Transcript of S4 E4 When People Have or Are Denied Abortions: The Turnaway Study with Diana Greene Foster

Tammy Kremer (00:09):

Coming Together for Sexual Health engages you in shameless conversations about sex-positive, identity-affirming sexual health care. We keep our attention on those most impacted by STIs, HIV and structural barriers. We're powered by nationally recognized experts in sexual health at the University of California, San Francisco and the California Prevention Training Center. All views expressed are those of the person speaking and not of the CAPTC or their employer.

(00:41):

My name is Tammy Kremer. Let's come together for sexual health.

(00:49):

Welcome to Coming Together for Sexual Health, Professor Diana Greene Foster. So glad to have you here today.

Diana Greene Foster (00:54):

Thank you so much, Tammy, for having me.

Tammy Kremer (00:57):

Today's episode is going to be one of three in our series on Reproductive Justice and Family Planning. Diana Greene Foster, PhD, is a demographer and professor at the University of California San Francisco. She led the United States Turnaway Study, a nationwide longitudinal prospective study of the health and wellbeing of women who seek abortion, including both women who do and do not receive the abortion.

(01:21):

She's leading a study of the health, legal and economic consequences of the End of Roe in the United States and a Turnaway Study in Nepal. She is the author of over 120 scientific papers as well as the 2020 book The Turnaway Study, Ten Years, A Thousand Women and the Consequences of Having or Being Denied an Abortion.

(01:42):

So as we jump in here, I just want to hear first of all if you could describe your body of work and what drives you to do the work that you do.

Diana Greene Foster (01:50):

I have been working for over 25 years to look at how access to contraception and abortion affects people's lives. And for a while, that meant things like estimating the effectiveness of family planning programs or showing that if you give a person a whole year supply of birth control pills, they're less likely to become pregnant. And that research led to law change in about 20 states. So, that had a big impact.

(02:18):

Certainly what I'm most famous for is the Turnaway Study which looks at the consequences for people who want an abortion, what happens if they can get that abortion, what happens if they can't. And at the time we started that study, really we were trying to address the question that was an open question

which is does abortion hurt women? Because the Supreme Court and many state governments had put restrictions on abortion with the idea that getting an abortion might cause people mental health harm.

(02:48):

And I don't know how sincerely they believed that, but there certainly wasn't great data to support it. And what's important is to compare people who get an abortion to people who want one and cannot get one because if you're going to restrict access to abortion, they won't magically become unpregnant. They'll instead carry a pregnancy to term.

(03:09):

When we started the studies, the main conversation was mental health of abortion versus no abortion. But unfortunately since then, abortion restrictions have become much stronger. In fact, there are 13 states with bans. And so, really the experience now of the group that was unable to get an abortion is the most interesting group because that's what's going to happen to anyone who isn't able to circumvent their state's laws.

Tammy Kremer (03:41):

I'm really struck as you're describing your body of work, how you have found ways to do research that really has a direct impact on practice and legislation. I'd love to hear a little bit about what that process is like to select those projects and how you position your work.

Diana Greene Foster (04:02):

I don't think I went into this trying to do the most policy-relevant work. Every time I started something new, it was because somebody said something that sparked an idea. I was talking to the physician Bimla Schwarz and she mentioned that people can remove their own IUDs. And it was news to me someone who's used IUDs that that was possible. And I realized that IUDs can be a coercive method of family planning if people don't know they can remove it.

(04:28):

And so, I did a series of studies to look at whether people can remove it and how it changes their attitudes about the method. If anything underpins all of my work, it's a feminist desire for people to have control over their own family planning, their own childbearing.

Tammy Kremer (04:48):

I recently sat in on a training for providers around placing IUDs. And the trainer mentioned the ability for folks to remove their own and how she would generally ask folks and leave the strings a bit longer to make that easier for their patients. Simultaneously, she noted it's not so to speak approved consistent practice according to the body that she was accountable to. So just seeing how much less coercive it could be to have folks really know that they can control that removal.

Diana Greene Foster (05:18):

What a wonderful clinician you were speaking with.

Tammy Kremer (05:21):

Yeah. I want to show you my shirt. It says, "Everybody knows I had an abortion." This work is very both professionally meaningful to me and also very personally meaningful to me. And after I had my abortion

about a year and a half later, I was seeing a provider and I shared a bit about where my mental health was at that point.

(05:41):

And this provider repeatedly asked me if the hardship that I was experiencing was due to my abortion even though I shared that timelines did not match up with that interpretation. I really feel the importance of this work of debunking these broadly accepted ideas that abortion has to be traumatic, abortion has to be something that causes pain where of course there's many different experiences of what that's like.

(06:08):

For me, abortion was freedom and choice about how I live my life. So, I just wanted to bring that personal grounding into this conversation.

Diana Greene Foster (06:19):

Yeah. You've encapsulated a lot of the debate right there. If we find higher depression among people who seek abortions, is it the abortion that caused it or might there be some other explanation? And you're right that people have a range of emotional responses and yet we find no evidence that abortion causes mental health problems. So you can feel sad and that doesn't mean that you're depressed. And it also doesn't mean that you feel like the abortion was the wrong decision.

(06:48):

And I'm not saying everyone feels sad. There's a big range of emotional responses.

Tammy Kremer (06:53):

Right. We can feel something is hard and we can be grateful for it and being able to hold that complexity that this experience can really have. So, what would you like providers to understand about the Turnaway Study? And if you can give us a little bit more information about some of the key findings there and how that might impact care.

Diana Greene Foster (07:15):

So, I'm going to direct this to the provider who suggested that the abortion was causing new mental health harm. What we find is that abortion is not associated with mental health problems. In fact, women who are denied abortions do worse than women who receive them. We see higher anxiety, lower self-esteem for people who cannot get the abortion they want. And that's in the short run.

(07:41):

In the long run, we see that in fact the mental health of people who receive and were denied abortions are similar. But they're not similar in other ways. There are huge differences in physical health. So, we see that women who are denied the abortion, carry the pregnancy to term, give birth have much higher, much more serious complications from the end of pregnancy than people who get an abortion, even people who get an abortion the second trimester.

(08:07):

And that's consistent with the medical literature and it's so grossly underestimated, underappreciated by the vast majority of us who take for granted childbirth and don't realize that it is an entire physiological stress test and every organ system is affected and anything that can go wrong will go wrong sometime.

(08:32):

And in fact, two women in our study died of childbirth-related causes. So, for some people, they have an uncomplicated pregnancy. And for some people, they die from complications of childbirth. And to act like that this should be something that people can't opt into that it should be forced upon them seems just clearly wrong.

(08:54):

In addition to the end of pregnancy, we see worse physical health that lasts for years among the people who give birth compared to the people who receive it. So, we need a much greater appreciation for the risks of childbearing and the sacrifice that people make when they want to give birth.

(09:11):

So, physical health is different but then there's a lot of other outcomes that we studied that differ for the people who receive an abortion and who are denied them. And I'm sure that your listeners won't be surprised that having a child, raising a child causes a slew of changes to one's life trajectory.

(09:29):

So, we see greater poverty, greater chance that the household is living without enough resources to pay for basic living needs, less chance that the person is working a full-time job. We see greater debt. We see less likely to set aspirational plans, less likely to be able to care for existing children, less likely to have intended children in the future, less likely to have a high-quality romantic relationship in the future. And all of those negative outcomes are for the people who carry the pregnancy to term, not the people who have the abortion.

(10:04):

The other striking thing about all of these findings is that when people are making the decision about what to do with an unexpected pregnancy and they decide on abortion, all the reasons they give us are exactly those outcomes that we see for people who are denied. So, when people are making this decision, they're making a careful decision, they totally understand what the consequences are going to be if they're unable to get that abortion and it's what motivates them to get that abortion.

(10:34):

The final conclusion is that we can trust people's decision making on abortion. And when someone else makes that decision, for example our government, people's outcomes will be worse. That's not just the pregnant person but their kids, their chance at achieving other life goals including having wanted kids later. That's why abortion is in the news all the time because people know at their core level that this basic ability to control your childbearing, to decide who to have kids with and when and whether are all so fundamental to enjoyment of life and living life on your own terms.

Tammy Kremer (11:16):

Yeah. I really appreciate understanding that kind of congruence between the considerations that folks have in the decision making and the outcomes that people have who are forced to proceed with unwanted pregnancies or are denied abortion.

(11:30):

I think that helps to demystify a bit and defog this very thick fog that I know I experienced when facing this decision myself because there's so many layers of political debate that finding one self among those things. And being able to trust my own perspective was a lot more labor because of all of these myths and stories about the impact of abortion.

(11:53):

So, seeing that congruence is really reassuring and affirming, like you said, that people can make choices for themselves.

Diana Greene Foster (12:01):

Yeah. I think that people's decision making is clearly affected by stigma about how stigmatized this topic is and affected by support from other people. But it's clear that when someone's made the decision that they are very likely right about the outcomes of their life and should be trusted to make their own decisions.

Tammy Kremer (12:23):

Can you speak a bit about the study design for the Turnaway Study? Who was included, who was not included, and maybe even some things you would do differently where you had to do it again?

Diana Greene Foster (12:32):

The idea of the study was we wanted two groups of people as similar as possible at baseline. And one group gets an abortion and one doesn't. And clearly, it would be unethical to randomize people. No one would agree to participate in that study.

(12:47):

But the world randomizes people because different clinics have different limits and so you might be denied that abortion at the same exact point in pregnancy. So, there were people at the same point in pregnancy, some of whom got it and some of whom didn't based on where they sought an abortion. And at each clinic, we got people who were a little bit too late to get their abortion and people who were just under the limit and did get their abortion.

(13:12):

From 30 abortion facilities across the country, most of these clinics were in the second trimester, but 90-something percent of people who get abortions do so in the first trimester so we also collected a first trimester sample.

(13:25):

And the study design was hoping that those two groups of people, the people who receive and the people who are denied would be similar at baseline. So when we follow them over time, we could see how their lives diverged and if their mental health diverged and if their physical health diverged.

(13:41):

And in that way, the study was a huge success. The two groups were very similar. The people who are denied abortions tended to be a little bit younger and less likely to have already had kids. And we adjusted for that in all of our analyses. When we recruited, we said that our eligibility criteria was pregnant women. And of course now in 2023, that's a mistake. I should have said pregnant people. And to my knowledge, no one who didn't identify as a woman was in the study.

(14:13):

So, if I had to do it again, I would not use gender-exclusive language. And also, I excluded people who were seeking abortion for fetal anomaly and from imminent maternal health risk. And I did that because they would find a way to make some exception or send them to another state. And I didn't want people with certain reasons for abortion to only end up in one study group, the received.

(14:40):

So, it was a study design reason why I excluded them. But in retrospect, I should have included them and analyzed their data separately because we know so little about the experience of people who terminate pregnancies for reasons of fetal diagnosis. And we really should know a lot more about that.

Tammy Kremer (14:59):

And I understand that now you're developing a study similar in Nepal. So, I'm curious how those findings and reflections have impacted that study design. Of course, it's in a very different cultural context so I would imagine there's other adjustments there too.

Diana Greene Foster (15:14):

Yeah, it's a different cultural context. It's a country with much better abortion laws than we have here in the United States. In Nepal, it's legal up to 12 weeks for any indication except for sex selection and up to something 18 maybe for reasons that are reasonable that you could get an abortion if you needed one.

(15:37):

And so the law is very good. It's free for low-income people through public facilities. But it's not law that's well implemented. So, many people who are eligible for abortion are still denied. And so, we're looking at people who couldn't get the abortion they wanted compared to people who did get the abortion they wanted. And it's in a context of much greater poverty.

(16:00):

So, even in the United States, we were able to detect differences in children's wellbeing by whether their mother received or was denied an abortion for a subsequent pregnancy. And I suspect that those differences, the hardships that children face will be even more severe in Nepal than they are here.

Tammy Kremer (16:23):

That piece of how children that a parent already has are impacted by denied abortions is critical and makes me think about how the Turnaway Study has or could help move beyond the kind of rigid binary ways of this, quote, abortion debate. Wondering how findings from this study have impacted the ways that we talk about abortion.

Diana Greene Foster (16:52):

It's hard to know what to take credit for, but there definitely has been a shift in the media coverage of abortion that focuses much more on the people who want one. Used to be articles on abortion would either have a picture of people carrying signs and debating as if it's only a political conversation and there isn't anyone real involved or you would get a pregnant abdomen, would be nearly at term pregnancy.

(17:23):

And an early article of mine was accompanied by an abdomen facing a rainy window, so it was like a depressed abdomen. There was no head. There was no family. There were no other children. Just absolutely reduced to her womb. And I haven't seen that in a while. It's just super important. At the very minimum, let's include a head. The person who is pregnant is all of her other responsibilities and aspirations.

(17:56):

If we just talk about a political argument, we ignore the very large effect it has on real people who are pregnant, don't want to be pregnant, don't feel they can support a child or another child.

Tammy Kremer (18:19):

As a podcast focused on sexual health in a public health setting primarily, I think a lot about folks, trans folks, people living with HIV. And I understand that in the future, you would include more representation of trans folks. But if anything did come across about the differential impact of being denied abortion across different communities and identities.

Diana Greene Foster (18:41):

Yeah. I think it's a weakness of the study that we absolutely did not do a good job on capturing people who don't identify as women. In our newest study, we are doing that. It's people seeking abortion post-Dobbs and we don't see people who identify as men but we do see people who identify as non-binary. There's more work to be done in and the assumption that everybody is a woman is clearly not accurate.

(19:10):

In terms of relationships, in the Turnaway Study, we ask about the relationship with the man involved in the pregnancy. And what we see is that many of the women in the study were in relationships with men that were violent. One in 20 experienced violence from the man involved in the pregnancy.

(19:29):

And when a person was able to get an abortion, she saw a dramatic decrease in violence. And if she was unable to get that abortion, it was leveled. Not because she was in an ongoing relationship but because she had ongoing contact because she was raising a child with that person. Later in the study, we added a question about the quality of relationships with other people, men, women or any other romantic partner. So we learned over time to be a little bit more inclusive.

(19:58):

And there were a few people who were in relationships that were with women. People had who received an abortion were more likely to say that their romantic relationship was very high quality than people who were denied an abortion.

Tammy Kremer (20:12):

And you mentioned, Diana, this next version of the study. Can you speak to what you were describing in post-Dobbs?

Diana Greene Foster (20:19):

We absolutely needed to look at the consequences of this Dobbs decision. And it's different from the Turnaway Study. The Turnaway Study really focused on giving birth versus having an abortion for an unwanted pregnancy. And this new study again recruits people who sought abortions. Some were the last people served in their state before a ban took effect compared to the next people who had an appointment or who sought abortions afterwards and were turned away.

(20:48):

But here, it's not birth versus abortion. It's who can circumvent their state law. So, who travels across state lines to get an abortion either in a clinic or through telehealth, who orders pills online either through Aid Access or through many websites that now will send you pills even in states that ban abortion. Those that do are often sending from abroad.

(21:15):

So, who's able to do it safely and then who does it unsafely? Does the word about medication abortion pills really make it to every 15-year-old in Arkansas or Alabama? And if so, it's just not at all impossible that we will have people trying to harm themselves to end their pregnancies.

(21:34):

And I want to know who doesn't get the information about safe ways of ending a pregnancy, who tries to do harmful things so how can we reach those people? And then who carries the pregnancy to term and what are the consequences for them?

Tammy Kremer (21:51):

I really appreciate the way that you're describing the attention to what people have access to based on their age, their familiarity. I'm curious if you're looking at race, ethnicity, immigration status, other types of markers that might impact people's outcomes?

Diana Greene Foster (22:09):

Yes. I have with a whole bunch of colleagues from across the country to brainstorm to make sure that we are asking about the factors that will be most likely to hinder someone from getting information or services. So, not just age, gender, race, ethnicity, whether they are physically able to move which could be about disability or incarceration or court supervision or hospitalization. There are many people who will have a very difficult time of getting around their state laws.

(22:47):

We shouldn't underestimate people's determination to do that. And so, it definitely worries me knowing how strongly someone can feel that this is not the right time to have a baby or to have another baby. It scares me when safe services are made hard to get or only available to people with the most money.

(23:07):

So far, what we've found is that having a car is absolutely critical to being able to get care quickly. So if you have a car, you can drive potentially hundreds of miles to get care. But if you don't have a car, everything is much more difficult especially for people who've never flown before, who would have to borrow a car from somebody who isn't supportive.

Tammy Kremer (23:33):

I had an experience when I was living abroad doing a project on birth stories where someone I had met called me up early one Saturday morning and said, "I need your help. I'm pregnant and I need an abortion." And she ultimately asked me to pick her up and drive her to an extra legal clinic we could say where she received an abortion by a provider whose training we didn't know much about.

(24:01):

The cost was quite high. And that provider and that space I learned they really preyed on young folks who did not have access to abortion because of the legal aspects of that environment and just charge huge amounts of cash. I had this kind of moment of, "Wow, I might be called upon to take action I haven't anticipated ever needing to take even in my home country. How do we navigate the spaces where our laws are not attuned to the needs of people living within those laws?"

Diana Greene Foster (24:39):

In that circumstance, you should advise your friend to go to Plan C Pills. It's a website that will tell you places that you can order pills and I think they even review the safety. They do some kind of checking to see whether the website sends the correct medications. It's much safer to take the same medications you would get in a clinic than it is to trust a provider who may not be trained or behaving ethically.

Tammy Kremer (25:12):

Thanks for sharing about Plan C. And I'm wondering if the study that you're working on now, if you look at different options for types of abortions, whether it's a procedure or medication abortion.

Diana Greene Foster (25:24):

So, we are absolutely doing that. We're asking them whether they prefer a procedure or pills and whether they were able to receive the type of abortion that they wanted.

Tammy Kremer (25:33):

Yeah. I think for me when I was faced with this decision, something that I learned from that was how not knowing about the stories of people around me who had had abortion, even people that I was close to, I didn't know their stories until I shared with them what I was going through. Then I started to get a whole lot of information, but I didn't have time to kind of take it all in and integrate it all. And so, I chose the version that felt less scary to me.

(25:57):

But had I had more familiarity and heard more abortion stories earlier, I think that could have really made some of these choices less intimidating. But when faced with the decision to have a procedure which involves being in a medical office versus a pill where you might bleed but we don't know how much, you might have pain but it will depend on your circumstance. That's quite a lot of information to try to process especially under the pressure that I think a lot of people feel because of this sense of a ticking clock.

Diana Greene Foster (26:32):

Yes. And broader point about sharing stories that sharing one-story reveals many other people's stories. I wrote in my book about my grandmothers. One of them had an illegal abortion pre-Roe and she went to Puerto Rico to get an abortion. And the other one became pregnant at age 19 and her very Christian parents pushed her to get an abortion because they were worried about the shame of an out-of-wedlock pregnancy. And she refused and they sent her to a Salvation Army home for unwed mothers and she gave birth to my mom and placed my mom for adoption.

(27:12):

So, I've told the story about it and I get flooded with grandparents' stories and heartbreaking stories. I was on Fresh Air with Terry Gross and one of the emails I got was a man whose partner had died of an illegal abortion pre-Roe. So, just heartbreaking stories.

Tammy Kremer (27:40):

In each of the three episodes on Family Planning and Reproductive Justice, we're showcasing relevant projects by our colleagues at the UCSF Bixby Center for Global Reproductive Health. The Bixby Center focuses on advancing reproductive and sexual health worldwide. Here's Bixby Center Director, Dr. Jody Steinauer, MD, PhD.

Jody Steinauer (28:03):

Thank you so much for creating this important miniseries of the Coming Together for Sexual Health podcast and for inviting me to share some related resources at the Bixby Center.

(28:12):

I've been passionate about supporting access to abortion care throughout my career. Back in medical school, I founded Medical Students for Choice to fight for medical students' rights to abortion education and to ensure that all physicians have the skills they need to provide care for future patients.

(28:28):

After medical school, I trained in abortion care and residency and have included it in my practice for more than 20 years. I also have the privilege of directing the Ryan Program, a national program which supports OB-GYN departments to include abortion training for all of their residents.

(28:44):

I'm proud that the Bixby Center is at the forefront of abortion research, training and clinical care. At Bixby Center, there are a few projects I want to mention trying to understand people's experiences of abortion care and to make abortion care better.

(28:58):

Research by Dr. Katie Brown and her colleagues explores Black women's abortion experiences. And research by Dr. Josie Urbina and her colleagues explores Latinx women's abortion experiences. Dr. Brown's work has been published and Dr. Urbina's will come soon.

(29:14):

I also want to highlight Dr. April Bell's important work. Dr. Bell's research honors the autonomy of Black women and creates the space for Black women to tell their own digital abortion stories in their own words using their own images. In this next clip, Jess, a digital storyteller in Indiana tells us how abortion freed her and allowed her to choose herself and prioritize the family she has right now.

Jess (29:39):

I didn't feel any pain before or after their procedure. I do remember though a distinct feeling of victory because I finally felt free. I wasn't raped, but I do feel I was misled and deceived. I lost myself in the process. Everything I had worked so hard for school, working at a great job at the hospital, taking care of myself physically and mentally, everything was just gone. I gave them up thinking I was building this family. In reality, I was chasing my Cinderella story with somebody who was not a prince charming.

(30:16):

At my first appointment, the processors scared me off. But the second appointment, I was right at the cutoff and I had to make a choice. My pregnancies were so hard on me physically, emotionally, mentally. I just couldn't even think about raising another child on my own. The procedure was the chance for a new start, a chance at a life free from this prison I was sentencing myself to.

(30:45):

A lot of times, I felt like a recovering love addict. Love is so strong and sometimes I just felt so high and then other times I felt so low and then low times can leave you feeling broken in every way. Now, I feel like in a lot of ways I'm in recovery, but I'm in recovery with three small children, 7, 2 and 1. And I'm 29. I don't have no income. And needless to say, I have no support from their fathers. What was I going to do with four kids? How was I supposed to survive and cope?

(31:17):

I would have probably fallen deeper into this love addiction chasing illusions and fallen deeper into a hole. Who knows what else could have happened and transpired? I chose life. I chose my life. I chose me. Something I hadn't done in a real long time. Now, I could be here for my kids and I could pick up the pieces of my life. I have hope and joy again. I'm back in school now. And most importantly, I have a chance because I took a chance on me.

Tammy Kremer (31:47):

Thanks, Dr. Steinauer. And now, back to the conversation.

(31:57):

I'm curious what your take is on what providers might be able to do or share when folks are coming in finding out they're pregnant considering their options.

Diana Greene Foster (32:08):

So I'm not a provider. I have this amazing position where I can talk to people about their experiences, but they aren't expecting health care from me. So I get a different twist on what people are thinking and needing. But I would say that many states mandated that clinicians read a script about the harms of abortion as someone was making a decision.

(32:32):

And what we found from our study is that when people got their abortion in a state that had such a law, they found they're care less helpful than people who were in states where this misinformation was not part of the script. So, I think it's clear that a clinician should stick to what's actually true and not be enforcing political ideology.

(32:57):

They should tell people honestly about the risks of abortion and the risks of childbirth. And they should tell people that the science shows that most people are very confident in their decision making and that the clinician also trusts this patient's decision making. That 95% of people who got abortions said it was the right decision for them. We find very low rates of people saying it wasn't the right decision. People have a wide range of emotional responses, but the positive emotions vastly outweigh negative emotions.

(33:33):

And this may not be an emotional event that stays with you for years. This may be something like a root canal that is unpleasant at the moment and that you eventually get over. People make it out to be this emotional event that is going to stick with you forever and that is not everybody's experience at all. In fact, when we interview people over time, they say the only time I think about the abortion is when you call me for these interviews.

Tammy Kremer (34:01):

One of the most valuable conversations that I had as I was making my choice was with someone that had been faced with the same choice and decided to not get an abortion. And hearing her ability to support my choice was extremely empowering as to recognize how you can have positive outcomes regardless of which choice it is as long as it's the right choice for you.

Diana Greene Foster (34:24):

Yes. And we see people in the study who got abortions go on to become pregnant and choose childbearing. Those who were unable to get abortion become pregnant again. And some of them choose abortion and some of them choose to give birth again. And it's a very small sample, but the very few people who chose to place the child for adoption did not choose that again.

(34:46):

I think that is a particularly difficult outcome. And maybe it's that the study entirely consisted of people who that wasn't their first choice. They chose an abortion and they ended up being denied abortion and placing the child for adoption. And so maybe if we had a study of people who chose adoption, it would be different.

(35:06):

But adoption is not an easy answer for the problem of unwanted pregnancy. And people who suggest that are really callous about the physical health risks and the emotional cost of placing a child.

Tammy Kremer (35:20):

Thanks for bringing in that conversation about adoption. Do you have a sense of what the numbers are at of how many folks who are denied abortion do put their kid up for adoption?

Diana Greene Foster (35:31):

Yes. Less than 10% of people who are denied an abortion and therefore give birth decide to place the child for adoption. And when we look at how people feel about being denied an abortion, over time people are resilient and say that they're glad that they gave birth. And the exception is the people who placed for adoption are more likely to say over time that they still wish they could have had that abortion. It's a very hard decision to make.

Tammy Kremer (36:00):

Wow. Unfortunately, because of the systems that surround adoption in our country, just kind of the challenges that young person might also experience. We're coming towards a close here. Are there any resources that you would like to share with our listeners?

Diana Greene Foster (36:23):

I would love to plug my book. The book is called The Turnaway Study, Ten Years, A Thousand Women and the Consequences of Receiving or Being Denied an Abortion. It tells the story of the science in a layperson's words.

(36:39):

Most interestingly, it shares the stories of people from the study told in their own words, so you can understand what it would be like to be pregnant, make this decision and then find that you're unable to get that wanted abortion or you are able to get the wanted abortion and what happens next.

(36:57):

We intentionally included someone who placed a child for adoption. We included people who had a rough time of it and people who didn't have a rough time of it just to really humanize this experience. It's not just science, it's not just numbers, it's real people. And what happens to your life when this critical aspect is out of your control.

Tammy Kremer (37:20):

I would love to hear a passage from the book if there's a part you'd like to share.

Diana Greene Foster (37:25):

I'd love to. I'm going to read a little bit of Brenda's story. She was living in New York and she had a bit of a rough childhood, had a period in her life where she was kind of out of control. Her mother shipped her off to some lockdown place to deal with wayward kids. She rebounds and goes to a very excellent university, got her degree and then unfortunately fell into a violent relationship. And she had an alcohol problem.

(38:00):

And she said about her decision making. "When the hospital turned me away, I was heartbroken. I was in no position at all to even think about raising a kid. I could not afford diaper, number one." So, she wasn't able to get that abortion. She had the child and just as she predicted was not able to care for a child. Child Protective Services showed up. She got in trouble with the law. Eventually, her mother took the child.

(38:27):

Towards the end of her story, she's really trying to get back on her feet. And she has a late period and she thinks, "You really feel the impact when you think, 'Oh my God, I might be pregnant again. And you start freaking out if your period is a week late because it is very difficult to find a job when you're pregnant, to keep a job when you're pregnant and to find and maintain a job with a baby, especially if your partner's a douchebag and doesn't want to help. So I think on that end that the incidence of domestic violence skyrockets because you're financially dependent on your partner because you have to be home with a kid.'"

(39:02):

And she goes on to say, "And we all know that a major contributing factors in domestic violence is being financially dependent on the person where you're like, 'Oh no, I don't want to be homeless. I can't be homeless with this kid. I need him for money and then he can do whatever he wants because he's a douchebag.' Pregnancy is an incredibly scary thing especially if you cannot trust the person you're with."

(39:25):

You really get to feel like you know her as a person and can relate to her struggles and want her to succeed. And the wider consequences of having a baby when you're not ready to have a baby shifts the power relationships between the couple. So all of a sudden, she's financially dependent on him and he is violent and she's stuck and trying to raise a child in the circumstances that are just not positive.

Tammy Kremer (39:51):

So, a question that I like to ask all of our guests at the end has to do with imagination, imagining the future that we are working towards as that's been a key part of movement building and social change. So, I'd love to hear from you, what's your vision? What is something that you hope we can create by coming together for sexual health?

Diana Greene Foster (40:13):

The root of many of our problems is misogyny and our inability to grant women in particular but all marginalized people the right to sexual pleasure, to bodily protection and autonomy and to have everyone's be equal partners in sex, in childbearing, in contraception, in pregnancy decision making.

What we need is a respect for bodily autonomy and to respect other people's sense of self and ability to craft their own life.

Tammy Kremer (40:49):

Thank you so, so much for coming on, Diana. I really enjoyed getting to speak with you. And I also just want to personally thank you for the work that you do for the benefit of all of us.

Diana Greene Foster (40:58):

Thank you so much. Thank you, Tammy, for having this great podcast. And I appreciate you and your listeners.

Tammy Kremer (41:07):

Thanks for listening. And please follow and rate us wherever you get your podcasts. This will help more people find us. Check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show.

(41:20):

Connect with us on Instagram at Coming Together Pod on Twitter @californiaptc and @comingtogetherpod.com. This podcast is produced by me, Tammy Kremer, and is edited by Isaiah Ashburn. Thank you for coming together for sexual health.