and the Court ruled that these provisions violated a woman's right to make her own decisions (Planned Parenthood, 2025).

In 1979, religious leader Jerry Falwell Sr. formed the Moral Majority political organization to advance US conservative social values in response to the social and cultural transformations that occurred in the US in the 1960s and 70s (Britannica, 2025). Christian fundamentalists were alarmed by the numerous developments that, in their view, threatened to undermine the country's traditional moral values. These included the civil rights movement, the

women's movement, the LGBTQ+ movement, the increasingly permissive sexual morality prevalent among young people, and increasing legal rights for abortion (Britannica, 2025). This coalition successfully positioned abortion as a central moral issue that defined conservative political identity (Britannica, 2025). By the 1980s, opposition to abortion had become a litmus test for Republican candidates, cementing the party's alliance with religious conservatives. Although the Moral Majority disbanded in 1989, it helped establish the religious right as a force in US politics. Political conservatism in the US and specifically support of the Republican party, is strongly associated with more negative attitudes toward abortion (Brandt and Maner, 2024, 113).

The United States has been the world's largest government funder of global health, that is, until the Trump administration announced a series of massive funding cuts in 2025. In 1984, President Ronald Reagan's administration implemented a foreign anti-abortion policy called the Mexico City Policy, which is now known as the Global Gag Rule. The Global Gag Rule prohibits non-governmental organizations that receive US healthcare funding from performing, promoting, or even referring to abortion as a method of family planning (Giorgio et al., 2022, 266). Reagan initially justified this policy as an extension of the Hyde Amendment, arguing that if the US government would not fund abortions for its own citizens, then US funds should not fund abortions for citizens of other countries. Since its initial implementation in 1984, the policy has been rescinded by every Democratic president and reinstated by every Republican president. President Bush's reinstatement of the Global Gag Rule in 2002 eliminated 34 million dollars in funding for the United Nations Population Fund (UNFPA). With this amount of money, the UNFPA (2004) estimates that it could have funded the prevention of two million unwanted

pregnancies, nearly 800,000 abortions, over 77,000 infant and child deaths, and 4,700 maternal deaths.

In light of the Trump administration dismantling the US Agency for International Development in 2025, all family planning grants previously administered by the agency have been terminated (Sully et al., 2025). The US Agency for International Development spent nearly $40 billion on global assistance annually, largely for health programs, and was one of the largest providers of family planning services worldwide (Bhutta et al., 2025, 67). The United Nations warns that the loss of funding could undo progress in reducing deaths in pregnancy and childbirth, particularly in war zones, and that the aid cuts could have "pandemic-like" effects on maternal deaths (Lay, 2025). Furthermore, the global consequences of healthcare funding cuts are being mirrored domestically, as Trump's legislation effectively gutted funds to Planned Parenthood. Although the courts are actively trying to block the defunding of Planned Parenthood, abortion access could be jeopardized even for those living in states where abortion is legal (Benner et al., 2025).

In 1992, the landmark case *Planned Parenthood of Southeastern Pennsylvania v. Casey* reaffirmed that the Constitution protects the right to abortion. The Court examined a Pennsylvania law that required informed consent, parental consent for minors, a twenty-four-hour waiting period, and spousal notification before getting an abortion. While the Court struck down the spousal notification requirement, it upheld the other three provisions, finding they did not constitute an "undue burden" on abortion access. In doing so, *Casey* created the "undue burden" framework, which established that laws restricting abortion access would be unconstitutional only if they placed substantial obstacles in the path of a woman seeking an abortion before fetal viability. This standard gave states more leeway to regulate abortion than

they had under *Roe* by establishing a less stringent test than the strict scrutiny standard previously applied. The ruling also shifted the focus from *Roe's* trimester framework to one based on fetal viability, maintaining that states could not ban abortion before viability but could regulate it if those regulations did not create an undue burden.

During the 1990s, conservative legislators introduced numerous bills banning intact dilation and extraction, a surgical procedure used for late-term abortions and to remove intact fetuses after miscarriages, until they were vetoed by Democratic President Bill Clinton (Jelen and Wilcox, 2005, 298). Conservative politicians successfully reframed the abortion issue using graphic descriptions of the procedure, adopting the anti-abortion movement's label of "partial birth" abortion (Jelen and Wilcox, 2005, 301). With a signature from Republican President George W. Bush in 2003, Congress passed the Partial-Birth Abortion Ban Act again. The Supreme Court upheld the ban in 2007 with *Gonzales v. Carhart* and *Gonzales v. Planned Parenthood Federation of America.* This federal legislation was the first to criminalize abortion, allowing Congress to ban certain second-trimester abortion procedures that are often the safest method for the patient. The bill does not contain an exception for the patient's health. Therefore, a key component of *Roe v. Wade* was overruled, namely that the patient's health must be of paramount concern in laws that restrict abortion access.

In the 2010s, states began enacting Targeted Regulation of Abortion Providers (TRAP) laws, which are regulations that limit the number of abortions performed in a state and the number of facilities that are authorized to perform abortions. In 2013, Texas enacted the House Bill 2 TRAP law despite 80 percent of Texas voters opposing the bill. Over the next three years, as a result, half of Texas's abortion providers were forced to close (Planned Parenthood, 2025). On June 27th, 2016, the Supreme Court ruled 5-3 in *Whole Woman's Health v. Hellerstedt* that

the 2013 TRAP laws in Texas were unconstitutional, reaffirming the constitutional right to access legal abortion. On January 23rd, 2017, just three days after Republican President Donald Trump was inaugurated, he reinstated the Global Gag Rule and expanded it for the first time in history. Throughout his first Presidential term, he nominated three anti-abortion conservative judges to the Supreme Court, solidifying an anti-abortion majority and sticking to his promise to appoint judges who would overturn *Roe v. Wade*. By 2021, Iowa, Georgia, and Texas had six-week bans, and Alabama enacted a near-total ban with no exceptions for rape or incest (CRR, 2025a).

On June 24th, 2022, with the release of the *Dobbs v. Jackson Women's Health Organization* decision, the Supreme Court overruled *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, revoking constitutional protections for abortion under the right to privacy. The Center for Reproductive Rights and its partners brought the case challenging Mississippi's ban on abortion on behalf of *Jackson Women's Health Organization*, the only remaining abortion clinic in the state. The decision not only allowed Mississippi's ban to take effect but also ended the federal protections for abortion under the constitutional right to privacy, meaning that it is the states' jurisdiction to decide how abortions are restricted or banned entirely. Thirteen Republican-led states had "trigger laws" that would automatically kick in to issue an immediate ban on abortions when *Roe* was overturned. Before overturning *Roe*, the United States already had the highest MMR among high-income OECD members, with Black women almost three times more likely to die from pregnancy-related complications than non-Hispanic white women (Gunja et al., 2022; Wong et al., 2022, 833). Estimates of the increase in maternal mortalities because of the Supreme Court's landmark decision are potentially an overall 21 percent increase and a 33 percent increase for Black women (Kheyfets, 2023, 2).

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (2022), concerns grew that other rights grounded in substantive due process could also be at risk, particularly access to contraception. Justice Clarence Thomas's concurring opinion specifically called for the Court to revisit precedents such as *Griswold v. Connecticut* (1965), which established the constitutional right to contraception. In response, congressional Democrats introduced the Right to Contraception Act (2022) to codify a federal right to obtain and use contraceptives, including oral contraceptives, condoms, emergency contraception, and intrauterine devices (IUDs). The bill also sought to protect healthcare providers' ability to offer contraceptive services and to prohibit states from enacting laws that restrict such access (US Congress, 2022a). Although the Act passed in the House of Representatives, it failed to advance in the Senate due to insufficient bipartisan support (Felix et al., 2024b). Prior to the Right to Contraception Act, other pro-choice legislations that were introduced in Congress were also blocked, such as the Women's Health Protection Act (2022) and the Equal Access to Abortion Coverage in Health Insurance Act (2019) (US Congress, 2022b; US Congress, 2019). These legislative failures illustrate the broader vulnerability of reproductive rights in the post-*Roe* era and signals the potential for future legal challenges to contraception access in politically conservative states, particularly in Republican states.

Nearly a year after the *Dobbs* decision, a survey found that 62 percent of adults in the United States said that abortion should be legal in all or most cases, while 36 percent said it should be illegal in all or most cases (Diamant et al., 2024). During the 2024 federal election, which resulted in President Donald Trump returning for a second term in office, ten states held referendums on whether abortion should be enshrined in their state constitution. As a result, 52 percent of voters in Missouri voted in favour of an amendment to protect reproductive freedom

in the state constitution, and the Court held that the state's trigger ban and other abortion restrictions were unconstitutional, making them the first state to reverse a total-ban (CRR, 2025a). However, this reversal has been actively contested by the Missouri State Legislator and the Missouri State Attorney General throughout 2025, which led to the Supreme Court of Missouri overturning the referendum in May 2025 (Keller, 2025). However, this court decision has now been overturned by a Circuit Court decision, reinstating the referendum (Keller, 2025). There is a now a movement to have another referendum on the 2026 ballot that would restrict abortion.

In Arizona, 62 percent voted on their ballot to approve the establishment of a fundamental right to abortion and increased the gestation limits from fifteen to twenty-four-weeks, repealing the pre-*Roe* ban (Sherman et al., 2024). In March 2025, an Arizona judge permanently blocked the previous fifteen-week abortion ban, declaring it unconstitutional under the 2024 voter-approved amendment (CRR, 2025b). New York passed a measure prohibiting discrimination on "pregnancy, pregnancy outcomes, and reproductive health with 62 percent of voters in favour" (Sáez, 2024). In Nevada, 64 percent voted in favour of an amendment to constitutionally protect abortion rights in the state and uphold its legality, which requires a second vote in 2026 to be effective (CRR, 2025a). Maryland (75 percent), Colorado (62 percent) and Montana (58 percent) also voted in favour of enshrining abortion rights in state constitutions and upholding its legality (Sherman et al., 2024).

However, Florida, Nebraska and South Dakota did not experience such victorious outcomes. Despite the majority (57 percent) of Florida voters supporting an amendment to roll back the state's six-week ban by adding the right to an abortion until viability, the bill required 60 percent to pass (Sherman et al., 2024). Nebraska had two ballot measures: the first would

enshrine the right to abortion until viability, which failed with 49 percent of votes in favour, and the second would enshrine the current twelve-week ban, which passed with 55 percent of votes in favour (Sherman et al., 2024). An anti-abortion group called Choose Life Now is trying to ban abortion outright with a new ballot to amend the Nebraska Constitution, which would require signatures from at least 10 percent of Nebraska voters (Salinas, 2025). South Dakota voters rejected a proposal to add protections for abortion rights during the first trimester in the state constitution, with 41 percent of votes in favour, and the outcome upholds that performing an abortion when the life of the mother is not at risk is a felony offence (Sherman et al., 2024). As of 2025, abortion is now illegal, heavily restricted or unprotected in twenty-six states, and the number of patients that are travelling out of state for abortion has doubled to 1 in 5 since 2020 (CRR, 2025a; Forouzan and Mariappuram, 2024). In 2023, it was estimated that 11.3 million US individuals must travel over an hour to reach the nearest abortion clinic (Kheyfets, 2023, 2).

Political conservatism in the United States, and specifically support of the Republican party, is strongly associated with more negative attitudes toward abortion (Brandt and Maner, 2024, 113). In addition, religious groups mobilizing against legalized abortion influence state abortion policies (Deflem, 1998, 795). For example, conservative Protestants have shaped abortion policy indirectly through public opinion (Deflem, 1998, 795). The Catholic church has directly influenced the passing of more restrictive abortion statutes through lobbying (Deflem, 1998, 795). In 2016, Evangelicals obtained abortions at half the rate of all women, and women with no affiliation at nearly double the rate of all women (Frohwirth et al., 2018, 381).

As of 2025, the US population is approximately 340 million. Of that population, 62 percent identify with a Christian denomination, namely Evangelical Protestant (23 percent) and Catholic (19 percent), with various other Christian denominations making up approximately 20

percent (Pew Research Center, 2025). Additionally, about 2 percent of US citizens identify as Jewish, a group that has traditionally supported abortion rights based on religious teachings that prioritize the life and health of the mother (National Council of Jewish Women, 2025). Most women in the United States are religious, and most major religions in the United States doctrinally disapprove of abortion. Both religious affiliation and the experience of having an abortion are common in the US, with one in four women having an abortion by the age of 40 (Kheyfets, 2023, 2).

Abortion laws and debates in the United States are particularly politicized. The topic is a leading voting cue, and abortion rights are associated with the liberal ideologies of the Democratic Party. Religious affiliation shaped voting patterns in the 2024 US presidential election, intersecting with gender, education, and region. Voters in the Deep South tended to be more conservative and racial minorities are concentrated in that region (Keefe et al., 2021). A ten-point gender gap emerged, with 45 percent of women and 55 percent of men voting for Trump (Center for American Women and Politics (CAWP), 2024). Among non-Hispanic white voters, 60 percent of men and 53 percent of women voted for Trump (CAWP, 2024). Black women were the strongest Democratic base, with 92 percent voting for Harris compared to 77 percent of Black men (CAWP, 2024). Among Hispanics, 57 percent of women and 44 percent of men voted Democrat (CAWP, 2024). Harris also saw more support from college-educated non-Hispanic white women (58 percent) and men (48 percent), while Trump drew 63 percent of non-college-educated non-Hispanic white women and 69 percent of men in the same category (CAWP, 2024).

Trump received 56 percent of the votes from self-identified Christians, who made up 72 percent of the electorate in the 2024 election (Cultural Research Center, 2024). Among non-

Hispanic Black US citizens, only 3 percent identify as atheist or agnostic (Pew Research Center, 2021a). However, Harris received votes from 86 percent of Black protestant voters in the election, surpassing the 77 percent who voted for Biden in the previous election (Smith, 2024). Non-Hispanic White born-again or Evangelical Protestant women backed Trump by 80 percent, with men showing even higher support. In contrast, 80 percent of non-religious non-Hispanic white women, 89 percent of Jewish women, and 69 percent of Jewish men voted for Harris. Jewish women were 21 points more likely to vote Democrat than Jewish men (CAWP, 2024). Harris won 65 percent of Jewish voters and 85 percent of atheists (Smith, 2024). Catholic voters were racially split, with 61 percent of non-Hispanic white Catholics supporting Trump, while 66 percent of Hispanic Catholics supported Harris (Smith, 2024).

Trump leverages Christian symbolism and rhetoric to advance his political objectives, appealing to religious constituencies while demonstrating a limited adherence to the foundational tenets of the faith (Cambridge, 2024, 79). His public displays, such as posing with a Bible despite infrequent church attendance and minimal scriptural literacy, suggest a performative rather than substantive engagement with Christianity (Cambridge, 2024, 79). Trump supporters view him not merely as a political leader, but as a figure who embodies their values and aspirations (Cambridge, 2024, 77). Trump's false representation of Christianity distorts its message for partisan purposes and aligns with the broader rise of Christian nationalism, which threatens the neutrality of democratic institutions and erodes religious freedom by conflating political authority with religious identity (Cambridge, 2024, p. 79, 81).

Catholicism, certain branches of Protestantism, and other forms of religious fundamentalism are associated with negative attitudes toward abortion (Brandt and Maner, 2024, 113). In the 2024 election, Catholics were slightly more likely than Protestants (23 percent

versus 19 percent, respectively) to mention abortion as a dominant decision-making issue (Cultural Research Center, 2024). Overall, the significance of abortion as a key voting cue rose from 13 percent in 2020 to 23 percent in 2024 (Cultural Research Center, 2024). However, organizations such as Catholics for Choice argue that 63 percent of US Catholics believe that abortion should be legal (Catholics for Choice, 2025).

In the US Congress, 99 percent of Republicans and 78 percent of Democrats identified as Christian in 2021 (Pew Research Center, 2021b). Although most Democrats in Congress are Christian, religiosity does not necessarily align with anti-abortion views. Only one member, a Democrat, was unaffiliated, while nearly all non-Christian members were Democrats, except for two Jewish Republicans and one unresponsive Republican (Pew Research Center, 2021b). The 78 percent majority of Christian Democrat members of Congress shows that religiosity and anti-abortion views are not mutually exclusive.

4.3 The Forces of Abortion Law Restrictions

Tracing the legal histories of abortion in Poland and the United States reveals the profound influence of religious, political, cultural, and social forces in shaping reproductive legislation. In both cases, the key explanatory variable for abortion restrictions is the strategic use of politically mobilized religion, which involves the deliberate transformation of theological beliefs into organized political action with specific legislative goals. While the mechanisms differ, the outcome is similar in both cases, as religious moral frameworks are actively translated into policy.

In the US, politically mobilized religion is largely driven by alliances between conservative politicians and evangelical or fundamentalist leaders operating outside of

centralized religious hierarchies. However, the identification of politically mobilized religion as a process in the US is hampered by a very clear separation of Church and State in the Constitution, which was included precisely to combat politically mobilized religion. Nonetheless, conservative political leaders co-opt religion in ways that serve their agendas. In Poland, this mobilization has been led by formal religious institutions, particularly the Catholic Church, which plays a centralized and institutionalized role in public life. Poland is much more homogenous than the US in religiosity, and its abortion restrictions are unaligned with other predominantly Catholic countries in the region where abortion is legal, such as Italy, which had a different political history on the path to democracy. Although the cases differ in structure and context, this analysis finds politically mobilized religion to be the most compelling partial explanation for the recent abortion restrictions in both countries.

In Poland, the public debate about abortion has focused on the overarching issue of the role of the Catholic Church in politics (Jelen and Wilcox, 2005, 315). Politically mobilized religion manifests through the Catholic Church's strategic positioning as both a defender of Polish national identity and a formal political actor. The Church deliberately leveraged its historical role in opposing Communist rule to establish formal influence through the *1993 Concordat*, securing privileges including religious education in public schools and significant impact in political affairs. This position enabled the Church to frame abortion restrictions as a rejection of the Communist era and a return to "traditional Polish values." The political mobilization of Catholicism created powerful mechanisms for translating religious doctrine into legislative outcomes, particularly through its close alliance with the Law and Justice Party (PiS).

In the US, as in Poland, there is a strong connection between individual religiosity and negative abortion attitudes (Frohwirth et al., 2018, 381). In 2025, 29 percent of US citizens

identified as religiously unaffiliated, compared to just 13 percent in Poland (Central Intelligence Agency, 2025). While no single religious institution has dominated US politics in the way the Catholic Church has influenced Poland, the rise of the Religious Right has significantly shaped US abortion politics. The Republican Party of the Nixon era was not particularly driven by religious concerns when *Roe v. Wade* was decided in 1973.

The political landscape shifted dramatically with the emergence of the Religious Right in the late 1970s. Central to this movement was the Moral Majority, an umbrella political organization composed of conservative Christian political action committees. These committees could endorse candidates and provide financial support, enabling the Moral Majority to merge conservative religious beliefs with broader conservative political ideologies. The Moral Majority advocates for traditional family values, which include the issue of abortion amongst other issues, such as same-sex marriage. Although the Republican party was once moderate on most women's equality issues, Republicans have become increasingly pro-life and opposed to the feminist agenda since the 1980s (Morgan, 2006, 140). While not accountable to any particular religious institution, the Moral Majority reshaped the Republican Party by elevating opposition to abortion as a litmus test for electoral support and advancing a broader agenda of social conservatism (Williams, 2010, 33). Religious conservatives also gained political leverage through their ability to turn out voters at the polls (Morgan, 2006, 140). By the 1980s, the influence of religiously motivated voters had become central to Republican identity, despite the party's primary function as a political entity with distinct positions on trade, governance, and other non-religious issues. Because it operated outside formal religious hierarchies, the Religious Right was able to circumvent constitutional barriers between Church and State, fundamentally transforming the party. As a result, there are now very few moderate Republicans remaining.

While the abortion restrictions in Poland and the US are not uniform, politically mobilized religion has provided similar motivations and justifications for the restrictive abortion legislation proposed by right-wing politicians in each case. However, it is important to note that not all adherents of these faiths oppose abortion rights. In Poland, this is reflected in the religious consensus and abortion attitude surveys. In the US, this is reflected in the fact that abortion is one of the most common medical procedures performed, whether through surgery or medication. Furthermore, organizations such as Catholics for Choice (2025) argue that most US Catholics are pro-choice. In the US Congress, 78 percent of Democrats identify as Christian, demonstrating that religious identity alone does not determine abortion policy positions. Furthermore, neither case directly recognizes institutionalized Christianity in their constitutions. What distinguishes these cases is not the prevalence of religious belief itself, but the specific political mobilization of religion by actors who insist their religious beliefs should become the law of the land.

Table 2: MDSD 2

VARIABLES	**UNITED STATES**	**POLAND**
A: Region	North America	Eastern Europe
B: Political system	Constitutional Federal Republic	Parliamentary Republic
C: GDP per capita (USD)	$85,809.90	$25,022.70
D: CRR Legal Change	Category 1 to 6 (2022)	Category 3 to 3 (2020)
E: MMR Progress	Stagnating (21.1)	Achieved (2)
F: CEDAW Ratification	NO	YES
X: **Politically mobilized religion partially explains variable Y.**	**YES**	**YES**
Y: Restricted abortion laws	YES	YES

The first research question is: What explains the abortion law restrictions in Poland and the US? The analysis in this chapter finds that the political mobilization of religion follows different institutional pathways in each country. Tracing the legal histories in each case has revealed that both recent abortion law restrictions were driven by politically mobilized religion, particularly of Christian denominations, which is the explanatory variable (X), as depicted in Table 2 above. However, the analytical findings do not fit into the concept of "politically mobilized religion" neatly, due to the political, demographic, and religious differences of the two cases. The Polish population is predominantly Roman Catholic, while Christians of various denominations comprise the majority in the United States. While these restrictions are shaped by different histories and numerous intervening factors, politically mobilized religion is a partial, yet impactful, explanatory variable of the restrictions in both cases.

Having established politically mobilized religion as a common explanatory variable of the abortion restrictions in both countries, a compelling paradox emerges that motivates the second research question: What factors explain why Poland's MMR is considerably lower than that of the US despite its history of stricter abortion laws? The conventional theory suggests that restrictive abortion laws lead to higher maternal mortality ratios, yet Poland maintains one of the world's lowest MMRs (2), which was also ten times lower than the US in 2020 (21). When considering that at the time the 2020 MMR data was collected, the US still had broader legal abortion access under Category 1 (abortion on request), while Poland was already operating under Category 3 (to preserve health). However, access to abortion was not uniform across the US, with variable parameters around the "request" aspect. Nonetheless, the US had constitutionally protected abortion access for nearly 50 years through *Roe v. Wade*, while Poland had maintained significant restrictions throughout the same period. If abortion access were the

primary determinant of maternal mortality, Poland would be expected to have a substantially higher MMR than the US, yet the opposite is true.

Such a discrepancy demands a deeper examination of the healthcare systems, social policies, and institutional structures in both countries beyond the narrow focus on abortion legislation. The legal history provides essential context for understanding the sociopolitical environments in which maternal healthcare systems operate. In the US, the federal structure requires navigating not only national laws but also the political and legal systems of 51 individual jurisdictions, which introduces significant variation in healthcare policies and outcomes and can mask disparities across states. Poland operates under a more centralized governance system, allowing for more uniform policy implementation. By identifying politically mobilized religion as a significant common force driving abortion restrictions in both countries, the research can explore how these same religious and political influences have shaped broader approaches to maternal health and family support, approaches that appear to have produced dramatically different maternal health outcomes.

The following chapter examines key SDG indicators related to maternal health to establish a baseline for comparing Poland and the US on measures beyond the level of abortion restrictions. The analysis helps identify which factors might explain the counterintuitive success of Poland in maintaining low maternal mortality despite restricted abortion laws, providing direction for the subsequent in-depth case studies. Having provided the historical context of the legal decisions, the next chapter returns to the variables identified in the literature review to begin exploring why Poland's MMR is lower than that of the US, considering its history of stricter laws.

CHAPTER V: EXPLORING SDG PROGRESS

The previous chapter examined how politically mobilized religion has interconnected with other factors to shape the abortion restrictions in both Poland and the United States. Despite identifying this as a common force driving restrictive legislation, Poland maintains one of the world's lowest MMRs at just two deaths per 100,000 live births, while the United States has an MMR of 17, the highest among high-income OECD members. This disparity challenges the conventional understanding that restrictive abortion laws are generally associated with higher maternal mortality.

The literature review in Chapter Two revealed several alternative factors that can influence maternal health outcomes beyond the legal status of abortion, including the quality and accessibility of healthcare systems, socioeconomic inequality, and education levels. The second research question emerges directly from this insight: What factors explain why Poland's MMR is considerably lower than that of the US despite its history of stricter abortion laws? Answering this question achieves several important research objectives. First, it tests the boundaries of the conventional theory linking abortion restrictions to maternal mortality, identifying the conditions under which exceptions might occur. Second, it isolates the specific institutional and systemic factors that might enable a country to maintain excellent maternal health outcomes even in restrictive reproductive rights environments. Finally, the findings can provide valuable guidance for policymakers seeking to reduce maternal mortality in contexts where abortion liberalization faces significant political barriers. To address this question systematically, this chapter analyzes relevant SDG indicators for both countries. Table 3 shows the indicators that are examined in the SDG analysis.

Table 3: Indicators Explored in the SDG Analysis

SDG	Indicator
1	Poverty rate after taxes and transfers
3	Maternal mortality ratio
3	Adolescent fertility rate
3	Skilled birth attendants
3	Universal Health Coverage (UHC) Index /100
4	Tertiary education completion
5	Female-male education
5	Family planning needs satisfied
6	Basic drinking water
6	Safely managed water
6	Basic sanitation
6	Safely managed sanitation
10	Gini coefficient /50
10	Palma ratio /2
11	Public transportation access
17	Government spending on health & education

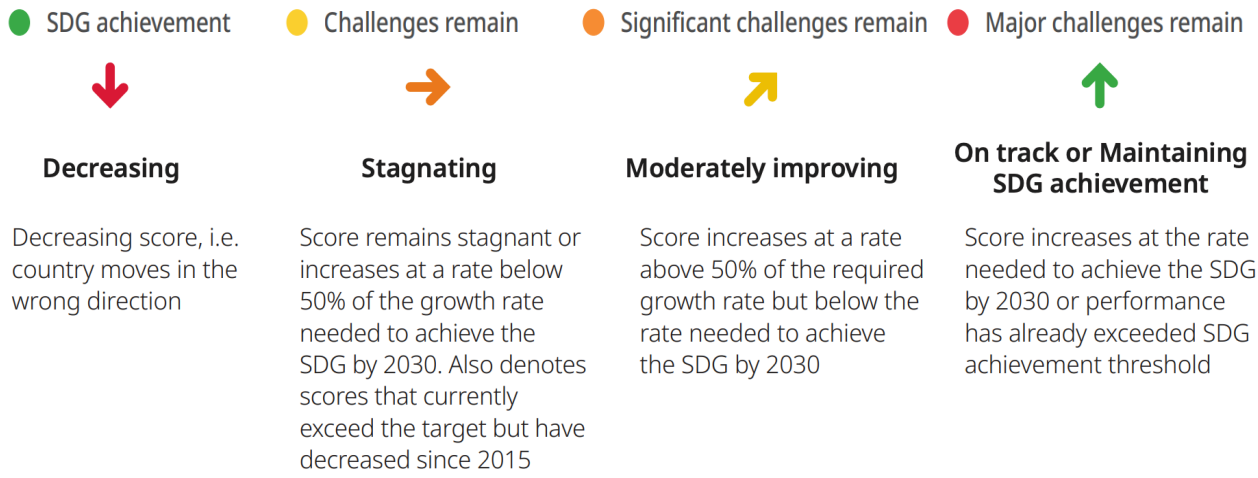
Source: Created by author based on data from Saches et al., 2024.

The SDG framework is valuable for this analysis because it explicitly recognizes the importance of maternal health and reproductive rights. SDG 3 aims to ensure good health and well-being, including target 3.1 to reduce the global MMR to less than 70 deaths per 100,000 live births and target 3.7 to provide universal access to sexual and reproductive healthcare, including family planning, information and education, and the integration of reproductive health into national strategies and programmes. Similarly, SDG 5 aims to achieve gender equality and empower women. SDG 5 includes target 5.6, which ensures universal access to SRHR as agreed in the ICPD Programme of Action and the Beijing Platform for Action and the outcome documents of their review conferences. These globally recognized targets provide a framework

for systematically comparing Poland and the United States' progress on improving multiple dimensions that are critical to maternal health.

All data points presented in this chapter are collected from the country profiles on the SDG data explorer (Sachs et al., 2024). The data explorer provides a single national figure for each country on each indicator and does not include further disaggregated data within country populations. Section 5.2 discusses the explanatory value of the analytical findings, highlighting any shortcomings of the data despite theoretical relevance. The relevant indicators flagged with yellow, orange or red circles or arrows in the SDG data explorer (see Figure 3 below) reveal the areas needing further examination in the within-case analyses and provide a baseline for the comparative analysis. Hence, the relevant indicators that Poland scores worse on than the US will not be insightful in explaining why Poland's MMR is lower.

Figure 3: SDG Trend Progress Symbols



Source: Saches et al., 2024.

Given the insufficient rate of SDG progress to achieve most of the goals by 2030, the data explorer uses a "long-term objective" framework, extending the timeline to meet the objectives by 2050 (Sachs et al., 2024, 4). However, countries should continue accelerating

efforts to meet the targets by 2030. Therefore, the trend data described in this chapter refers to how fast a country is progressing towards achieving an SDG since 2015 and whether the pace is sufficient to achieve the goal by 2030 (Sachs et al., 2024, 74). Therefore, the long-term objectives described in this chapter refer to goals that countries should strive to achieve by 2030, though the objectives stand until 2050.

5.1 Sustainable Development Goals Analysis

SDG 1 is to *end poverty in all its forms everywhere.* The literature review findings indicate that MMRs tend to be among low-income populations (Singh, 2021). Poverty is a leading barrier to healthcare disparities within domestic contexts (Wong et al., 2022, 833). Using 2021 data, the poverty rate after taxes and transfers SDG indicator assesses the share of the population whose incomes fall below half the median disposable income for the entire population. The income threshold for relative poverty changes over time with changes in median disposable income. The long-term objective for this indicator is 6.1 percent of the population, which is the average of the three best OECD performers. Major challenges remain in the US, with 18 percent (2023), and the trend data is worsening. Comparatively, Poland is on track to achieve the target with 8.8 percent (2022), meaning that the score is increasing at the rate needed to achieve the long-term objective of 6.1 by 2050. The data explorer does not provide trend projections.

SDG 2 is to *end hunger, achieve food security and improved nutrition, and promote sustainable agriculture.* Indicator 2.2.3 shows anemia prevalence in women aged 15 to 49 by pregnancy status. The literature review found that anemia is a leading cause of indirect maternal deaths, particularly among young mothers (Makuei et al., 2020, 2; Ndyanabangi et al., 2021, 44).

However, indicator 2.2.3 is not included in the data explorer. The WHO (2024b) database only provides data for non-pregnant and lactating women.

SDG 3 aims *to ensure healthy lives and promote well-being for all ages.* Target 3.1 aims to reduce the global MMR to less than 70 deaths per 100,000 live births. The country-level objective is 3.4 for OECD members, the average of the top five OECD performers. The country-level objective of 3.4 supersedes the global SDG target of 70 because high-income countries are expected to meet more ambitious targets based on their healthcare capacity. This differentiated standard reflects the principle that nations with greater resources must remain accountable to their capacity to improve maternal health, avoid complacency, and contribute to global health leadership by striving for outcomes that are both equitable and feasible within their context.

The data explorer draws from 2020 MMR data, when the US MMR was estimated as 21.08. The US is on track to achieve the goal; however, trend data is either stagnating or increasing at less than 50 percent of the required rate to meet the 2030 goal. With the release of the April 2025 MMR report from the WHO, which estimates the US MMR to have been 22 in 2020 and 17 in 2023, the trend data may be updated as moderately improving in the next SDG report. The 2020 WHO MMR report notes Poland's achievement in maintaining one of the lowest MMRs at 1.96. The large confidence intervals in maternal mortality estimates may limit their effectiveness in tracking trends over time. Therefore, the United Nations also tracks country-level process indicators. For example, indicator 3.1.2 is the proportion of births attended by skilled health personnel, including doctors, nurses, and midwives, with a long-term objective of 100 percent. The US (98.6 percent) and Poland (99.6 percent) achieved near-universal skilled birth attendance in 2021.

Target 3.7 aims to provide universal access to sexual and reproductive healthcare, including family planning, information and education, and the integration of reproductive health into national strategies and programmes (UN, 2015). Indicator 3.7.1 is the proportion of women of reproductive age, ages 15 to 49 years, who have their need for family planning satisfied with modern methods of contraceptives, which includes the intrauterine device (IUD), implant, pill, injectable, condoms, sterilization, vaginal barrier methods, lactational amenorrhea method (LAM) and emergency contraception. Meeting the demand for family planning with modern methods reduces MMR by preventing unintended pregnancies, which are at higher risk for poor obstetrical outcomes (UNDESA, 2025a). The US is on track to achieve the universal "leave no one behind" target of 100 percent, standing at 80.7 percent in 2024. However, challenges remain in Poland, with only 73.2 percent. Poland's score is improving at an insufficient rate to achieve the objective by 2030.

Indicator 3.7.2 is the adolescent fertility rate, which reflects the number of births (ages 10 to 14 and ages 15 to 19) per 1,000 women in that age group (WHO, 2025a). The adolescent fertility rate is relevant to this study as adolescents are at a higher risk of adverse health outcomes, and teenage births are closely linked to unsafe abortions, often resulting in maternal mortality or maternal morbidity (UNDESA, 2025a). The long-term objective for the 15 to 19 range is 2.5. As of 2022, both cases are on track to achieve the target, with an adolescent fertility rate of 13.5 in the US and 6 in Poland. The 10 to 14 age range is not included in the dashboard.

Target 3.8 aims to achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and safe, effective, quality and affordable essential medicines and vaccines for all (UN, 2015). Indicator 3.8.1 is the coverage of critical health services, which is measured by the UHC index discussed in Chapter Three, ranging from 0 to a

perfect score with a long-term objective of 100. The UHC assesses reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases, and service capacity and access among the general and the most disadvantaged populations. Both countries are progressing toward a score of 100. Poland scores 82 on the UHC index, while the US scores 86.

SDG 4 ensures *inclusive and equitable quality education and promotes lifelong learning opportunities for all*. Target 4.1 ensures that all girls and boys complete free, equitable, and quality primary and secondary education, leading to relevant and effective learning outcomes, including university, by 2030. As noted in the literature review, US MMRs are higher among women without college degrees (Singh, 2021). The long-term objective is 52.2 percent of the population, ages 25 to 34, who have completed tertiary education. As of 2022, both cases are on track to achieve the target by 2030. However, since 2015, the US score of 51.26 percent has increased, while Poland's 40.5 percent has remained stagnant.

Target 4.5 is to eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, Indigenous peoples and children in vulnerable situations. The percentage ratio of female-to-male mean years of education received is a metric to monitor this target. This percentage is calculated by dividing the mean years of education received by women aged 25 and older by the mean years of education received by men aged 25 and older. In 2022, both cases slightly surpassed the target of 100, indicating that both have a slightly higher percentage of educated women than men. The US ratio is 101.19 percent, and Poland's is 102.87 percent.

SDG 5 aims to achieve gender equality and empower all women and girls. Target 5.6 aims to ensure universal access to SRHR and emphasizes the importance of gender equality in healthcare decision-making. Indicator 5.6.1 is the proportion of women of reproductive age, 15

to 49, who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare. This indicator is partially monitored by assessing the percentage of women of reproductive age, 15 to 19, who have their demand for family planning satisfied by modern methods, which uses the same metric as indicator 3.7.1. Indicator 5.6.2 is the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive healthcare, information and education. While this indicator is also relevant to this study, progress is not displayed in the SDG dashboard.

SDG 6 ensures the availability of sustainable water and sanitation management for all. Koch et al. (2012, 1) note that clean water and sanitation infrastructure were key factors in Chile's MMR reduction during a total abortion ban. However, a lesser percentage of Poland's population (90.37 percent) has access to basic drinking water services than the US (99.96 percent). Furthermore, a lesser percentage of Poland's population (88.91 percent) uses safely managed water services than the US (97.47 percent). Similarly, a lesser percentage of Poland's population has access to basic sanitation services (98.96 percent) than the US (99.63 percent). The percentage of the Polish population (97.92 percent) using safely managed sanitation services is marginally higher than the US population (97.04), though not significant enough to explain their difference in MMRs insightfully. Sex disaggregated data is not provided in the dashboard.

SDG 7 ensures *access to affordable, reliable, sustainable and modern energy for all*, with no targets directly related to maternal mortality. *SDG 8* promotes *sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all*. The literature review highlighted that low-income countries have higher MMRs, and that MMR disparities within high-income countries are characterized by within-country socioeconomic

inequalities (Latt et al., 2019, 1; Wong et al., 2022, 833). Given that both case studies are high-income, the SDG 8 indicators relating to total GDP are not useful for the present analysis.

SDG 9 is to *build resilient infrastructure, promote inclusive and sustainable industrialization, and foster innovation*, with no targets directly related to maternal health outcomes. *SDG 10* is to *reduce inequality within and among countries.* The literature review identifies socioeconomic inequality as a critical structural factor shaping maternal health outcomes. Indicator 10.4.2 is the Gini coefficient, which measures how income distribution among individuals or households within an economy deviates from a perfectly equal distribution. The long-term objective is 27.5 out of 50. Significant challenges remain in the US, with a score of 39.8, which is stagnant. Poland has achieved the goal, scoring 28.8. Similarly, indicator 10.1.1 is the Palma ratio, which is the share of all income received by the 10 percent of people with the highest disposable income divided by the share of all income received by the 40 percent of people with the lowest disposable income. The long-term objective for the Palma ratio is 0.9 out of 2. Major challenges remain in the US, with a worsening ratio of 1.82. Poland, however, maintains a better ratio, namely 0.89. The SDG data explorer does not provide baseline income or sex-disaggregated data for either indicator.

SDG 11 is to *make cities and human settlements inclusive, safe, resilient and sustainable.* Indicator 11.2.1 is the accessibility of public transportation, which is necessary to ensure equal accessibility to healthcare services. Lack of transportation is one of the most common preventable causes of maternal deaths (Kheyfets, 2023, 1; Mukuru et al., 2022, 2128). The long-term objective is 100 percent. Significant challenges remain in the US, with only 62.14 percent of the population having convenient access to public transportation in 2020. Poland, however, is maintaining an increasing score of 93.31 percent.

No indicators from SDGs 12 to 16 are directly relevant to MMR as they pertain to climate action, sustainable production practices, and government accountability. *SDG 17* is to *strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development*. One particularly relevant indicator is the percentage of GDP that the governments spend on health and education, which has a long-term objective of 15 percent. The US (15.06 percent) has achieved the goal, while challenges remain in Poland despite its increasing score (9.58 percent).

5.2 Findings of the Sustainable Development Goals Analysis

This analysis aims to interpret the significance of the selected indicators in explaining why Poland's MMR (2) is lower than that of the US (17), despite both countries restricting abortion laws. Table 4 shows the results for each indicator compared in the SDG analysis. Of the 16 analyzed indicators related to factors impacting maternal health, Poland exhibits no major or significant challenges. Poland's challenges are limited to family planning needs satisfied by modern methods, access to basic and safely managed drinking water, and the funding of healthcare and education systems. By contrast, the US performs particularly poorly on five indicators. Using the data explorer's terminology, major challenges persist in the poverty rate and the Palma ratio, while significant challenges remain on the Gini coefficient and access to public transportation. Notably, four of these five indicators pertain directly to income inequality, and inadequate public transportation systems disproportionately restrict healthcare access for low-income populations. Together, these findings each relate, at least in part, to structural inequality, reinforcing the need to explore maternal mortality disparities by income. This pattern is consistent with existing literature, which identifies income inequality as a major barrier to

healthcare access, particularly among racial minorities and low-income women in the US (Kheyfets, 2023, 2).

Table 4: SDG Analysis Findings

SDG	Indicator	Objective	United States	Poland
1	Poverty rate after taxes and transfers	6.1%	18%	8.8%
3	MMR	3.4	21.08	1.96
3	Adolescent fertility rate	2.5	13.5	6
3	Skilled birth attendants	100%	98.6%	99.6%
3	UHC /100	100	86	82
4	Tertiary education completion	52.2%	51.26%	40.5%
5	Female-male education	100%	101.19%	102.87%
5	Family planning needs satisfied	100%	80.7%	73.2%
6	Basic drinking water	100%	99.96%	90.37%
6	Safely managed water	100%	97.47%	88.91%
6	Basic sanitation	100%	99.63%	98.96%
6	Safely managed sanitation	100%	97.04%	97.92%
10	Gini coefficient /50	27.5/50	39.8	28.8
10	Palma ratio /2	0.9/2	1.82	0.89
11	Public transportation access	100%	62.14%	93.31%
17	Govt. spending on health & education	15%	15.06%	9.58%

Source: Created by author based on data from Saches et al., 2024.

Poland scores worse than the US on seven of the 16 analyzed indicators, which are highlighted in red in Table 4 above. Therefore, those seven maternal mortality-related variables are unlikely to have an impact on explaining what accounts for Poland's lower MMR. The first three relate to water and sanitation. Poland also has a lower tertiary education completion rate. Surprisingly, the remaining three indicators where Poland scores lower may be those most directly related to maternal health: family planning needs satisfied by modern methods, UHC index, and government spending on health and education. Given that Poland maintains a

dramatically lower MMR, despite these disadvantages, challenges the conventional wisdom that contraceptive availability, higher education levels, or greater healthcare expenditure necessarily result in better maternal health outcomes.

The percentage of the population whose family planning needs are met by modern contraceptive methods is notably lower in Poland (73.2 percent) than in the US (80.7 percent). This finding suggests that contraceptive accessibility and usage alone do not explain the MMR disparity, highlighting the need for within-case analyses to prioritize the quality of maternal healthcare over family planning measures aimed at preventing pregnancy.

Poland scores four points lower than the US on the UHC index, a key measure of healthcare accessibility and affordability. Furthermore, as identified in Chapter Three, Poland (82) scores seven points lower than the US (89) on the UHC sub-index specific to reproductive and maternal health. These results are somewhat counterintuitive given that Poland offers universal healthcare coverage, whereas the US system is fragmented and heavily privatized. One possible explanation is that UHC indices may be influenced by service availability on paper rather than adequate accessibility in practice. For example, the better score in the US may reflect the presence of specialized reproductive health services in certain states, despite their unequal distribution. In Poland, the political constraints and religious stigma may limit the scope and quality of reproductive healthcare services within an otherwise accessible system.

Certain indicators provide limited explanatory value despite their theoretical relevance. While the US allocates a greater share of its GDP to healthcare and education (15.06 percent) than Poland (9.58 percent), this figure does not account for the privatized US healthcare system. In the US, federal and state investments represent only one dimension of access, as many

individuals rely on private providers to fill the gaps left by public systems. As a result, higher spending does not necessarily translate into broader or more equitable access to healthcare.

Similarly, although access to public transportation is crucial for ensuring equitable access to healthcare services, this variable's explanatory value is also limited when accounting for the significant geographic, demographic, and infrastructural differences between the two countries. The US must contend with a much larger and more dispersed population, including remote areas in Alaska and Hawaii which pose unique transportation challenges. Additionally, Poland benefits from coordinated EU infrastructure funding, whereas US public transportation depends on a fragmented mix of federal, state, and local investments, making comparisons difficult (European Parliament, 2025). Moreover, the similar levels of tertiary education completion and gender parity in education across both cases suggest that education alone does not account for the differences in maternal mortality. The lack of data measuring the availability or quality of sex education remains a notable gap, which the following chapter addresses.

The SDG analysis has instead revealed structural factors that appear more significant in determining maternal health outcomes in these cases. Most notably, the United States exhibits major challenges in areas related to socioeconomic inequality. While the analysis lacks an intersectional lens, these findings provide a targeted framework for the case study analyses in Chapter Six. Rather than examining all possible variables that might influence maternal mortality, the next chapter can focus specifically on how each country's healthcare system addresses (or fails to address) these structural inequalities. Furthermore, ruling out these potential explanatory variables allows for a more intersectional analysis in the subsequent chapters. The case studies will investigate how Poland's approach to maternal healthcare delivery overcomes its relatively limited resources and lower contraceptive access to achieve exceptional outcomes.

The subsequent chapters examine why the US system, despite greater overall wealth, fails to translate these advantages into better maternal health outcomes due to the disproportionate accessibility of healthcare across marginalized and low-income populations.

Additionally, following the finding in Chapter Four that politically mobilized religion has played a central role in driving abortion restrictions in both countries, Chapter Six investigates how religious influence may also shape national priorities for maternal healthcare. While religious forces have influenced the restrictions on abortion in both Poland and the US, their broader impacts on healthcare provision, funding, and service delivery differ. In Poland, Catholic influence has coexisted with a universal healthcare system that provides consistent maternal care. In contrast, in the US, conservative religious influence appears intertwined with a more fragmented and privatized healthcare model, contributing to pronounced disparities in maternal health outcomes. This connection between the two research questions, legal restriction and maternal health outcomes, offers insight into how similar ideological forces can produce vastly different policy consequences depending on institutional context.

Chapter Six moves beyond the high-level indicators examined in this chapter to investigate the specific mechanisms, policies, and practices through which Poland achieves its remarkably low maternal mortality despite more restrictive abortion laws and fewer resources. Particular attention is given to how Poland's healthcare system structure, standardized maternal care protocols, and approach to postpartum care may compensate for its limitations, while examining how systemic inequality in the US creates barriers to maternal healthcare access despite greater overall wealth and resources.

CHAPTER VI: CASE STUDY ANALYSES

The SDG analysis in the previous chapter narrowed down priority areas by providing a generalized overview of both countries' progress in addressing MMR-related issues. While it identified significant differences in socioeconomic inequality, healthcare access, and public transportation, these indicators do not sufficiently explain the dramatic disparity in maternal mortality outcomes. Historically, abortion laws have been substantially stricter in Poland than in the US. However, in 2020, the risk of maternal death was ten times higher for a US mother than a Polish mother. Furthermore, while access to contraceptives is a key variable in the relationship between abortion and maternal death, the US has higher modern contraceptive usage (67 percent versus Poland's 59 percent) (UNDESA, 2024). This chapter draws on the literature review, legal history analysis, and SDG findings to examine how healthcare systems, maternal care protocols, and socioeconomic contexts suggest a possible or partial explanation for why Poland maintains one of the world's lowest MMRs while the US has the highest among high-income OECD members. By examining the strength of healthcare systems and healthcare disparities among populations, these analyses also assess the risk of MMRs worsening, considering recent legal restrictions to abortion.

6.1 Poland

Poland has sustained one of the lowest MMRs in the world for over a decade, at two maternal deaths per 100,000 live births, tied with Australia and Israel and just behind Norway and Belarus at one and the Cook Islands at zero. Eastern Europe had the most significant regional MMR reduction between 2000 and 2023 (74 percent), and Belarus had a 95 percent reduction (WHO, 2025b). The MMR reduction rate stagnated in most regions from 2016 to 2022 but rose in Latin

America, North America, the Caribbean, and Western Europe (UNICEF, 2023). Poland's MMR of two has been maintained each year since 2011, except in 2020 when it briefly increased to three during the height of the COVID-19 pandemic. Some scholars argue that Poland is under-researched in terms of health policy analysis (Mikuła and Kaczmarek, 2019, 33). Poland has a universal healthcare system, and women are guaranteed full coverage from the beginning of pregnancy to the postpartum period. This section explores the Polish systems that are essential for maintaining the low prevalence of maternal death.

6.1.1 Healthcare System Structure and Maternal Care Protocols

After the fall of Communism in 1989, Poland was the largest European post-Soviet country (after Russia). Mikuła and Kaczmarek (2019, 29) argue that it adopted a New Public Management (NPM) model for the organization and delivery of public administration. NPM-driven healthcare institutional reforms simulate entrepreneurial hospital management, such as transforming patients into customers in a competitive market and expanding the role of private healthcare service providers (Mikuła and Kaczmarek, 2019, 30). The Polish Ministry of Health introduced the first maternal healthcare regulation in 2012 to improve the quality of care further, despite having a consistent MMR of three and improving to two in 2011. The Standards of Perinatal Care focused on the physiological aspects of pregnancy and birth, the postpartum period and newborn care (Rodzić po Ludzku Foundation, 2023). Furthermore, the Standard outlines the schedule of prenatal visits, recommended tests, and consultations for all pregnancies.

When the right-wing Law and Justice Party (PiS) won the 2015 election, they began de-marketing healthcare and reversing some of the NPM-driven healthcare reforms of the 1990s (Mikuła and Kaczmarek, 2019, 29). The Ministry of Health lost its ability to issue medical

standards, and in 2016, the Perinatal Care Standards were challenged (Rodzić po Ludzku Foundation, 2023). After a strong public backlash, the Minister of Health's Regulation of Organizational Standard of Perinatal Care entered force in 2019. The new regulation is stronger than that of 2012 as it reduces unnecessary medical interventions and extends the scope of services to include pain management, miscarriages, stillbirths and sick babies (Rodzić po Ludzku Foundation, 2023).

The Standard outlines the national protocols for obstetric care to ensure consistency in managing emergencies. For example, if a Polish woman hemorrhages after delivery, the protocol for response is the same whether she is in Warsaw or a more rural area. Although the new regulation reduces the number of medically unnecessary interventions compared to the 2012 regulation, the existence of standardized protocols may still contribute to a high rate of interventions overall. For instance, while the updated guidelines aim to promote individualized and less invasive care, the uniform application of protocols across all regions can sometimes result in a default to Caesarean sections or other interventions, even when not strictly necessary. This tension between improving the quality of care and maintaining consistency in emergency management may help explain why 42 percent of hospital births in Poland still resulted in Caesarean sections in 2021 (Yang, 2024).

Poland's Caesarean section rate is the fifth highest among OECD members (Yang, 2024) and well above the WHO's recommendation of 10 to 15 percent (WHO, 2015). However, Poland's low MMR suggests that the surgical safety risks are well managed. The new Standard also mandates that midwives must conduct a three-stage screening of symptoms of prenatal and postpartum depression and mood disorders (Chrzan-Dętkoś and Walczak-Kozłowska, 2020, 1).

Although Poland has few maternal deaths from direct obstetric causes, the Standard recognizes that indirect causes, such as mental wellbeing, are also important to address.

In 2021, a 30-year-old woman died in a hospital in Pszczyna because the doctors feared legal repercussions in light of the near-total abortion ban. As a result, the Polish government issues a new set of guidelines titled “The Mother’s Life and Health are the Most Important”. The health minister, Adam Niedzielski, stated that the law “clearly specifies that a risk to mother’s life or health constitutes a premise [for terminating a pregnancy]” and that doctors cannot be afraid of taking obvious decisions based on their medical knowledge (Notes from Poland, 2021). The guideline stresses that the current regulations allow termination of the pregnancy if there is a threat to a pregnant woman’s life, including suspicion of infection in the uterus or haemorrhage (Notes from Poland, 2021).

6.1.2 Healthcare Access, Coverage, and Affordability

All maternal care services are free for women if they use public facilities funded by the National Health Fund (Narodowy Fundusz Zdrowia; NFZ), established in 2003 (Mastylak et al., 2023, 2). As a result, most women begin prenatal care quite early. Under NFZ, women are entitled to 10 prenatal visits with a maternal care provider of their choice, most commonly gynaecologists-obstetricians, and free midwife-led prenatal education classes (Mastylak et al., 2023, 2). The Standard states that there should be a consultation with the care provider at least every three to four weeks and more often when necessary (Rodzić po Ludzku Foundation, 2023). The public healthcare system’s capacity to offer this level of support is well-adjusted. For every 1,000 live births, there are 87 midwives and 20 gynaecologists-obstetricians (OECD, 2024a). Poland has Europe’s second-highest rate of practicing midwives after Iceland (Węgrzynowska et al., 2020,

1338). The number of practicing Polish physicians comprises 7.2 percent of the EU's total, and this figure is increasing (Eurostat, 2024b). Poland also scores strongly on SDG indicator 11.2.1, with 93 percent of the population having convenient access to public transportation, which further increases the accessibility of healthcare services. Over 98 percent of births occur in publicly funded hospitals, and the proportion of births attended by skilled health personnel has reached 100 percent (Węgrzynowska et al., 2023, 2; WHO, 2024c).

In 2022, Poland reported that 27.8 percent of people not at risk of poverty faced severe difficulty paying for medical care, which was the highest percentage in the EU (Eurostat, 2024c). Despite having universal public health and dental, not all services and medications are covered, and public healthcare is less accessible in terms of convenience and speed. For example, dentists offer both public and private treatment, but some services are only available privately and public services may not be available every day of the week (European Commission, 2025). Over 40 percent of women pay out of pocket for private care (Węgrzynowska et al., 2023, 2). Women who use private services usually do so to avoid public-sector waiting times and establish a more personal relationship with the provider (Węgrzynowska et al., 2023, 1). Private care is mainly utilized during the prenatal period for check-ups, medications, ultrasounds, blood tests, and visits to other specialists (Mastylak et al., 2023, 6). A private prenatal consultation costs around 100 Polish złoty (PLN), about $37.00 CAD (as converted on April 1st, 2025), but can range up to several hundred PLN (Węgrzynowska et al., 2023, 2). Women opting for private-sector maternal care usually spend a total of PLN 500 to 5,000 ($185 to $1,850 CAD) (Mastylak et al., 2023, 6). Although these costs are significantly lower than those in the US (see section 6.2 below), the price can still be a substantial portion of household income, given that the average monthly wage was PLN 5226 in 2020 (Węgrzynowska et al., 2023, 2).

Homebirths are not available through any public, national maternity programme and are only offered by a small group of independent midwives who work mainly in and around big urban centres (Węgrzynowska et al., 2020, 1338; Baranowska et al., 2022). However, the capacity of hospitals is also growing. In 2021, the north-western Polish region of Zachodniopomorskie and the Romanian capital region of Bucureşti-Ilfov were the only regions in the EU with over 1,000 hospital beds per 100,000 people (Eurostat, 2024d). Due to the nationally standardized protocols and low prevalence of maternal death, the quality of care is consistent across facilities, and regional differences in MMR are unavailable.

6.1.3 Demographic Factors and Role of Midwives in Childbirth

Poland's demographic homogeneity contributes to the consistency in maternal health outcomes. The Polish population is distinctly undiversified, and ethnic Poles comprise 96.9 percent of the population (CIA, 2025). The 2021 Polish Population Census did not include non-white demographics; however, a 2016 analysis found fewer than 4,000 Black people in the country (Ohia, 2016, 148). Poland also has the lowest foreign-born population in the EU, at just 2.6 percent, and only 1.2 percent of the population is from a country that is not an EU member state (Eurostat, 2024a). Because of the low population of non-white people, Poland reported the lowest rate of racial discrimination in access to healthcare in the EU, tied with France at 5 percent each (Eurostat, 2024e). Data on discrimination against ethnic minorities is not specified. However, given that only 3.1 percent of the population is comprised of non-ethnic Poles, it is likely that the rate is also relatively low. Furthermore, Poland has a low adolescent fertility rate of 6, and age is not a significant risk factor for maternal mortality (Saches et al., 2024).

Midwives are the primary care providers for childbirth, and doctors typically do not attend low-risk births unless the hospital has a policy that requires a doctor's presence at birth (Węgrzynowska et al., 2023, 2). Since 98 percent of births occur in a publicly funded hospital, doctors are always available if complications arise. However, several public hospitals have begun offering extra services for a fee, such as private rooms and delivery care by a dedicated private midwife (Węgrzynowska et al., 2023, 2). Depending on the hospital, the cost of dedicated midwifery care varies between around PLN 800 and 3500 PLN, which translates to $300.95 to $1,316.55 CAD (as converted on July 10th, 2025) (Węgrzynowska et al., 2023, 2). This service includes meeting with the midwife weeks before the delivery to discuss the woman's individual preferences and hospital procedures, and the woman notifies this midwife to meet her at the hospital when she goes into labour (Węgrzynowska et al., 2023, 2).

6.1.4 Postpartum Care and Parental Leave Policies

After childbirth, the NFZ coverage includes six weeks of postpartum healthcare. Over these six weeks, both mothers and newborns receive continuous care from a midwife of their choice. The midwives conduct a minimum of four home visits to assess the physiological and psychological health of the mother and baby and provide guidance (Mastylak et al., 2023, 2). After six weeks postpartum, women remain insured under the public NFZ universal coverage. The Polish labour law mandates that women receive paid maternity leave for twenty weeks for the birth or adoption of one child and longer for multiple children (Government of Poland, 2025). Women can choose to begin this leave up to six weeks before the expected delivery date. Mothers are required to take fourteen weeks of maternity leave. The mothers can try to opt out of the remaining six weeks if they transfer it to the father or another employee, provided that the baby is cared for by

an insured childcare professional or the father. Parental leave policies do not recognize same-sex couples, as there is no legal recognition for same-sex marriage in Poland.

After twenty weeks, there is an additional thirty-four-week parental leave with reduced pay that can be taken by either parent or shared between them (Government of Poland, 2025). This option is available at any point before the child turns six-years-old. There are regulations on pregnancy and parent working conditions, such as pregnant employees and employees with children under four are not allowed to work overtime or at night (Government of Poland, 2025). Notices of employment termination cannot be issued at any point during pregnancy or any type of maternity leave (Government of Poland, 2025). A two-week paternity leave is also available until the child turns two-years-old unless specific adoption or school attendance postponement circumstances apply (Government of Poland, 2025). There is also childcare leave lasting up to three years, which parents must use before the child turns six-years-old. For children with disabilities, childcare leave extends up to six years at any point until the child turns 18-years-old (Government of Poland, 2025). Parents with at least one child under 14-years-old can take two paid days off work per year, specifically on the grounds of parenthood (Government of Poland, 2025).

6.1.5 Sex Education and Contraceptive Access

Due to the widespread traditional Catholic values, sex education is highly stigmatized in Poland, and there are no comprehensive programs offered in or out of schools. Conservative politicians associate sex education with broader notions of "gender ideology" that vaguely conflates unrelated issues, including LGBTQ+ rights, abortion and pedophilia (Warzecha et al., 2019, 6; Davies, 2020, 17). Sex educators are attacked on social media by politicians, right-wing activists,

and Poland's state television broadcaster, which answers to PiS. Some educators reported getting letters and phone calls from people calling them pedophiles and murderers (Davies, 2020, 17).

Warzecha et al. (2019) surveyed over 20,000 Polish women with a mean age of 28 to assess levels of reproductive health education. Warzecha et al. (2019, 1) find significant knowledge gaps about available contraceptive methods, especially among women with lower education levels and those living in smaller cities. Although Poland is on track to achieve the indicator 3.7.2 adolescent fertility rate goal of 2.5, its rate of 6 may be attributed to the difficult accessibility to contraception and the cultural restrictions that limit its usage (Warzecha et al., 2019, 6). The lack of sex education may also explain why challenges remain on indicator 3.7.1, with only 73 percent of women of reproductive age having their need for family planning satisfied by modern methods. The quality and availability of modern contraceptives have remained limited amidst the deficient provision of sex education (Kulczycki, 2023, 4). However, Poland's birth rate is on the decline, despite already being one of the lowest anywhere in the world (Notes from Poland, 2025). The total fertility rate of a population is the average number of children that are born to a woman over her lifetime. Poland's fertility rate has reached a record low, dropping from 1.991 in 1990 to 1.099 in 2024 (Statistics Poland, 2025).

Poland avoids maternal deaths through strong national policies and practices despite its lack of sex education, limited contraceptive use and high rates of medical intervention. Although gynaecologist-obstetricians primarily drive maternity care, Poland has a much stronger integration of midwife roles than many countries, which are considered skilled birth attendants. Recent policies direct more attention to the psychological aspects of maternity to protect the mental health of mothers. Furthermore, regional, racial and ethnic disparities are insignificant, and there are minimal reports of racial or ethnic discrimination in healthcare. Astoundingly, the

Catholic-influenced traditional family values that reject abortion and contraceptive rights are the same values driving maternal health improvements. The numerous options for paid parental leave and prioritization of frequent healthcare visits reaffirm that the mother's health is essential to maintaining strong family units.

6.2 The United States

The United States spends the most money per person on healthcare among high-income OECD countries while simultaneously being the only one without near-universal healthcare (Fleszar et al., 2023, 53; Rice et al., 2014, 895). While maternal mortality is decreasing globally, the US has increased over the last 20 years despite having a substantially larger health budget than most countries that have made significant progress (Darney et al., 2020, 1362). The MMR rose from 13 in 2011 to 18 in 2019, and jumped to 31 in 2021, reflecting a weak healthcare system response to the COVID-19 pandemic. In 2020 and 2021, COVID-19 accounted for a quarter of maternal deaths due to reduced lung capacity and weakened immune systems, posing high risks for pregnant women (Katella, 2023). The 2023 MMR of 17 is tied with Bahrain and Egypt, slightly worse than China, Iran and Palestine, which each have an estimated MMR of 16 (WHO, 2025b). Nationally reported data, which undergo different standardization procedures from the WHO, show higher figures. According to the NVSS, the MMR was 20.1 in 2019, peaked at 32.9 in 2021, the highest since 1965, and decreased to 18.6 by 2023 (CDC, 2025). Despite recent declines from pandemic peaks, the MMR remains unacceptably high, and the present section analyzes the structural and systemic barriers to reducing maternal deaths.

6.2.1 Healthcare System Structure and Maternal Care Protocols

About 84 percent of maternal deaths in the US are thought to be preventable (Katella, 2023). Gender minorities have been systematically excluded from medical and scientific knowledge, which has resulted in a healthcare system that has been shaped by and catered to men (Kheyfets, 2023, 2). The male-centred bias in healthcare and clinical research has far-reaching implications for obstetric health and medical practices, which compromises the quality of care (Kheyfets, 2023, 2).

The United States does not have a national prenatal care protocol. The American College of Obstetricians and Gynecologists recommends twelve to fourteen prenatal care appointments for uncomplicated pregnancies (Balk et al., 2022). However, the recommended number of appointments is not always accessible to all patients. In 2022, 8 percent of women received no prenatal care (Osterman et al., 2024, 6). Barriers such as a lack of transportation and inability to get time off work can impede access even when coverage exists. The SDG analysis revealed that the US faces significant challenges, with only 62 percent of the population having convenient access to public transportation (UN Statistics Division (UN), 2025).

The lack of standardized approaches to emergency obstetric care likely contributes to the high prevalence of maternal mortality. The National Partnership for Maternal Safety emphasized the need for the development of safety bundles addressing obstetric emergencies, such as obstetric hemorrhage, severe hypertension, and venous thromboembolism, to standardize approaches to address these conditions (Ahn et al., 2020, S4). Hospital practices vary widely across the states; the quality can depend on location. However, the scope of telemedicine massively expanded during the COVID-19 pandemic. Telemedicine can increase access to and

improve the quality of care for high-risk pregnant women, especially in rural, medically underserved areas (Ahn, 2020, S8).

The leading causes of maternal death in the United States include heart disease, stroke, cardiomyopathy (weakened heart muscle) and suicide (Katella, 2023). Geographic and socioeconomic disparities are prevalent, and MMR is higher in low-income rural areas. The NVSS provides state-by-state MMR estimates using averages from 2018 to 2022. The highest state MMRs are in Tennessee (41.1), Alabama (38.6), Arkansas (38.3) and Louisiana (37.3), which are, notably, all Republican states with restrictive abortion laws (CDC, 2025). These states also have higher-than-average poverty rates and large African American populations, who face systemic barriers to quality reproductive care and experience disproportionately high maternal mortality. Additionally, these southern states reflect a regional pattern of limited access to healthcare and lower insurance coverage (US Census Bureau, 2025). These factors are important to consider as they demonstrate how the national US MMR masks disparities across states and peoples. Tennessee has the same 2020 MMR as Jordan, and eleven states have higher MMRs than Syria's 2020 MMR of 30 (CDC, 2025; CIA, 2025). It is worth noting that Syria is experiencing a civil war and may not be providing reliable statistics.

6.2.2 Healthcare Access, Coverage, and Affordability

The United States has a fragmented health system with a mix of private insurance and public programs. However, these pathways to coverage are not accessible to everyone. In 2021, 27.2 million citizens did not have any health insurance (Keisler-Starkey and Bunch, 2022). Many women of reproductive age are uninsured or underinsured, especially in the states without expanded Medicaid, the joint federal-state health insurance program developed in 1965.

Medicaid is designed to provide coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities, and it finances about 41 percent of all births (Centers for Medicare and Medicaid Services, 2025). States adhere to federal requirements to administer Medicaid, and decisions regarding eligibility requirements and covered services are made within-state. While pregnancy itself is a qualifying condition for Medicaid, not all women enroll early enough, and some fall through coverage gaps. A lack of insurance in early pregnancy leads to inadequate prenatal care, which the literature review highlights is associated with higher risks of health complications that can become life-threatening if they are unaddressed.

Despite scoring 86 percent on the UHC index, the United States has numerous systemic coverage issues that negatively impact maternal health outcomes. For example, in 2020, about 1 in 9 (11.6 percent) women of reproductive age had no health insurance (March of Dimes, 2025). Even before the Supreme Court overturned *Roe v. Wade*, 54 percent of adolescents reported paying out of pocket for their abortions, which cost $500 USD on average, or $715 Canadian Dollars (CAD) (Forouzan and Mariappuram, 2024).

Texas has the highest rate of uninsured women ages 19 to 64 of any state, 20 percent in 2023, and the average cost of a vaginal birth with no complications is $17,738 USD (KFF, 2024; Learish, 2020), which translates to about $25,320 CAD. The cost of giving birth varies by state; however, all uninsured births are unaffordable for most citizens. The lowest average price of an uninsured vaginal birth with no complications is $8,805 USD in Nebraska, and the highest average price is $29,048 in New Jersey (Learish, 2020). Some states, including California, charge more than $10,000 for the hospital room alone. California is the second most expensive state to give birth, with uninsured and uncomplicated vaginal births costing $26,380 on average.

However, California is also the safest state to give birth in, with the lowest MMR of 10.5 (CDC, 2025).

As a result of these unaffordable costs, in combination with other motivations, such as the unreliability of quality and non-discriminatory care in hospitals, the home birth rate has increased by 60 percent since 2017 (Coleman, 2024). In 2023, there were 46,918 home births reported in the US, accounting for 2 percent of all births (Coleman, 2024). Between 2016 and 2018, 27 percent of mothers who had home births were uninsured (Goyal et al., 2020, 1). Coleman (2024) explains that the number of Black women having home births increased by 36 percent between 2019 and 2020. Some insured women opt for home births to avoid unnecessary medical interventions at hospitals. For Black women, home births with a quality midwife can eliminate the racial discrimination faced in hospitals, where their chance of dying in childbirth is three times higher than it is for non-Hispanic white women (Wong et al., 2022, 833). Medicaid covers home births attended by midwives in about half the states, averaging about $4,650, but prices vary widely and can be much more expensive. However, the likelihood of the price being higher than it would be in a hospital is marginal. Some private insurers that cover home births, but many do not have midwives in their network due to the limited supply.

6.2.3 Demographic Factors and Disparities in Maternal Care

Obstetric racism in US perinatal care is a significant contributor to inequity in access to care and disparities in maternal health outcomes (Boakye et al., 2023, 10). The lack of universal healthcare disproportionately affects marginalized populations. In 2021, the MMR was 26.6 for non-Hispanic white women, 28.0 for Hispanic women, and significantly higher at 69.9 for Black women (Hoyert, 2023, 1). Even as national figures improve post-pandemic, racial disparities

remain pronounced. In 2023, the MMR was 50.3 for Black women and 14.5 for non-Hispanic white women (Hoyert, 2025, 1). Hispanic women (28.0 MMR) also experience higher maternal mortality than white women, though the disparity is less severe than for Black women. Restrictions creating geographic, transportation, and financial barriers to obtaining an abortion can result in increased rates of maternal death and adverse outcomes across all groups, though especially among the Black population (Kheyfets, 2023, 1). Furthermore, the largest Black populations are in the poorest states with the most restrictive policies regarding abortion and the states with the least amount of people with health insurance (Kheyfets, 2023, 2; US Census Bureau, 2025).

Abortion rates also vary across demographics, including race, age and marital status. In 2021, there were 28.6 abortions per 1,000 Black women ages 15 to 44, 12.3 for Hispanic women, 6.4 for non-Hispanic white women, and 9.2 for other races (Diamant et al., 2024). Most women who had abortions were in their twenties (57 percent) and unmarried (87 percent) (Diamant et al., 2024). The risk of maternal mortality is almost twice as high for unmarried women as it is for married women, which is likely a reflection of household income (Singh, 2021, 33).

Historically, the high adolescent fertility rate in the US was an explanatory factor of its high MMR. However, expanded access to contraceptives and family planning services has significantly reduced the US fertility rate. The adolescent fertility rate dropped from 47.7 in 2000 to 13.5 in 2022 (Saches et al., 2024). More than a third of the fertility decline between 2007 and 2016 is attributed to a reduction in unintended pregnancies (OECD, 2024b, 21). Despite a decline of 72 percent since 1991, the US continues to have a significantly higher rate of teen pregnancy compared with other high-income countries. The US currently has the seventh-highest adolescent fertility rate among the 38 OECD member states at 13.5, after Colombia, Mexico,

Costa Rica, the Slovak Republic, Hungary and Chile, respectively (Saches et al., 2024). The teen birth rate differs widely across racial and regional demographics. In 2018, birth rates for Black and Hispanic teens were more than twice as high as births to non-Hispanic white teens (Cox, 2020, 313). Geographically, teen birth rates varied from 30.4 in Arkansas to 7.2 in Massachusetts (Cox, 2020, 313).

6.2.4 Role of Midwives and Postpartum Care

Although the SDG analysis shows that 98.6 percent of births in the United States are attended by skilled health personnel (UNSD, 2025), nearly seven million women live in counties where no hospitals or birth centres are offering obstetric care and no obstetric providers (Gunja et al., 2024). The US has one of the lowest supplies of obstetrician-gynecologists among high-income countries, with only 12 providers per 1,000 live births (OECD, 2024a). Obstetricians attend most births in the United States. However, obstetricians lack the capacity to provide continuous care and are typically only present during delivery or for intermittent checks.

Midwives offer continuous care for uncomplicated pregnancies, such as assisting with childbirth and providing postpartum care. There are only four midwives per 1,000 live births, whereas, in most other high-income countries, there are between thirty and seventy midwives. (Combellick et al., 2023, S983). Suicide is also a leading cause of death during both pregnancy and the postpartum period (Katella, 2023), and midwives can provide personalized support for postpartum depression. Midwives are the primary providers of reproductive healthcare in many countries. Gunja et al. (2024) explain that “a midwife workforce, integrated into healthcare delivery, could provide 80 percent of essential maternal care around the world and potentially avert 41 percent of maternal deaths, 39 percent of neonatal deaths, and 26 percent of stillbirths.”

Furthermore, many states have regulatory restrictions on midwives that limit the scope of their practice.

The Midwifery Integration Scoring System (MISS) is a tool that ranks states' integration of midwives to help identify opportunities for improving access to midwifery services (Ahn et al., 2020, S5). The scoring system accounts for numerous factors, such as whether the state offers Medicaid reimbursement for certified midwives. No state has a perfect MISS score of 100. In 2020, midwives attended only 10 percent of the 3.6 million births (Combellick et al., 2023, S986). Washington has the highest MISS score at 61, and North Carolina has the lowest at 17 (Vedam et al., 2018, 1). States with higher levels of midwife integration are associated with better health outcomes, such as more spontaneous vaginal birth and less obstetric intervention, such as caesareans and preterm births (Ahn et al., 2020, S5). The reduced role of midwives and less personalized care is a significant explanatory factor of the high MMR.

Given that the system relies on employer-based insurance and Medicaid, the continuity of care can be disrupted at any time. Moreover, the United States is the only OECD country without a nationally paid family leave around childbirth and for the early months and years of a child's life (OECD, 2024b). Low-income, uninsured women are pressured to return to work quickly to pay off the exorbitant accumulation of medical bills from giving birth. Paid maternity leave allows women to manage early motherhood's physiological and psychological demands, thereby improving maternal health, reducing symptoms of postpartum depression and providing more financial stability for families (Romig and Bryant, 2021, 1). Returning to work too quickly can hinder recovery and follow-up appointments. Half of women report experiencing pain within the first two months after childbirth, and many experience more serious, potentially life-threatening postpartum complications (Romig and Bryant, 2021, 7). Tikkanen et al. (2020) comparatively

analyze maternity care in ten high-income countries and find that the US is the only country that does not guarantee access to provider home visits despite a significant share of maternal deaths occurring in the postpartum period.

The WHO recommends at least four to six postpartum follow-up appointments in the first six weeks after birth (Gunja et al., 2024). However, postpartum care in the US is usually limited to a single six-week postpartum follow-up appointment. Two of five women who lack support, often young low-income women, do not attend this visit due to losing insurance, a lack of childcare or means of transportation (Gunja et al., 2024). Until recently, many women lost Medicaid coverage sixty-days postpartum. However, the American Rescue Plan Act of 2021 allowed states to extend Medicaid postpartum coverage to twelve months. Since the option took effect in 2022, forty states have adopted the extension and have reported better maternal health outcomes, particularly a reduction of MMR for women of colour (KFF, 2025; Gunja et al., 2024).

6.2.5 Sex Education and Reproductive Healthcare Access

There have been many restrictions on sex education in recent years, and it is not mandatory in every state. Only twenty of the states that provide sex education require the information to be medically accurate, and most states are required to advocate for abstinence (Forouzan and Mariappuram, 2024). In 2024, legislators from eleven states introduced bills that would mandate the viewing of medically inaccurate anti-abortion videos in sex education classes (Forouzan and Mariappuram, 2024). However, only Tennessee was successful in passing the law. Limited access to sex education negatively impacts the ability to make informed healthcare choices,

contributing to lower utilization of the available reproductive healthcare services and increasing the likelihood of preventable complications during pregnancy and childbirth.

Although 80.7 percent of the population, aged 15 to 49, has their need for family planning satisfied with modern methods of contraceptives, the US have yet to reach the long-term goal of 100 percent. The percentage of the population using modern contraceptive methods increased from 37 percent in 1955 to 67 percent in 2024 (UNDESA, 2024). Birth control pills were approved by the US Food and Drug Administration for menstrual cycle management in 1957 and approved for use as a contraceptive in 1960. The most dramatic increase came in the early 1970s, rising 14 percent from 57 percent in 1970 to 73 percent by 1975. This increase can be attributed to two Supreme Court decisions in 1965, which affirmed the right of married couples to use contraception, and in 1972, which extended this right to unmarried couples. After *Roe* was decided in 1973, there was a 10 percent increase in just two years. The heightened reproductive rights movement led to a broader acceptance of reproductive healthcare at the beginning of the *Roe* era.

However, there have been many restrictions on contraceptive access in recent years. In 2022, a court ruling in Texas blocked clinics that receive federal funding from providing prescription contraceptives to minors without parental consent (Forouzan and Mariappuram, 2024). In 2024, anti-abortion legislators in Indiana amended a Medicaid contraceptive coverage bill to remove IUDs and included the false notion that IUDs cause abortions (Forouzan and Mariappuram, 2024). These restrictions limit the accessibility of contraception, especially for those with lower incomes who rely on Medicaid. Telemedicine abortion reduces travel, cost and stigma-related barriers and increases convenience for patients (Upadhyay et al., 2024, 1191). Some states, including Washington and California, have adopted laws to give patients the option

to access medication abortion through telemedicine permanently (Forouzan and Mariappuram, 2024). In states where abortion is legal but neighbouring states have bans, such as Illinois, Kansas and Colorado, telehealth is vital to meeting the increasing demand for clinics (Upadhyay et al., 2024, 1191).

6.2.6 Impact of Abortion Restrictions on Broader Reproductive Care

Anti-abortion initiatives are affecting all areas of reproductive healthcare. In 2024, the Alabama Supreme Court ruled that embryos created through in-vitro fertilization (IVF) are considered children under their *Wrongful Death of a Minor* law, which forced many clinics to discontinue treatments (Forouzan and Mariappuram, 2024). One Alabama patient in the final stages of IVF reported being unable to use her fertilized embryos that she had spent $30,000 on and had to restart the process in another state (Barbaro et al., 2024). The *LePage v. Mobile Infirmary Clinic* law resulted in public backlash, leading to another bill that protects IVF treatments, which went into effect soon after. However, some clinics continue terminating services due to ongoing litigation and legal confusion (Forouzan and Mariappuram, 2024).

Women with IUDs and women undergoing IVF treatment have a higher risk of developing ectopic pregnancies, which can be life-threatening. Ectopic pregnancies occur when a fertilized egg grows outside of the uterus. Most ectopic pregnancies implant in the fallopian tubes, which can rupture the tube and cause life-threatening internal bleeding. In the United States, 1 in 50 pregnancies are ectopic (Ries and Mohney, 2022). These pregnancies are not viable as the embryo will not develop into a baby. Legislators in some states have tried to include a medically impossible provision requiring doctors to move an ectopic pregnancy from the fallopian tubes to the uterus (Ries and Mohney, 2022). Some states' abortion laws specify that

abortive care for ectopic pregnancies and pregnancy loss is not criminalized (Felix et al., 2024a). Most of these states allow the removal of a dead fetus or embryo, but usually not for an active miscarriage if fetal cardiac activity is still detectable (Felix et al., 2024a).

By the age of 40, one in four US women undergo at least one abortion procedure in their lives, making abortion one of the most common healthcare procedures in the country (Kheyfets, 2023, 2). Before the Supreme Court legalized abortion in 1973 with *Roe v. Wade*, illegal abortions resulted in at least 200 maternal deaths annually (Darney et al., 2020, 1363). In 2020, there were fewer than ten abortion-related deaths out of the estimated 930,160 abortions that year, which equates to 0.45 deaths per 100,000 abortions (Darney et al., 2020, 1363; Diamant et al., 2024). While the figure of nearly one million abortions is significant, at 14.4 abortions per 1,000 women ages 15 to 44, it is 40 percent lower than it was in 1991 (Diamant et al., 2024). Harper et al. (2023, 240) find that the increasing number of restrictive laws, including those with trigger bans, was associated with increasing maternal and infant mortality; however, the study period ended in 2019 and did not include the fall of *Roe v. Wade.*

The high maternal mortality issue in the United States is shaped by intersecting racial, geographic, socioeconomic, and policy-driven factors. Structural challenges such as unguaranteed healthcare coverage, inconsistent maternal and reproductive care across regions and demographics, inadequate sex education, and the costs of life compound these issues. The rise in restrictive policies exacerbates maternal health risks and creates even more barriers to accessing timely and potentially life-saving care.

CHAPTER VII: CONCLUSION

While the literature review in Chapter Two suggests that countries with restrictive abortion laws have higher maternal mortality ratios (MMRs), Poland is a notable exception to this relatively consistent theory. The most recent MMR data published by the WHO shows that in 2023, Poland maintained one of the lowest MMRs in the world, with just two maternal deaths per 100,000 live births. The US had the second-highest MMR among high-income OECD members at 17, just after Latvia at 19. Poland and the US were selected for comparison because they are the only two countries that have removed legal grounds for abortion since the adoption of the SDGs in 2015, moving against the global trend toward liberalization. This shift toward restricting abortion, despite their differing healthcare and social systems, has provided a valuable basis for comparison. The present research has examined the abortion laws and MMRs in both countries by exploring two research questions to explain the differences in MMRs, despite Poland's historically stricter approach to abortion.

The first research question is: What explains the abortion law restrictions in Poland and the US? To answer the first question, the MDSD in Chapters Three and Four found that the restrictive abortion laws in both cases are partially shaped by politically mobilized religion through ideological and moral arguments. Rather than seeing a single explanatory variable (X), the abortion restrictions in both countries are strongly correlated by intersecting forces of religious institutional powers that emerge in political mobilizations of religion and traditional family values. In Poland, the Roman Catholic Church's historical role in shaping national identity and moral values has enabled conservative legislators to enact restrictive abortion laws. Similarly, the predominance of various denominations of Christianity in the US government and society is connected to the political processes through which the Supreme Court removed the

constitutional protections for abortion in 2022 that were established in the 1973 *Roe v. Wade* decision. The Supreme Court of the US is comprised of six Catholics, two Protestants, and one Jewish justice (Newport, 2022), while those identifying with Christian denominations comprise 88 percent of Congress and 62 percent of the total US population (Newport, 2022; Pew Research Center, 2021b; Pew Research Center, 2025).

By exploring the factors that explain how Poland maintains a significantly lower MMR than the US despite its history of stricter abortion laws, this research has addressed the second research question: What factors explain why Poland's MMR (2) is considerably lower than that of the US (17) despite its history of stricter abortion laws? The within-case analyses in Chapter Six revealed that Poland's considerably lower MMR could be attributed to an emphasis on standardizing preventative care and implementing a range of policies that reflect a more genuine desire to protect lives than in the US. The factors that seem the most directly connected are Poland's national protocols for administering maternal healthcare, strong integration of midwives and paid parental leave options. The within-case analysis of the US found that its maternal mortality issue is primarily characterized by socioeconomic and racial inequities and barriers to accessing quality, consistent and affordable healthcare. This concluding chapter highlights the key comparative findings that explain the different MMRs in these cases, offers a broader discussion on the issue and draws the research to a close by providing suggestions for future research and policies.

7.1 Comparative Findings

The within-case analyses in Chapter Six revealed stark differences between Poland and the United States in maternal healthcare approaches, despite both countries having recently restricted

abortion access. While similar religious and conservative political forces have influenced both cases, they diverge significantly in healthcare system design, access to care, midwife integration, and social support policies. This comparative analysis examines these key differences to suggest one possible explanation for why Poland maintains one of the world's lowest MMRS. At the same time, the US struggles with the highest MMR among high-income OECD countries, demonstrating that structural healthcare and social welfare differences, rather than abortion laws alone, are the dominant factors explaining this disparity.

7.1.1 Healthcare System Structure and Maternal Care Protocols

Poland's national protocols for the administration of healthcare ensure that the quality of healthcare is consistent across hospitals. The Organizational Standard of Perinatal Care in Poland eliminates disparities in maternal health outcomes and overcomes urban-rural differences. The Standard outlines detailed protocols for obstetric emergencies, such as hemorrhage, ensuring consistent response regardless of location. These standardized approaches have created a healthcare system where maternal care is predictable, evidence-based, and uniformly implemented. In contrast, the US lacks national maternal care protocols, with practices varying significantly across states and facilities. The National Partnership for Maternal Safety has highlighted the need for standardized "safety bundles" for obstetric emergencies, but implementation remains inconsistent. Hospital practices differ widely across the country, with the quality of care often dependent on location, facility type, and provider expertise. Despite the American College of Obstetricians and Gynecologists recommending twelve to fourteen prenatal visits for uncomplicated pregnancies, access to this level of care varies dramatically based on insurance status, geographic location, and socioeconomic factors.

The COVID-19 pandemic impacted maternal mortality worldwide. However, Poland's MMR only increased from two to three in 2020 and readjusted to two in 2021. Comparatively, the US MMR was significantly more impacted by the pandemic, rising from 18 in 2019 to 31 in 2021, reflecting the preexisting inadequacy of its healthcare system. Therefore, restrictive state abortion laws will likely exacerbate the maternal mortality problem.

Previous research suggests that the risk of maternal death increases with unnecessary medical interventions, such as Caesarean sections, as these procedures increase the risk of complications and infections. Interestingly, Poland's Caesarean birth rate of 42 percent is notably higher than the 32 percent in the US (Yang, 2024), and both are well above the WHO's recommendation of 10 to 15 percent (WHO, 2015). Therefore, Poland's strong standardization of hospital protocols and postpartum care likely overpowers the heightened risk of maternal death from surgical procedures.

7.1.2 Healthcare Access, Coverage, and Affordability

The stark contrast in healthcare systems fundamentally shapes maternal health outcomes in both countries. Poland provides universal healthcare through the National Health Fund (NFZ), guaranteeing women full coverage from pregnancy through postpartum. All maternal care services, including prenatal visits, hospital births, and postpartum care, are free when using public facilities. While 40 percent of Polish women choose to supplement with private care for convenience or personalized attention, the core maternal health services remain universally accessible, regardless of employment or socioeconomic status.

Despite spending more per capita on healthcare than any other high-income country, the US operates a fragmented system of private insurance and public programs with significant

coverage gaps. In 2021, 27.2 million US citizens had no health insurance, including approximately 11.6 percent of women of reproductive age. While Medicaid covers pregnancy as a qualifying condition, many women enroll too late for adequate prenatal care or face coverage gaps postpartum.

The cost disparities are particularly striking. While Polish women might spend PLN 500 to 5,000 ($185 to 1,850 CAD) for supplementary private prenatal care, the average cost of an uncomplicated vaginal birth for an uninsured woman in the US ranges from $8,805 in Nebraska to $29,048 in New Jersey. These high costs create significant barriers to care and financial strain that can impact postpartum recovery and follow-up care.

Transportation accessibility represents another critical difference. Poland scores well on public transportation access at 93.3 percent, compared to just 62.1 percent in the US. This disparity disproportionately affects low-income women who may lack reliable private transportation to reach healthcare facilities. Nearly 7 million US women live in counties with no hospitals or birth centres offering obstetric care, creating maternal care deserts that do not exist to the same extent in Poland's more uniformly distributed healthcare system.

7.1.3 Demographic Factors, Intersectionality and Healthcare Disparities

Poland's population is ethnically homogeneous, with 96.9 percent identifying as ethnic Poles and approximately 85 percent as Roman Catholic (CIA, 2025). This demographic uniformity results in healthcare services designed for a relatively homogeneous population, with minimal disparities in maternal mortality reported on race or ethnicity. The 2021 Polish census did not include non-white demographics, and a 2016 analysis found fewer than 4,000 Black people in the entire country (Ohia, 2016, 148). The relatively absent racial discrimination in Polish

healthcare is attributable to their homogenous population and not a lack of racism. However, the nationally implemented protocols and publicly funded hospitals help to ensure that the quality of care is uniform across every facility.

Comparatively, the prevalence of maternal deaths in the US differs widely across states and socioeconomic demographics. State-level data reveals alarming disparities, with MMRs ranging from 10.5 in California to over 40 in states such as Tennessee and Alabama. The intersection of unequal healthcare access and structural racism leads to Black women having a risk of maternal mortality that is more than three times higher than the risk for non-Hispanic white women (Gunja et al., 2022; Wong et al., 2022, 833). This disparity persists across education and income levels. College-educated Black women still face higher maternal mortality risks than white women with less education, indicating that racism, not merely socioeconomic factors, drives these outcomes.

A significant research limitation when studying US maternal mortality is the invisibility of approximately eleven million undocumented immigrants (Passel and Krogstad, 2024). Many undocumented women avoid prenatal care due to deportation fears and lack Medicaid eligibility despite pregnancy. Their maternal outcomes may remain uncaptured in MMR data, likely underrepresenting the true US MMR. This statistical gap is virtually nonexistent in Poland, where foreign-born residents comprise just 2.6 percent of the population, making Poland's MMR data more representative (Eurostat, 2024a).

These demographic disparities are inseparable from religious and political dynamics. While white Evangelical Protestants form the core of anti-abortion advocacy in the US, Black Protestant denominations often hold more complex views on reproductive rights despite theological conservatism on other issues. As noted in Chapter Four, 80 percent of non-Hispanic

white Evangelical Protestant women supported Trump in 2024, while 92 percent of Black women, many of whom identify as religious, supported Harris. This political-religious divide reflects how religious identity intersects with race to influence both abortion policy and maternal healthcare access.

Religious heterogeneity in the US further complicates the relationship between faith and reproductive rights. US Catholics, like their Polish counterparts, receive anti-abortion messaging from Church officials, yet 63 percent believe abortion should be legal (Catholics for Choice, 2025). As a result, there is tension between official doctrine and lived practice, influencing policy and personal healthcare decisions. Jewish Americans, who constitute approximately 2 percent of the population, generally support abortion rights based on religious teachings that prioritize the mother's life and health.

The comparative analysis reveals that Poland's low MMR partly reflects its demographic homogeneity and universal access regardless of identity factors. The US's high MMR partly stems from a healthcare system that disadvantages minorities and exacerbates existing inequalities. These disparities are not mere demographic facts but rather manifestations of structural inequalities embedded in socioeconomic systems that determine who receives quality maternal care and who does not. The Polish system, while operating within a religiously conservative framework, delivers more equitable maternal health outcomes by ensuring standardized care for its homogeneous population.

7.1.4 Role of Midwives and Postpartum Care

The integration and utilization of midwives represent one of the most significant differences between the two maternal healthcare systems. Poland has 87 midwives per 1,000 live births, with

midwives serving as the primary care providers for childbirth in most cases. This high ratio makes Poland's midwifery workforce one of the strongest in Europe, second only to Iceland. Midwives in Poland conduct comprehensive prenatal education classes and serve as the leading providers during low-risk births, with doctors available but typically not attending unless complications arise.

Comparatively, the United States has just four midwives per 1,000 live births, one of the lowest ratios among high-income countries. Midwives attended only 10 percent of the 3.6 million US births in 2020, with obstetricians being the primary birth attendants despite their limited capacity to provide continuous care. The Midwifery Integration Scoring System reveals significant variation in midwifery integration across states, with Washington scoring highest at 61 out of 100 and North Carolina lowest at 17. This limited role of midwives reduces access to personalized, continuous care during pregnancy, birth, and postpartum.

Postpartum care also differs dramatically between the two countries. After childbirth in Poland, the NFZ guarantees six weeks of postpartum care where midwives conduct a minimum of four home visits to assess the physical and psychological health of both the mother and infant. Women in Poland typically spend four-and-a-half days recovering in the hospital after birth, significantly longer than in most European countries, and hospitals rarely discharge patients early even for uncomplicated births. By comparison, postpartum care in the US is usually limited to a single six-week follow-up appointment, which approximately 40 percent of women, particularly those of low socioeconomic status, do not attend due to insurance loss, childcare difficulties, or transportation issues. The average hospital stay after birth is just 24 to 48 hours, and the US is the only high-income country that does not guarantee access to provider home

visits during the postpartum period, despite evidence that a significant portion of maternal deaths occur postpartum.

7.1.5 Parental Leave Policies and Work Protections

Employment-protected paid family leave entitlements are a key factor in reducing maternal deaths. The US ranks 35th of the 38 OECD member states on public expenditure on family benefits, compared to Poland, which ranks 4th (OECD, 2024b, 30). Polish women receive twenty weeks of paid maternity leave, with the option to begin up to six weeks before delivery. After this initial period, an additional thirty-four-week parental leave with reduced pay can be shared between parents. The system includes strong employment protections, including prohibitions on terminating employment during pregnancy or maternity leave and restrictions on overtime and night work for pregnant employees and those with children under four.

The US is the only OECD country without a nationally paid parental leave entitlement. This lack of support forces many mothers, particularly those with lower incomes, to return to work prematurely to meet financial obligations, including medical bills from giving birth. Policies for working parents in the US have undergone minimal changes since the mid-1970s, when the politicization of social values intensified. Several gender and family issues became central to national political debates, such as the Equal Rights Amendment, abortion, and same-sex marriage (Morgan, 2006, 139). These issues catalyzed a mobilization in the defence of traditional family values in which conservatives argued that feminist advocacy for maternity leave threatens parental control over children (Morgan, 2006, 139). Although the Family and Medical Leave Act of 1993 guarantees twelve weeks of unpaid leave for some workers, efforts to introduce a national paid leave program have repeatedly stalled (Morgan, 2006, 137).

In much of Western Europe, there are comprehensive welfare systems that provide income support and subsidize essential services. The widespread popularity of these programs has strengthened the political position of Left-leaning parties and limited the influence of neoliberal movements seeking to reduce state intervention (Morgan, 2006, 141). However, the US follows a more market-oriented path, emphasizing individual responsibility and limited government intervention. The ideological foundation of these cultural values that prioritize personal responsibility and view social protections as entitlements rather than rights has reinforced political opposition and resistance against federal social programs, including paid parental leave. National reforms are complicated further by the decentralized nature of the US political system, where states retain significant control over labour laws.

7.1.6 Sex Education and Contraceptive Access

Both cases face challenges in comprehensive sex education, though for different reasons. In Poland, sex education is highly stigmatized due to traditional Catholic values, with conservative politicians often associating it with “gender ideology” and other controversial topics. As a result, there are significant knowledge gaps about contraceptive methods, particularly among women with lower education levels and those in smaller cities. The US has a patchwork approach to sex education, with no national curriculum and significant state-by-state variation. Only twenty states require sex education to be medically accurate, and most mandate abstinence advocacy. Recent legislation in some states has further restricted content, including requirements to show medically inaccurate anti-abortion videos in sex education classes.

Regarding contraceptive access, just 73 percent of Polish women of reproductive age have their family planning needs met by modern methods, compared to 80.7 percent in the US.

This finding suggests that Poland's lower MMR is not explained by superior contraceptive access. Both countries have seen increased restrictions in recent years, with Poland's limitations largely stemming from cultural and religious factors. Meanwhile, the US has experienced policy-based restrictions, including blocking clinics from providing contraceptives to minors without parental consent and exclusions of certain contraceptive methods from coverage, such as IUDs.

7.1.7 Abortion Statistics and Impacts

In 2023, only 425 legal abortions were performed in Poland with a population of around 37 million, compared with the 1,037,000 legal abortions in the US with a population of around 335 million (Notes from Poland, 2024; Guttmacher Institute, 2024). By my own calculation, this equates to approximately 0.012 abortions per 1,000 people in Poland compared with approximately 3.10 abortions per 1,000 people in the United States. However, due to the stigmatization and contested legality of abortion, official Polish statistics on how many women have abortions have long been considered unreliable and incomplete (Kulczycki, 2023, 4).
The US has a much higher adolescent fertility rate of 13.5 compared to Poland's, which is at 6. While the US teenage fertility rate has significantly declined, it is still the seventh highest among OECD member states, while Poland's is the eighteenth highest (Saches et al., 2024). This disparity suggests that factors beyond legal abortion access are influencing both reproductive choices and maternal health outcomes.

7.2 Discussion

In 2020, Poland's Constitutional Tribunal removed one of the only legal exceptions for abortion and the one that grounded 98 percent of legal abortions in previous years. Comparatively,

abortion was broadly legal in the US in 2020, constitutionally protected under the right to privacy until 2022. While *Roe v. Wade* granted women reproductive agency for nearly half a century, the underlying principle was ultimately that abortion is a matter of domestic privacy. The US was founded on the values of personal autonomy and self-determination, which are established in the Constitution and protected by the rule of law (Cambridge, 2024, 76). The legalization of abortion in terms of the privacy right reveals the individualistic nature of the US legal system to institutionalize rights of self-determination in terms of principles related to personal freedom (Deflem, 1998, 803). The decision fundamentally lacked an acknowledgement of bodily autonomy and disregarded the deeper issues of gender equality in reproductive freedom. Regardless of *Roe's* foundation, the US having a significantly higher 2021 MMR than Poland, 31 compared with 2, while abortion was still broadly legal, suggests that the presence of systemic issues already created significant challenges for minimizing maternal deaths.

While these two countries differ in numerous respects, the US Republican Party embodies some of the same religiously rooted traditional family values as the PiS in Poland. One of the most common indications that religiously rooted traditional family values influence a nation is the presence of fetal personhood laws, which grant fetuses, and sometimes embryos and fertilized eggs, the same legal right to life as living humans. In both cases, there are countless legislative proposals suggesting that life begins at conception, abortion is equivalent to murder, and sex education is pedophilic. Since being sworn in in January 2025 as the 47th President of the United States, Donald Trump has signed numerous executive orders that quietly incorporate tenets of fetal personhood (Sherman, 2025). Legal and judicial decisions on fetal personhood have been established in seventeen states (Pregnancy Justice, 2025).

The nationalist right wing in Poland continues to treat its alliance with the Catholic Church as its main instrument of political legitimacy without a definitive secularization and institutional reformation (Żuk and Żuk, 2019, 207). Poland's restrictive approach to abortion is a violation of reproductive rights and women's agency in their bodies and futures. However, despite having restrictive abortion laws, Poland's maternal healthcare policies suggest a more genuine desire to save lives in the country and protect personhood rather than solely fetal personhood. The US falls short in implementing the key element of traditional family values that protect and support families. The US invokes similar family-oriented rejections of reproductive rights as Poland, while simultaneously making minimal moves to protect maternal health. Republican implementations of traditional family values are surface-level and primarily driven by discriminatory and patriarchal anti-abortion objectives.

The United States exposes its lack of care toward protecting lives and children in many ways. While conservative lawmakers are relentlessly fighting to protect the "lives" of fetuses, people are purchasing firearms at Walmart, which is the leading cause of death of children (Everytown for Gun Safety, 2024). Gun violence takes 125 US lives a day, and the gun homicide rate is 26 times higher than in other high-income countries (Everytown for Gun Safety, 2024). Over 22 million guns were sold in 2022, and there were 328 school shootings throughout the school year (Rapa et al., 2024, 2, 3). Comparatively, gun violence in Poland is extremely low, with an average of 18 firearm homicides a year, and there is no data available on mass shootings since 2000 (Chlebowicz et al., 2022, 40; Gun Violence EU, 2023). With the US having 57 times more school shootings than all other major industrialized countries combined, it is clear that protecting lives and children is not a core cultural value (Rapa et al., 2024, 1). Furthermore, homicide is a leading cause of maternal death in the US. Pregnant women die more often by

homicide than of pregnancy-related causes (Subbaraman, 2021, 539). Women who are pregnant or postpartum between the ages of 10 and 44 are killed 16 percent more often than women who are not (Subbaraman, 2021, 539).

Poland's success in maintaining a low MMR is primarily attributed to the focus on standardizing preventative care, which the US lacks almost entirely. The culture in the US is highly work-driven and individualistic rather than family-oriented. The lack of attention to maternal health is blatant, and cultural priorities are more concerned with economic participation. Paid maternity leave is not guaranteed, and returning to work promptly is praised, increasing the risks of maternal death. While there have been recent efforts to expand postpartum Medicaid coverage, without addressing the systemic discriminatory barriers and adopting national standards, it is unlikely that the result of these efforts will be sufficient to improve the US MMR.

7.3 Suggestions for Future Research and Policies

Comparative approaches to political analyses with the US as a case study are challenging, as many legal mechanisms are controlled at the state level. Nonetheless, this research has provided a comparative analysis of abortion laws and maternal mortality in Poland and the US that has yet to be covered in existing literature extensively. Most studies on maternal mortality focus on the Global South, which has the highest MMRs. As the world learnt from the failures of the MDGs, sustainability and maternal mortality are the responsibilities of all countries, not just the Global South. Analyzing the issue in high-income countries in the Global North shines a light on an under-researched area of this global health issue. The present study does not address all the possible variables that would be needed of a study that provides a sufficient explanation of the

intersectional factors complicating the relationship between abortion laws and maternal health. While many of the insights offered by the present study complement insights from existing literature, the findings of this research can be used as a springboard for future research avenues.

As more data becomes available, further research is required to sufficiently unpack the Polish systems that can maintain one of the lowest MMRs in the world despite having some of the strictest abortion laws in Europe. Future researchers seeking to explain the different MMRs in Poland and the US should provide a deeper analysis of prenatal and postpartum care. For example, further research should examine the quality of care provided to immigrants without legal status. The US has far more newcomers than Poland, and future studies should explore the accessibility of maternal healthcare for these women and how the existence of more people with limited care impacts national MMRs. MMR differences could be explained from a more global perspective by conducting a Most Similar Systems Design, using wealthy countries that are mostly similar but have different policies and approaches to prenatal and postpartum care. As more MMR data becomes available, researchers should conduct longitudinal studies to examine the long-term impacts of the new abortion restrictions in Poland and the US on maternal health outcomes.

Understanding the Polish systems and policies making a low MMR maintainable provides a valuable model for all countries, especially in those with otherwise limited reproductive rights. With abortion bans in place, both countries should prioritize destigmatizing and nationally implementing sex education to avoid more women being forced to carry unwanted pregnancies to term. Proper education about contraception should be provided and easily accessible. Globally, policymakers should work to reform abortion laws and provide safe, accessible services to protect women from harm.

Reducing maternal mortality in the US requires more comprehensive attention to women's mental, physical and financial stability, especially in the postpartum period. Adopting national protocols would reduce regional and demographic disparities by ensuring a more balanced quality of care across hospitals and regions. Attention should be focused on improving access to self-managed medication abortion that women can choose to access outside the clinic setting. Midwives should be integrated more deeply into the maternal healthcare system to ensure more personalized, attentive and consistent care.

If state abortion bans continue to be enacted and upheld in the US, policymakers should consider adopting Polish-inspired healthcare models that also aim to protect living people as wholly as their abortion laws aim to protect fetuses. However, any transposition of Polish models to the US must contend with structural and political differences. The Affordable Care Act, also known as Obamacare, was a significant step toward expanding access to healthcare, yet the US system remains deeply influenced by privatization and powerful interest groups. Political action committees, lobbyists, and wealthy donors often shape electoral outcomes and legislative priorities, including those related to reproductive healthcare. As a result, profit-driven sectors such as private insurers and pharmaceutical companies are strongly represented in policymaking processes. Consequently, effectively reducing maternal deaths requires systemic reform.

The US federal government should ensure paid maternal leave and, if not universal, at the very least, guaranteed healthcare coverage from the beginning of pregnancy to one year postpartum. Despite the prominence of "traditional family values" within the political platform of the Religious Right in the US, the country remains the only high-income OCED member without a national paid maternity leave policy. While conservative movements emphasize

motherhood, fetal personhood, and traditional family values, they rarely advocate for structural support for women after childbirth.

The political priorities of the Religious Right have focused on restricting abortion and promoting the pro-life rhetoric, rather than advancing policies that enable mothers to care for their children without economic consequences. Therefore, there is a clear tension between religious moral conservatism and neoliberal economic principles. Unlike Poland, which has integrated religious values with family policy, the US treats family care as a private responsibility rather than a public good. As a result, motherhood is valorized rhetorically but unsupported in practice. Women in the US are suffering the consequences of a policy framework where the state intervenes to force childbirth, but retreats when it comes to protecting mothers. Reducing maternal mortality under restrictive abortion laws demands a reimagining of state responsibility toward women's lives. By prioritizing equitable access to safe and comprehensive reproductive healthcare and addressing the political and structural barriers that halt reform efforts, governments can do more to protect maternal health.

References

Adinma, E. (2011). Unsafe abortion and its ethical, sexual and reproductive rights implications. *West African Journal of Medicine, 30*(4), 245–249.

Ahn, R., Gonzalez, G. P., Anderson, B., Vladutiu, C. J., Fowler, E. R., & Manning, L. (2020). Initiatives to reduce maternal mortality and severe maternal morbidity in the United States: A narrative review. *Annals of Internal Medicine, 173*(11_Supplement), S3–S10. https://doi.org/10.7326/M19-3258

Alkenbrack, S., Chaitkin, M., Zeng, W., Couture, T., & Sharma, S. (2015). Did equity of reproductive and maternal health service coverage increase during the MDG era? An analysis of trends and determinants across 74 low- and middle-income countries. *PLOS ONE, 10*(9).

Balk, E. M., Konnyu, K., Cao, W., Bhuma, M. R., Danilack, V. A., Adam, G. P., & Peahl, A. F. (2022). *Schedule of visits and televisits for routine antenatal care: A systematic review* (Comparative Effectiveness Review No. 257). Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK582024

Baranowska, B., Węgrzynowska, M., Tataj-Puzyna, U., & Crowther, S. (2022). "I knew there has to be a better way": Women's pathways to freebirth in Poland. *Women and Birth*, *35*(4), e328–e336. https://doi.org/10.1016/j.wombi.2021.07.008

Barbaro, M., Ghorayshi, A., Krupke, E., Stern, A., Harper, S., & Wilson, M. (2024). *The Alabama ruling that could stop families from having kids*. The Daily, The New York Times. https://www.nytimes.com/2024/02/26/podcasts/the-daily/alabama-embryo-ivf.html

Benner, K., Fahrenthold, D. A., & Sanger-Katz, M. (2025). Planned Parenthood Must Choose Between Abortion or Millions in Federal Funding. *The New York Times.* https://www.nytimes.com/2025/07/02/us/politics/planned-parenthood-abortions-senate-medicaid-funding.html

Benson, J., Andersen, K., & Samandari, G. (2011). Reductions in abortion-related mortality following policy reform: Evidence from Romania, South Africa and Bangladesh. *Reproductive Health, 8*(39). https://doi.org/10.1186/1742-4755-8-39

Bhalotra, S., Clarke, D., Gomes, J. F., & Venkataramani, A. (2023). Maternal mortality and women's political power. *Journal of the European Economic Association, 21*(5), 2172–2208. https://doi.org/10.1093/jeea/jvad012

Bhutta, Z. A., & Rulisa, S. (2025). Implications of the USAID U-turn on women's health globally. *Obstetric Medicine, 18*(2), 67–68. https://doi.org/10.1177/1753495X251332669

Boakye, P. N., Prendergast, N., Bandari, B., Anane Brown, E., Odutayo, A., & Salami, S. (2023). Obstetric racism and perceived quality of maternity care in Canada: Voices of Black women. *Women's Health*, *19*, 1-13. https://doi.org/10.1177/17455057231199651

Brandt, E., & Maner, J. K. (2024). Attitudes and Laws About Abortion Are Linked to Extrinsic Mortality Risk: A Life-History Perspective on Variability in Reproductive Rights. *Psychological Science*, *35*(2), 111–125. https://doi.org/10.1177/09567976231217410

Briozzo, L. (2016). From risk and harm reduction to decriminalizing abortion: The Uruguayan model for women's rights. *International Journal of Gynecology & Obstetrics, 134*, S3–S6. https://doi.org/10.1016/j.ijgo.2016.06.003

Britannica. (2025). Moral Majority American Organization. https://www.britannica.com/topic/Moral-Majority

Cambridge, C. (2024). The Perils of Political Idolatry: Trump's Exploitation of Christianity. *Taboo*, *22*(3), 76-82.

Catholics for Choice. (2025). Welcome to Catholics for Choice! https://www.catholicsforchoice.org/welcome-to-catholics-for-choice/

Center for American Women and Politics (CAWP). (2024). Gender Differences in Voter Turnout. *Eagleton Institute of Politics.* New Brunswick, NJ. https://cawp.rutgers.edu/facts/voters/gender-differences-voter-turnout#NPGR

Center for Reproductive Rights (CRR). (2025a). *After Roe fell: Abortion laws by state*. New York, NY. https://reproductiverights.org/maps/abortion-laws-by-state/

Center for Reproductive Rights (CRR). (2025b). Arizona Judge Permanently Blocks State's 15-Week Abortion Ban, Declaring it Unconstitutional. New York, NY. https://reproductiverights.org/arizona-15-week-abortion-ban-blocked/

Center for Reproductive Rights (CRR). (2025c). *The World's Abortion Law Maps.* New York, NY. https://reproductiverights.org/maps/worlds-abortion-laws/

Center for Reproductive Rights (CRR). (2023). Center Continues Work to Enforce the Constitutional Right to Abortion in Kenya. https://reproductiverights.org/kenya-case-hearing-republic-s-m-abortion/

Center for Reproductive Rights (CRR). (2014). *Abortion worldwide: 20 years of reform.* New York, NY. https://www.reproductiverights.org/sites/crr.civicactions.net

Centers for Disease Control and Prevention (CDC). (2025). *National Vital Statistics System*. U.S. Department of Health & Human Services. https://www.cdc.gov/nchs/nvss/index.htm

Centers for Medicare and Medicaid Services. (2025). *What is Medicaid?* U.S. Department of Health & Human Services. https://www.medicaid.gov/about-us/index.html

Central Intelligence Agency. (2025). *The world factbook*. https://www.cia.gov/the-world-factbook/

Chen, Y., Shiels, M. S., Uribe-Leitz, T., Molina, R. L., Lawrence, W. R., Freedman, N. D., & Abnet, C. C. (2025). Pregnancy-Related Deaths in the US, 2018-2022. *JAMA Network Open*, *8*(4), e254325. https://doi.org/10.1001/jamanetworkopen.2025.4325

Chin, K., Wendt, A., Bennett, I. M., & Bhat, A. (2022). Suicide and Maternal Mortality. *Current Psychiatry Reports*, *24*(4), 239–275. https://doi.org/10.1007/s11920-022-01334-3

Chlebowicz, P., Moszczyński, J., Safjański, T., & Buczyński, S. (2022). *The success story? An in-depth analysis of illicit firearm trafficking and gun violence in Poland*. Flemish Peace Institute. https://vlaamsvredesinstituut.eu

Chrzan-Dętkoś, M., & Walczak-Kozłowska, T. (2020). Antenatal and postnatal depression: Are Polish midwives really ready for them? *Midwifery, 83*, 102646. https://doi.org/10.1016/j.midw.2020.102646

Coleman, T. (2024). *More women opt for home births despite high costs*. The Week US. https://theweek.com/health/home-births-rise

Combellick, J. L., Telfer, M. L., Ibrahim, B. B., Novick, G., Morelli, E. M., James-Conterelli, S., & Kennedy, H. P. (2023). Midwifery care during labor and birth in the United States. *American Journal of Obstetrics and Gynecology, 228*(5), S983–S993. https://doi.org/10.1016/j.ajog.2022.09.044

Cox, J. E. (2020). Understanding the Differences in Pregnancy and Birth Rates for Black and White Teens. *Journal of Adolescent Health*, *67*(3), 313–314. https://doi.org/10.1016/j.jadohealth.2020.06.010

Cultural Research Center. (2024). 2024 Election Research – Report #2 Decisive Christian Vote Carries Trump to Historic Victory, Post-Election Research Shows. *Arizona Christian University.* Glendale, Arizona. https://www.arizonachristian.edu/wp-content/uploads/2024/11/CRC-Release-Post-Election-Nov-13-2024-Christian-Vote-Hands-Trump-Victory.pdf

Darney, P. D., Nakamura-Pereira, M., Regan, L., Serur, F., & Thapa, K. (2020). Maternal Mortality in the United States Compared With Ethiopia, Nepal, Brazil, and the United Kingdom: Contrasts in Reproductive Health Policies. *Obstetrics & Gynecology*, *135*(6), 1362–1366. https://doi.org/10.1097/AOG.0000000000003870

Davies, C. (2020). Poland's Law and Justice party targeting sex education. *The Lancet, 395*(10217), 17–18. https://doi.org/10.1016/S0140-6736(19)33168-X

Deflem, M. (1998). The Boundaries of Abortion Law: Systems Theory from Parsons to Luhmann and Habermas. *Social Forces*, *76*(3), 775–818. https://doi.org/10.2307/3005694

Diamant, J., Mohamed, B., & Leppert, R. (2024). *What the data says about abortion in the US*. Pew Research Center. https://www.pewresearch.org/short-reads

Dibaba, Y., Dijkerman, S., Fetters, T., Moore, A., Gebreselassie, H., Gebrehiwot, Y., & Benson, J. (2017). A decade of progress providing safe abortion services in Ethiopia: Results of national assessments in 2008 and 2014. *BMC Pregnancy and Childbirth, 17*(76). https://doi.org/10.1186/s12884-017-1266-z

Doyle, S. (2021). Maternal health, epidemiology and transition theory in Africa. In M. Vaughan, K. Adjaye-Gbewonyo, & M. Mika (Eds.), *Epidemiological change and chronic disease in Sub-Saharan Africa: Social and historical perspectives*. UCL Press.

Ernst, J., Katzive, L., & Smock, E. (2004). The global pattern of US initiatives curtailing women's reproductive rights: A perspective on the increasingly anti-choice mosaic. *University of Pennsylvania Journal of Constitutional Law, 6*(4), 752–795.

Eska-Mikołajewska, J. (2021). Evolution of the abortion law and its practice in Poland against the background of the current legal framework in New Zealand. *National Security Journal, 3*(1). https://doi.org/10.36878/nsj20210405.02

European Commission. (2025). *Poland - European Health Insurance Card*. European Union. https://employment-social-affairs.ec.europa.eu/policies-and-activities

European Commission. (2023). *The European Commission decides to Refer Poland to the Court of Justice of the European Union for violations of EU law by its Constitutional Tribunal.* European Union. https://ec.europa.eu/commission/presscorner/detail/ga/ip_23_842

European Parliament. (2025). Cohesion Fund. *Fact Sheets on the European Union.* https://www.europarl.europa.eu/factsheets/en/sheet/96/cohesion-fund

Eurostat. (2024a). *EU population diversity by citizenship and country of birth*. European Commission. https://ec.europa.eu/eurostat/statistics

Eurostat. (2024b). *Healthcare personnel statistics - physicians*. European Commission. https://ec.europa.eu/eurostat/statistics

Eurostat. (2024c). *Health problems and financial burden of care*. European Commission. https://ec.europa.eu/eurostat/statistics

Eurostat. (2024d). *Health statistics at regional level*. European Commission. https://ec.europa.eu/eurostat/statistics

Eurostat. (2024e). *SDG 3 - Good health and well-being*. European Commission. https://ec.europa.eu/eurostat/statistics

Everytown for Gun Safety. (2024). *Gun violence in America*. Everytown For Gun Safety Support Fund. https://everytownresearch.org/report/gun-violence-in-america/

Faúndes, A., & Shah, I. H. (2015). Evidence supporting broader access to safe legal abortion. *International Journal of Gynecology & Obstetrics, 131*(S1). https://doi.org/10.1016/j.ijgo.2015.03.018

Felix, M., Sobel, L., & Salganicoff, A. (2024a*).* A Review of Exceptions in State Abortion Bans: Implications for the provision of abortion services*. KFF*. https://www.kff.org/womens-health

Felix, M., Sobel, L., & Salganicoff, A. (2024b). The Right to Contraception: State and Federal Actions, Misinformation, and the Courts. *KFF.* https://www.kff.org/womens-health-policy/issue-brief/the-right-to-contraception-state-and-federal-actions-misinformation-and-the-courts/

Feyssa, M. D., & Gebru, S. K. (2022). Liberalizing abortion to reduce maternal mortality: Expanding access to all Ethiopians. *Reproductive Health, 19*(S1), 151. https://doi.org/10.1186/s12978-022-01457-z

Fleszar, L. G., Bryant, A. S., Johnson, C. O., Blacker, B. F., Aravkin, A., Baumann, M., Dwyer-Lindgren, L., Kelly, Y. O., Maass, K., Zheng, P., & Roth, G. A. (2023). Trends in state-level maternal mortality by racial and ethnic group in the United States. *JAMA, 330*(1), 52. https://doi.org/10.1001/jama.2023.9043

Forouzan, K., & Mariappuram, R. (2024). *Midyear 2024 state policy trends: Many US states attack reproductive healthcare, as other states fight back*. Guttmacher Institute. https://www.guttmacher.org/2024/06/midyear-2024-state-policy-trends

Frohwirth, L., Coleman, M., & Moore, A. M. (2018). Managing Religion and Morality Within the Abortion Experience: Qualitative Interviews with Women Obtaining Abortions in the U.S. *World Medical & Health Policy*, *10*(4), 381–400. https://doi.org/10.1002/wmh3.289

Fuszara, M. (1991). Legal regulation of abortion in Poland. *Signs: Journal of Women in Culture and Society, 17*(1), 117–128. https://doi.org/10.1086/494716

Ganatra, B., Gerdts, C., Rossier, C., Johnson, B. R., Tunçalp, Ö., Assifi, A., Sedgh, G., Singh, S., Bankole, A., Popinchalk, A., Bearak, J., Kang, Z., & Alkema, L. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model. *The Lancet*, *390*(10110), 2372–2381. https://doi.org/10.1016/S0140-6736(17)31794-4

Gebrehiwot, Y., & Liabsuetrakul, T. (2008). Trends of abortion complications and a transition of abortion law revisions in Ethiopia. *Journal of Public Health, 31*(1), 81–87. https://doi.org/10.1093/pubmed/fdn068

Gilby, L., Koivusalo, M., & Atkins, S. (2021). Global health without sexual and reproductive health and rights? Analysis of United Nations documents and country statements, 2014–2019. *BMJ Global Health, 6*(3), e004659. https://doi.org/10.1136/bmjgh-2020-004659

Giorgio, M., Makumbi, F., Kibira, S. P. S., Bell, S. O., Chiu, D. W., Firestein, L., & Sully, E. (2022). An investigation of the impact of the Global Gag Rule on women's sexual and reproductive health outcomes in Uganda: A difference-in-differences analysis. *Sexual and Reproductive Health Matters, 30*(1), 2122938. https://doi.org/10.1080/26410397.2022.2122938

Gold, R. B. (2003). Lessons from before Roe: Will past be prologue? *The Guttmacher Report on Public Policy*, 8–11.

Government of Poland. (2025). *Parenthood-related rights*. European Union. https://www.gov.pl/web/your-europe/parenthood-related-rights

Goyal, S., Kortsmit, K., Cox, S., D'Angelo, D. V., Romero, L., Henderson, Z. T., & Barfield, W. D. (2020). Prevalence of home births and associated risk profile and maternal characteristics, 2016–2018. *Obstetrics & Gynecology, 136*(6), 1–16. https://doi.org/10.1097/AOG.0000000000004129

Gun Violence European Union. (2023). *Key data gun violence Poland 2023*. European Union's International Security Fund. https://gunviolence.eu/wp-content/uploads/2023/12/Poland.pdf

Gunja, M., Gumas, E. D., Masitha, R., & Zephyrin, L. C. (2024). *Insights into the U.S. maternal mortality crisis: An international comparison*. The Commonwealth Fund. https://doi.org/10.26099/cthn-st75

Gunja, M., Seervai, S., Zephyrin, L., & Williams II, R. (2022). *Health and healthcare for women of reproductive age*. The Commonwealth Fund. https://doi.org/10.26099/4pph-j894

Guttmacher Institute. (2024). *Abortion in the United States*. https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

Hall, C., Daire, J., & Hendrie, D. (2023). A scoping review considering the processes involved in changing abortion laws in low- and middle-income countries. *Health Policy and Planning*, *38*(10), 1181–1197. https://doi.org/10.1093/heapol/czad081

Harper, L. M., Leach, J. M., Robbins, L., Blanchard, C., Metz, T. D., Mazzoni, S., Nash, E., & Szychowski, J. (2023). All-cause mortality in reproductive-aged females by state: An analysis of the effects of abortion legislation. *Obstetrics & Gynecology, 141*(2), 236–242. https://doi.org/10.1097/AOG.0000000000005035

Hawkins, S. S., Ghiani, M., Harper, S., Baum, C. F., & Kaufman, J. S. (2020). Impact of state-level changes on maternal mortality: A population-based, quasi-experimental study. *American Journal of Preventive Medicine, 58*(2), 165–174. https://doi.org/10.1016/j.amepre.2019.09.012

Hegde, S., Hoban, E., & Nevill, A. (2012). Unsafe abortion as a birth control method: Maternal mortality risks among unmarried Cambodian migrant women on the Thai-Cambodia border. *Asia Pacific Journal of Public Health, 24*(6), 989–1001. https://doi.org/10.1177/1010539511409024

Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., Lopez, A. D., Lozano, R., & Murray, C. J. (2010). Maternal mortality for 181 countries, 1980–2008: A systematic analysis of progress towards Millennium Development Goal 5. *The Lancet, 375*(9726), 1609–1623. https://doi.org/10.1016/S0140-6736(10)60518-1

Hoyert, D. L. (2025). *Maternal mortality rates in the United States, 2023* (Health E-Stats). National Center for Health Statistics. https://dx.doi.org/10.15620/cdc/174577

Hoyert, D. L. (2023). *Maternal mortality rates in the United States, 2021* (Health E-Stats). National Center for Health Statistics. https://doi.org/10.15620/cdc:124678

IPAS Africa Alliance. (2016). *Securing women's reproductive rights in Kenya*. Endline evaluation report. TNS RMS East Africa Limited.

Jackson, E., Johnson, B. R., Gebreselassie, H., Kangaude, G. D., & Mhango, C. (2011). A strategic assessment of unsafe abortion in Malawi. *Reproductive Health Matters, 19*(37), 133–143. https://doi.org/10.1016/S0968-8080(11)37563-5

Jaraczewski, J. (2025). Poland's ongoing rule-of-law crisis explained. *Notes from Poland.* https://notesfrompoland.com/2025/03/17/polands-ongoing-rule-of-law-crisis-explained/

Jelen, T. G., & Wilcox, C. (2005). Continuity and change in attitudes toward abortion: Poland and the United States. *Politics & Gender, 1*(2). https://doi.org/10.1017/S1743923X05050099

Johnson, B. R., Mishra, V., Lavelanet, A. F., Khosla, R., & Ganatra, B. (2017). A global database of abortion laws, policies, health standards and guidelines. *Bulletin of the World Health Organization*, *95*(7), 542–544. https://doi.org/10.2471/BLT.17.197442

Jones, G. L., Mitchell, C. A., Hirst, J. E., Anumba, D. O. C., & the Royal College of Obstetricians and Gynaecologists. (2022). Understanding the relationship between social determinants of health and maternal mortality: Scientific Impact Paper No. 67. BJOG: *An International Journal of Obstetrics & Gynaecology*, *129*(7), 1211–1228. https://doi.org/10.1111/1471-0528.17044

Katella, K. (2023). Maternal mortality is on the rise: 8 things to know. *Yale Medicine*, 22. https://www.yalemedicine.org/news/maternal-mortality-on-the-rise

Keefe, J., Wolfe, D. & Hernandez, S. (2021). Race and ethnicity across the nation. CNN. https://www.cnn.com/interactive/2021/us/census-race-ethnicity-map/

Keisler-Starkey, K., Bunch, L. N., & the U.S. Census Bureau. (2022). Current Population Reports, P60-278, Health Insurance Coverage in the United States: 2021, U.S. Government Publishing Office. Washington, DC. https://www.census.gov/library/publications/2022/demo/p60-278.html

Keller, R. (2025). Missouri abortion rights amendment trumps most restrictions, judge rules. *Missouri Independent.* Jefferson City, MO. https://missouriindependent.com/2025/07/03/missouri-abortion-rights-amendment-trumps-most-restrictions-judge-rules/

KFF. (2025). Medicaid Postpartum Coverage Extension Tracker. San Franscico, CA. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/

KFF. (2024). Women's Health Insurance Coverage. San Franscico, CA. https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/

Kheyfets, A., Dhaurali, S., Feyock, P., Khan, F., Lockley, A., Miller, B., Cohen, L., Anwar, E., & Amutah-Onukagha, N. (2023). The impact of hostile abortion legislation on the United States maternal mortality crisis: A call for increased abortion education. *Frontiers in Public Health*, *11*, 1–6. https://doi.org/10.3389/fpubh.2023.1291668

Knight, M., Bunch, K., Tuffnell, D., Jayakody, H., Shakespeare, J., Kotnis, R., Kenyon, S., & Kurinczuk, J. (2018). Saving Lives, Improving Mothers' Care—Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16. (978-0-9956854-1–3; Maternal, Newborn and Infant Clinical Outcome Review Programme). MBRRACE-UK.

Koch, E., Thorp, J., Bravo, M., Gatica, S., Romero, C. X., Aguilera, H., & Ahlers, I. (2012). Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007. *PLoS ONE*, *7*(5), e36613. https://doi.org/10.1371/journal.pone.0036613

Koralewska, I., & Zielińska, K. (2022). 'Defending the unborn', 'protecting women' and 'preserving culture and nation': Anti-abortion discourse. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, *24*(5), 673–687. https://doi.org/10.1080/13691058.2021.1878559

Kulczycki, A. (2023). Between a Rock and a Hard Place: Abortion, Catholicism, the Populist Right and Public Health Threats in Poland. *Religions*, *14*(10), 1271. https://doi.org/10.3390/rel14101271

Latt, S. M., Milner, A., & Kavanagh, A. (2019). Abortion laws reform may reduce maternal mortality: An ecological study in 162 countries. *BMC Women's Health*, *19*(1), 1–9. https://doi.org/10.1186/s12905-018-0705-y

Lawrence, E. R., Appiah-Kubi, A., Lawrence, H. R., Lui, M. Y., Owusu-Antwi, R., Konney, T., & Moyer, C. A. (2022). "There is no joy in the family anymore": A mixed-methods study on the

experience and impact of maternal mortality on families in Ghana. *BMC Pregnancy and Childbirt*h, *22*(1), 683. https://doi.org/10.1186/s12884-022-05006-1

Lay, K. (2025). Aid cuts could have 'pandemic-like effects' on maternal deaths, WHO warns. *The Guardian.* https://www.theguardian.com/global-development/2025/apr/06/aid-cuts-pandemic-like-effects-maternal-deaths-childbirth-haemorrhage-pre-eclampsia-malaria-who-warns

Learish, J. (2020). The cost of giving birth in each state. *CBS News.* New York, NY. https://www.cbsnews.com/pictures/cost-giving-birth-in-united-states/6/

Levenstein, L. (2018). A Social Movement for a Global Age: U.S. Feminism and the Beijing Women's Conference of 1995. *Journal of American History*, *105*(2), 336–365. https://doi.org/10.1093/jahist/jay147

Lommerse, K. M., Mérelle, S., Rietveld, A. L., Berkelmans, G., van den Akker, T., & The Netherlands Audit Committee Maternal Mortality and Morbidity. (2024). The contribution of suicide to maternal mortality: A nationwide population-based cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *131*(10), 1-7. https://doi.org/10.1111/1471-0528.17784

Loren, A. (2025). Pope Leo confirms stance on gay marriage and abortion. *The Independent.* London, UK. https://www.independent.co.uk/news/world/europe/pope-leo-abortion-gay-marriage-b2753502.html

MacDorman, M. F., Declercq, E., Cabral, H., & Morton, C. (2016). Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues. *Obstetrics & Gynecology*, *128*(3), 447–455. https://doi.org/10.1097/AOG.0000000000001556

Makuei, G., Abdollahian, M., & Marion, K. (2020). Optimal Profile Limits for Maternal Mortality Rates (MMR) Influenced by Haemorrhage and Unsafe Abortion in South Sudan. *Journal of Pregnancy*, 2020, 1–13. https://doi.org/10.1155/2020/2793960

Manyeh, A. K., Nathan, R., & Nelson, G. (2018). Maternal mortality in Ifakara Health and Demographic Surveillance System: Spatial patterns, trends and risk factors, 2006 – 2010. *PLOS ONE*, *13*(10), e0205370. https://doi.org/10.1371/journal.pone.0205370

March of Dimes. (2025). Maternal and Infant Health Data. Perinatal Data Center: Arlington, VA. https://www.marchofdimes.org/peristats/data

Mastylak, A., Miteniece, E., Czabanowska, K., Pavlova, M., & Groot, W. (2023). The "Blessing" of Pregnancy? Barriers to accessing adequate maternal care in Poland: A mixed-method study among women, healthcare providers, and decision-makers. *Midwifery*, *116*, 103554, 1-9. https://doi.org/10.1016/j.midw.2022.103554

Maxwell, C., Tunde-Byass, M., & Wilson-Mitchell, K. (2024). Achieving equity in reproductive care and birth outcomes for Black people in Canada. *Canadian Medical Association Journal*, *196*(10), E343–E345. https://doi.org/10.1503/cmaj.231105

McGee, A., Jansen, M., & Sheldon, S. (2018). Abortion law reform: Why ethical intractability and maternal morbidity are grounds for decriminalisation. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *58*(5), 594–597. https://doi.org/10.1111/ajo.12817

Mikuła, Ł., & Kaczmarek, U. (2019). From marketization to recentralization: The health-care system reforms in Poland and the post-New Public Management concept. *International Review of Administrative Sciences*, *85*(1), 28–44. https://doi.org/10.1177/0020852318773429

Mills, A., Durepos, G., & Wiebe, E. (2010). Most Different Systems Design. In *Encyclopedia of Case Study Research* (pp. 571–572). SAGE Publications, Inc. https://doi.org/10.4135/9781412957397

Morgan, K. (2006). Chapter 5. The Consolidation of the Private Market Model in the United States. In *Working Mothers and the Welfare State: Religion and the Politics of Work-Family Policies in Western Europe and the United States*. 135-156. Redwood City: Stanford University Press. https://doi.org/10.1515/9781503625983-007

Mukuru, M., Gorry, J., Kiwanuka, S. N., Gibson, L., Musoke, D., & Ssengooba, F. (2021). Designed to Fail? Revisiting Uganda's Maternal Health Policies to Understand Policy Design Issues Underpinning Missed Targets for Reduction of Maternal Mortality Ratio (MMR): 2000-2015. *International Journal of Health Policy and Management*, 1, 2124-2134. https://doi.org/10.34172/ijhpm.2021.127

Mutua, M. M., Manderson, L., Musenge, E., & Achia, T. N. O. (2018). Policy, law and post-abortion care services in Kenya. *PLOS ONE*, *13*(9), e0204240. https://doi.org/10.1371/journal.pone.0204240

National Council of Jewish Women. (2025). Judaism and Abortion. https://www.ncjw.org/wp-content/uploads/2019/05/Judaism-and-Abortion-FINAL.pdf

Ndyanabangi, B., Livingstone, M., Gobeh, W., Logan, G. G., & Atukunda, L. (2021). Unsafe abortion – A Risk factor for maternal mortality in Liberia—An analysis of the characteristics of unsafe abortion clients and risk factors for maternal morbidity and mortality. *African Journal for Reproductive Health*, *25*(6), 43–50.

Nehme, L., Ye, P., Huang, J. C., & Kawakita, T. (2023). Decision and economic analysis of hostile abortion laws compared with supportive abortion laws. *American Journal of Obstetrics & Gynecology MFM*, *5*(8), 101019. https://doi.org/10.1016/j.ajogmf.2023.101019

Newport, F. (2022). The Religion of the Supreme Court Justices. *Gallup.* Washington, DC. https://news.gallup.com/opinion/polling-matters/391649/religion-supreme-court-justices.aspx

Ngo, N. V., Pemunta, N. V., Basil, N., Fokunang, E. T., Mbong, S. E., Ezra, K., Che, H. N., & Umbugadu, E. S. (2024). Reproductive health policy saga: Restrictive abortion laws in low- and middle-income countries (LMICs), unnecessary cause of maternal mortality. *Health Care for Women International*, *45*(1), 5–23. https://doi.org/10.1080/07399332.2021.1994971

Notes from Poland. (2025). Poland's fertility rate fell to new low in 2024. *Fundacja Notes from Poland*. Kraków, Poland. https://notesfrompoland.com/2025/06/02/polands-fertility-rate-fell-to-new-low-in-2024/

Notes from Poland. (2024). Number of legal abortions in Poland more than doubled in 2023. *Fundacja Notes from Poland*. Kraków, Poland. https://notesfrompoland.com/2024/07/26/number-of-legal-abortions-in-poland-more-than-doubled-in-2023/

Notes from Poland. (2021). "The mother's life is most important": Polish government issues abortion guidance to doctors. *Fundacja Notes from Poland*. Kraków, Poland. https://notesfrompoland.com/2021/11/08/the-mothers-life-is-most-important-polish-government-issues-abortion-guidance-to-doctors/

OECD. (2024a). Data Explorer Archive. Organisation for Economic Co-operation and Development. Paris, France. https://data-explorer.oecd.org/vis?tenant=archive

OECD. (2024b). Society at a Glance 2024: OECD Social Indicators, OECD Publishing, Paris, France. https://doi.org/10.1787/918d8db3-en

Ohia, M. A. (2016). Racism in Public Discourse in Poland: A preliminary analysis. *Edutainment*, *1,* 147-161. https://doi.org/10.15503/edut.2016.1.147.161

Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP (2024). Births: Final data for 2022. *National Vital Statistics Reports*; (73)2: 1-56. Hyattsville, MD, United States: National Center for Health Statistics. https://dx.doi.org/10.15620/cdc:145588

Palfi, R., & Askew, J. (2022). Hungarian women must hear foetus' heartbeat before abortion decision. *Euronews*. Brussels, Belgium. https://www.euronews.com/2022/09/13

Parliamentary Elections in Poland. (2015). Parliamentary Elections in Poland—25th October 2015 Results. *Robert Schuman Foundation*, 1–4. https://old.robert-schuman.eu//en/doc/oee/oee-1614-en.pdf

Passel, J. M., & Krogstad, J, M. (2024). What we know about unauthorized immigrants living in the U.S. Pew Research Center. pewresearch.org/short-reads/2024/07/22/what-we-know-about-unauthorized-immigrants-living-in-the-us/

Pew Research Center. (2025). 2023-24 US Religious Landscape Study Interactive Database. Washington, DC. https://www.pewresearch.org/religious-landscape-study/

Pew Research Center. (2021a). Faith Among Black Americans. Washington, DC. https://www.pewresearch.org/religion/2021/02/16/faith-among-black-americans/

Pew Research Center. (2021b). Faith on the Hill - The religious composition of the 117th Congress. Washington, DC. https://www.pewresearch.org/religion/2021/01/04/faith-on-the-hill-2021/

Pew Research Center. (2018). Eastern and Western Europeans Differ on the Importance of Religion, Views of Minorities, and Key Social Issues. Washington, DC. https://www.pewresearch.org/religion/2018/10/29/eastern-and-western-europeans-differ-on-importance-of-religion-views-of-minorities-and-key-social-issues/

Planned Parenthood. (2025). Historical Abortion Law Timeline: 1850 to Today. New York, NY. https://www.plannedparenthoodaction.org

Pregnancy Justice. (2025). Fetal Personhood Legal Landscape. https://www.pregnancyjusticeus.org/legal-landscape/

Purchasing Power Parity Calculator. (2025). PPP Salary Converter. Purchasing Power Parity (PPP) Calculator. https://pppcalculator.pro/

Rapa, L. J., Katsiyannis, A., Scott, S. N., & Durham, O. (2024). School Shootings in the United States: 1997–2022. *Pediatrics*, *153*(4), 1–8. https://doi.org/10.1542/peds.2023-064311

Ries, J., & Mohney, G. (2022). Ectopic Pregnancies Are Dangerous. Will They Be Affected by Abortion Bans? *Healthline.* https://www.healthline.com/health-news/ectopic-pregnancy-and-abortion-laws-what-to-know#The-bottom-line

Rodzić po Ludzku Foundation. (2023). The Organizational Standard of Perinatal Care in Poland. https://rodzicpoludzku.pl/uncategorized

Romig, K. & Bryant, K. (2021). A National Paid Leave Program Would Help Workers, Families. Center on Budget and Policy Priorities: Washington, DC. 1-17. https://www.cbpp.org/research/economy

Sáez, M. (2024). Mixed Results on US Abortion Rights on the Ballot: State Initiatives Mostly Yield Progress, but Also Setbacks. *Human Rights Watch:* New York, NY. https://www.hrw.org/news/2024/11/06/mixed-results-us-abortion-rights-ballot

Sachs, J. D., Lafortune, G., & Fuller, G. (2024). The SDGs and the UN Summit of the Future. Sustainable Development Report 2024. Paris: SDSN, Dublin: Dublin University Press. DOI: 10.25546/108572 Supplementary visual data explorer: https://dashboards.sdgindex.org/

Salinas, J. (2025). Nebraska group seeks to turn state's 12-week abortion ban into total one. *Nebraska Examiner.* Lincoln, NE. https://nebraskaexaminer.com/2025/06/11/nebraska-group-seeks-to-turn-states-12-week-abortion-ban-into-total-one/

Shah, P. S., Zao, J., Al-Wassia, H., Shah, V., & Knowledge Synthesis Group on Determinants of Preterm/LBW Births (2011). Pregnancy and neonatal outcomes of aboriginal women: a systematic review and meta-analysis. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *21*(1), 28–39. https://doi.org/10.1016/j.whi.2010.08.005

Sheppard, A. J., Shapiro, G. D., Bushnik, T, Wilkins, R, Perry, S, Kaufman, J. S., Kramer, M. S., Yang, S. (2017). Birth outcomes among First Nations, Inuit and Métis populations. Health Rep; 28(11):11-16. PMID: 29140536. https://pubmed.ncbi.nlm.nih.gov/29140536/

Sherman, C. (2025). Trump's executive order on gender uses language pointing to 'fetal personhood'. *The Guardian.* https://www.theguardian.com/us-news/2025/jan/23/trump-executive-order-fetal-personhood

Sherman, C., Yachot, N., & Witherspoon, A. (2024). Tracking abortion ballot measures: Missouri and Arizona expand rights as Florida vote falls short. *The Guardian.* https://www.theguardian.com/us-news

Singh, G. K. (2021). Trends and Social Inequalities in Maternal Mortality in the United States, 1969-2018. *International Journal of MCH and AIDS*, *10*(1), 29–42. https://doi.org/10.21106/ijma.444

Smith, G. (2024). White Protestants and Catholics Support Trump, but Voters in Other U.S. Religious Groups Prefer Harris. *Pew Research Center*. https://www.pewresearch.org/short

Songane, F. (2013). Maternal mortality: An overview. In P. Hunt & T. Gray (Eds.), Maternal mortality, human rights and accountability. Routledge: London UK. 3-12.

Statistics Canada. (2024). Fertility in Canada, 1921 to 2022. Ottawa, Canada. https://www150.statcan.gc.ca/n1/pub/91f0015m/91f0015m2024001-eng.htm

Statistics Poland. (2025). Polska w liczbach 2025 [Poland in Numbers 2025]. *National Reporting Platform.* Warsaw, Poland. https://stat.gov.pl

Subbaraman, N. (2021). Homicide is a top cause of maternal death in the United States. *Nature*, *599*(7886), 539–540. https://doi.org/10.1038/d41586-021-03392-8

Sully, A., Owolabi, O., & Rosenberg, J. D. (2025). Family Planning Impact of the Trump Foreign Assistance Freeze. *Guttmacher Institute.* https://www.guttmacher.org/2025/01/family-planning-impact-trump-foreign-assistance-freeze

Szelewa, D. (2019). Invention–Institutionalization–Implementation: The Origins of Childcare Policies in Poland. *Social Politics: International Studies in Gender, State & Society*, *26*(1), 139–163. https://doi.org/10.1093/sp/jxy009

Tikkanen, R., Gunja, M. Z., FitzGerald, M., Zephyrin., L. C. (2020). Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries. *Commonwealth Fund.* https://www.commonwealthfund.org/publications

UNDESA. (2025a). E-Handbook on Sustainable Development Goals Indicators. Department of Economic and Social Affairs of the United Nations. New York, NY. https://unstats.un.org/wiki/display/SDGeHandbook

UNDESA. (2025b). Family Planning Indicators. The Population Division of the Department of Economic and Social Affairs of the United Nations. New York, NY. https://www.un.org/development/desa/pd/data/family-planning-indicators

UNDESA. (2024). World Contraceptive Use Dataset. The Population Division of the Department of Economic and Social Affairs of the United Nations. New York, NY. https://www.un.org/development/desa/pd/data/world-contraceptive-use

UNDESA. (2004). Poland Abortion Policy. The Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat. New York, NY.

UNFPA. (2004). UNFPA Regrets U. S. Administration's Decision Not to Restore Funding. United Nations Population Fund. New York, NY. https://www.unfpa.org/press/unfpa-regrets

UNICEF. (2023). Maternal mortality rates and statistics. Data: Trends in Maternal Mortality: 2000 to 2020. United Nations Children's Fund, United Nations Population Fund, the World Bank and the World Health Organization. Geneva, Switzerland. https://data.unicef.org/topic/maternal-health/maternal-mortality/

United Nations. (2025a). Committee on the Elimination of Discrimination Against Women. Human Rights Office of the High Commissioner. Geneva, Switzerland. https://www.ohchr.org/en/treaty-bodies/cedaw

United Nations. (2015). The 17 Sustainable Development Goals. UN Department of Economic and Social Affairs: Sustainable Development. New York, NY. https://sdgs.un.org/goals

United Nations General Assembly. (2015). A/RES/70/1 - Transforming Our World: The 2030 Agenda for Sustainable Development: Sustainable Development Knowledge Platform. New York, NY. https://sdgs.un.org/2030agenda

United Nations General Assembly. (2010). MDG Summit 2010, A/RES/65/1. Keeping the promise: United to achieve the Millennium Development Goals. New York, NY. https://sustainabledevelopment.un.org/index.php?page=view&type=111&nr=8496&menu=35

UNSD. (2025). SDG Data Portal. United Nations Statistic Division. New York, NY. https://unstats.un.org/sdgs/dataportal

UN Treaties. (2025). United Nations Treaty Collection: Human Rights. https://treaties.un.org/pages/viewdetails.aspx?src=treaty&mtdsg_no=iv-8&chapter=4&clang=_en#51

Upadhyay, U. D., Koenig, L. R., Meckstroth, K., Ko, J., Valladares, E. S., & Biggs, M. A. (2024). Effectiveness and safety of telehealth medication abortion in the USA. *Nature Medicine*, *30*(4), 1191–1198. https://doi.org/10.1038/s41591-024-02834-w

US Census Bureau. 2025. Data Profiles. *US Departement of Commerce.* Washington, DC. https://data.census.gov/profile?q=United+States&g=010XX00US

US Congress. (2022a). H.R.8373 – 117th Congress (2021-2022): Right to Contraception Act. (2022, July 21). https://www.congress.gov/bill/117th-congress/house-bill/8373

US Congress. (2022b). H.R.3755 – 117th Congress (2021-2022): Women's Health Protection Act of 2021. (2022, February 28). https://www.congress.gov/bill/117th-congress/house-bill/3755

US Congress. (2019). H.R.1692 – 116th Congress (2019-2020): Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2019. (2019, March 13). https://www.congress.gov/bill/116th-congress/house-bill/1692

Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., Fisher, T., Butt, E., Yang, Y. T., & Powell Kennedy, H. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PLOS ONE*, *13*(2), e0192523, 1-20. https://doi.org/10.1371/journal.pone.0192523

Warzecha, D., Szymusik, I., Pietrzak, B., Kosinska-Kaczynska, K., Sierdzinski, J., Sochacki-Wojcicka, N., & Wielgos, M. (2019). Sex education in Poland – a cross-sectional study evaluating over twenty thousand polish women's knowledge of reproductive health issues and contraceptive methods. *BMC Public Health*, *19*(1), 689. https://doi.org/10.1186/s12889-019-7046-0

Węgrzynowska, M., Nenko, I., Raczkiewicz, D., & Baranowska, B. (2023). Investment in the peace of mind? How private services change the landscape of maternity care in Poland. *Social Science & Medicine*, *337*, 116283, 1-8. https://doi.org/10.1016/j.socscimed.2023.116283

Węgrzynowska, M., Doroszewska, A., Witkiewicz, M., & Baranowska, B. (2020). Polish maternity services in times of crisis: In search of quality care for pregnant women and their babies. *Health Care for Women International*, *41*(11–12), 1335–1348. https://doi.org/10.1080/07399332.2020.1830096

WHO. (2025a). The World Health Organization's Global Health Observatory (GHO) data. Geneva, Switzerland. https://www.who.int/data/gho

WHO. (2025b). Trends in Maternal Mortality Estimates 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.

WHO. (2024a). Abortion Fact Sheet. World Health Organization. Geneva, Switzerland. https://www.who.int/news-room/fact-sheets/detail/abortion

WHO. (2024b). Adolescent Pregnancy. World Health Organization. Geneva, Switzerland. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

WHO. (2024c). World Health Organization Data. Geneva, Switzerland. https://data.who.int/countries

WHO. (2015). World Health Organization Statement on Caesarean Section Rates. WHO/RHR/15.02. *Human Reproduction Programme.* Geneva, Switzerland. https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf

WHO, & World Bank. (2023). Tracking universal health coverage 2023 global monitoring report. *World Health Organization and International Bank for Reconstruction and Development*, 1–156. Geneva, Switzerland.

Williams, D. K. (2010). God's Own Party: The making of the Christian right. *Oxford University Press.* https://doi.org/10.1093/acprof:oso/9780195340846.003.0002

Wolk, L., & Snead, O. C. (2021). Fearfully and Wonderfully Made: The Catholic Church's Position on Abortion. In A. Bagheri (Ed.), *Abortion: Global Positions and Practices, Religious and Legal Perspectives* (pp. 51–62). Springer International Publishing. https://doi.org/10.1007/978-3-030-63023-2_5

Wong, C. A., Galley, H. F., & Leslie, K. (2022). Maternal mortality, safe abortion, and the anaesthetist. *British Journal of Anaesthesia*, *129*(6), 833–835. https://doi.org/10.1016/j.bja.2022.08.020

World Bank. (2025). World Bank Data. Washington, DC. https://data.worldbank.org/indicator/NY.GDP.PCAP.CD

World Population Review. (2025). Poland. https://worldpopulationreview.com/countries/poland

Yang, J. (2024). Cesarean section rates in OECD countries in 2021 (per 1,000 live births). *Statistica.* https://www.statista.com/statistics/283123/cesarean-sections-in-oecd-countries

Żuk, P., & Żuk, P. (2019). Dangerous Liaisons between the Catholic Church and State: The religious and political alliance of the nationalist right with the conservative Church in Poland. *Journal of Contemporary Central and Eastern Europe*, *27*(2–3), 191–212. https://doi.org/10.1080/25739638.2019.1692519