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POLICY BRIEF

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Bridging the Gap: Medicaid, Maternal Health Deserts, and Reproductive Inequity in the United States

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EXECUTIVE SUMMARY

Black women, low-income women, and rural communities face disproportionate barriers to reproductive healthcare in the United States. Medicaid finances **41% of births nationally** while **64% of births from Black mothers are financed by Medicaid**. Despite the great number of mothers that rely on Medicaid for reproductive healthcare, state-level restrictions, like the Hyde Amendment, and work requirements have limited coverage. At the same time, over 2.2 million women live in maternity care deserts, which are areas without adequate maternal health infrastructure. After the passing of ***Dobbs v. Jackson Women's Health Organization (2022)***, legal protections for reproductive healthcare continue to vary across the different states, deepening the existing inequities.

This policy brief will argue that federal Medicaid reform, targeted infrastructure investment, strengthened legal protections, and community centered healthcare workforce development are essential to advancing reproductive justice and supporting women in underserved communities. By pairing federal policy with state and local innovation, we can move toward a more equitable healthcare system.

BACKGROUND

History has shown that access to reproductive healthcare has always been unevenly distributed across different demographics of people in the United States. From slavery and forced sterilization to abortion restrictions, reproductive control has always disproportionately impacted Black women and poor communities. Medicaid plays a significant role in reproductive healthcare in the United States because it currently covers 41% of all births nationally and 64% of births among Black women. (Ranji et al., 2025). Because of the Affordable Care Act, many states expanded Medicaid. For these states, they saw an administration of prenatal care earlier and lower maternal mortality rates. On the other hand, the states that did not expand their Medicaid coverage, most of which were located in the South, saw high health disparities. (Eliason, 2020).

The Hyde Amendment of 1976 prohibits the use of federal Medicaid funds to cover abortion services, except for rape, incest, or severe medical circumstances. This restriction forces low-income women, especially women of color, to navigate the financial and logistical barriers of abortion and reproductive healthcare. In Georgia state, they introduced work requirements for Medicaid eligibility. This puts women at risk for losing postpartum care under Medicaid, which will undermine their access to critical care during those vulnerable periods(Mador).

Beyond just coverage, geographic access to reproductive healthcare is a major obstacle for many women. More than 2.2 million women live in maternity care deserts around the United States (March of Dimes). These care deserts are found in the South and the Midwest and they often overlap with states that have not expanded Medicaid coverage. The compounding effect of Medicaid coverage gaps, workforce and infrastructure shortages, and legal restrictions, the barriers continue to increase for Black, low-income, and rural women who are seeking reproductive healthcare. While telehealth helped to provide some solutions to this, access depends on state-level shield laws and legal protections for both the patient and the provider. In states like New York and California, their shield laws protect the providers who are offering telehealth abortion care to out of state patients. Despite these protections, it still poses a significant risk for providers, so access is still not equitable.

Reproductive healthcare access is heavily influenced by the partnership between the federal and state government. Medicaid is a prime example of a stakeholder that is handled between both governments. While the federal government can establish the general guidelines and provide funding, the states can determine eligibility, covered services, and the policies for reimbursement. Because of these factors, there is variation in access to reproductive healthcare between Medicaid expansion and Medicaid restriction states. Generally, states with increased Medicaid coverage have improved maternal health outcomes compared to states with restrictive Medicaid coverage. Under Dobbs v. Jackson Women's Health Organization, the disparities have been intensified

by returning the authority to regulate abortion back to individual states. Some states now have stricter abortion laws, which includes bans on abortion pills, limitations on accessing care across different states, and more. On the other hand, other states have expanded coverage to include shield laws to protect providers and patients. This has created a fragmented policy landscape that has deepened existing inequities in healthcare, especially for low-income women who rely on Medicaid as they have to navigate restrictive state laws and varying limitations in coverage.

POLICY PROBLEM

The reproductive healthcare inequities that exist in the United States stem from restrictive Medicaid policies, geographic disinvestment in maternal health infrastructure, workforce shortages, and a divided legal system. When these issues compound upon each other, they pose a great threat to Black and Brown women, low-income women, and women living in rural communities.

Geographic access remains a major barrier to healthcare with over 2.3 million women living in maternity care deserts with limited to no access to obstetric and gynecologic services. In these areas, Medicaid coverage cannot guarantee healthcare coverage because of the hospital and clinic closures, transportation barriers, and the distance to travel to nearby healthcare facilities. These are prominent issues particularly in the South and the Midwest where the maternal mortality rates are the highest.

Coverage restrictions further limit access to healthcare. Many states have not expanded Medicaid coverage or have policies that interrupt continuous care for patients. The Hyde Amendment prevents coverage for abortion under Medicaid. Work requirements and limited postpartum coverage threaten access to essential care that could be provided by health insurance.

Workforce shortages place extra strain on an already tense system due to continued disinvestment, which leave underserved communities with limited maternal health providers and little to no access to culturally competent care.

Lastly, Dobbs v. Jackson Women's Health Organization has increased the variation in reproductive healthcare access between different states. With abortion bans and restrictions on providers, these regulations disproportionately impact women with already limited resources.

These overlapping barriers create a reproductive healthcare system where access to quality care is determined by race, geography, and income.

POLICY RECOMMENDATIONS

1. **Federal Medicaid Reform**

    a. Extend Postpartum Coverage Nationwide - Implement a mandate that provides postpartum care under Medicaid for 12 months under every state without work requirements

    b. Incentivize Expansion in Non-Expansion States: Provide increased federal matching funds to fix the coverage gaps in the South and the Midwest

2. **Strengthen Legal Protections for Reproductive Care**

    a. Enact federal shield law protections and encourage states to adopt similar laws to protect cross-state abortion services via telehealth

    b. Affirm Protections under EMTALA: Ensure that hospitals can provide emergency abortion care nationwide despite state law.

3. Invest in Maternal Health Infrastructure in Undeserved Communities

a. Expand Infrastructure in the Maternity Care Deserts: We need to fund the reopening, expansion, AND maintenance of labor and delivery units in rural hospitals, birthing centers, and community centers

b. Support Midwives, Nurse Practitioners, Physician Assistants, Doulas: Provide grants to hire and integrate Midwives, Nurse Practitioners, Physician Assistants, Doulas into the healthcare team, especially in rural communities or maternal deserts.

4. Strengthen Community Health Pipeline Programs and the Current Workforce

a. Empower Community Health Workers: We need to fund community health worker programs that provide culturally competent primary and maternal care to underserved communities where there are physician shortages. We need to ensure that these workers are integrated into health systems with Medicaid reimbursement systems.

b. Create Healthcare Pipeline Programs: We should establish federally funded partnerships and programs with high schools, community colleges, and medical colleges to recruit students from marginalized communities to receive education and serve in communities that have shortages. These programs will offer mentorship, scholarships, and paid internships that will help build a sustainable workforce that can alleviate the shortage on a long term basis.

In order to address the financial and structural barriers to reproductive care, the federal government, states, AND local communities must work together. As a start, policymakers should:

- Expand Medicaid coverage and dismantle the restrictions under the Hyde Amendment
- Protect Providers AND patients administering and receiving abortion care across state lines.
- Invest in infrastructure and the development of the workforce in maternity care deserts in the South and the Midwest.
- Invest in community health worker programs and pipeline initiatives to empower communities
- Through these coordinated actions and policy solutions, we can ensure that reproductive care is not determined by one's race, geography, income, or social class.

CONCLUSION

Reproductive justice requires the existence of equitable systems of coverage and care. The reformation of Medicaid will address many of the federal and state barriers while the local strategies will help to build a resilient and trusted healthcare infrastructure in marginalized communities. Through intentional investment in Medicaid coverage expansion and local maternal health infrastructure, policymakers can address the maternal health gaps that are disproportionately affecting Black women, low-income women, and women from rural communities.

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POLICY BRIEF

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VOTER SUPPRESSION

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INTRODUCTION

Voting is a fundamental pillar of democracy, yet for many African Americans, access to the ballot box has been shaped by centuries of systemic barriers. Although there are over 49 million Black Americans living in the United States, voter turnout within this community remains lower than that of other racial groups. In the 2024 general election, approximately 60% of eligible Black voters cast ballots, leaving nearly 40% unrepresented in the electoral process (U.S. Census Bureau, 2025).

This review argues that voter suppression against Black communities is not merely a relic of the past but an evolving set of practices that continue to undermine democratic participation. These practices are deeply rooted in historical disenfranchisement, perpetuate generational distrust in government, and require both structural reforms and community-level engagement to be effectively dismantled. By tracing the historical roots of suppression, analyzing its modern forms, and exploring its psychological impacts, this review highlights why protecting voting rights is essential for the survival of Black civic engagement and American democracy itself.

HISTORICAL ROOTS OF BLACK VOTER SUPPRESSION

The disenfranchisement of Black Americans has its roots in the post-Reconstruction era. After the passage of the 15th Amendment, which granted Black men the right to vote, Southern states enacted measures designed to restrict their political power. These included poll taxes, literacy tests, and property requirements, policies that appeared race-neutral but disproportionately excluded Black voters (Foner, 2014).

Photo by: Voice of America

Violence and intimidation were equally central. White supremacist groups such as the Ku Klux Klan used lynching, threats, and mob attacks to discourage Black citizens from voting or running for office (Blight, 2020). A notorious example was the Wilmington Massacre of 1898, when a violent coup by white supremacists overthrew a multiracial local government, killing dozens and displacing thousands of Black residents (McLaughlin, 2019). Such events instilled deep fear and reinforced the belief that civic engagement by Black Americans would be met with violence and retaliation.

These systemic barriers resulted in little to no Black political representation, allowing discriminatory policies in housing, education, and employment to flourish unchecked. While the Voting Rights Act of 1965 was a landmark victory in dismantling these explicit tactics, the psychological trauma and distrust seeded by this era continue to shape voting behaviors and turnout rates today.

CONTEMPORARY FORMS OF VOTER SUPPRESSION

Despite legal protections, reproductive healthcare access is uneven across states and populations due to federal inaction, funding restrictions, and state-level variability. This patchwork leaves marginalized communities disproportionately affected, perpetuating health disparities, economic inequities, and systemic injustice.

While poll taxes and literacy tests are now illegal, modern forms of voter suppression have emerged, often framed as neutral policies but disproportionately harming communities of color, especially Black voters.

Restrictive Voting Laws

The 2013 Supreme Court decision in Shelby County v. Holder weakened the Voting Rights Act by removing the requirement for certain states to obtain federal approval before changing voting laws. In the aftermath, several states introduced restrictions such as strict voter ID laws, voter roll purges, reduced early voting periods, and closures of polling places in predominantly Black neighborhoods (Berman, 2015).

These barriers directly impact turnout. For instance, Black voters are statistically more likely to lack government-issued identification, making strict ID laws a significant obstacle to participation (Hajnal et al., 2017). Similarly, polling location closures and understaffing lead to long wait times in urban and low-income areas, disproportionately affecting Black communities. These experiences not only deter voting in the moment but also reinforce long-standing distrust, perpetuating the psychological legacy of suppression.

Digital Disinformation and Modern Intimidation

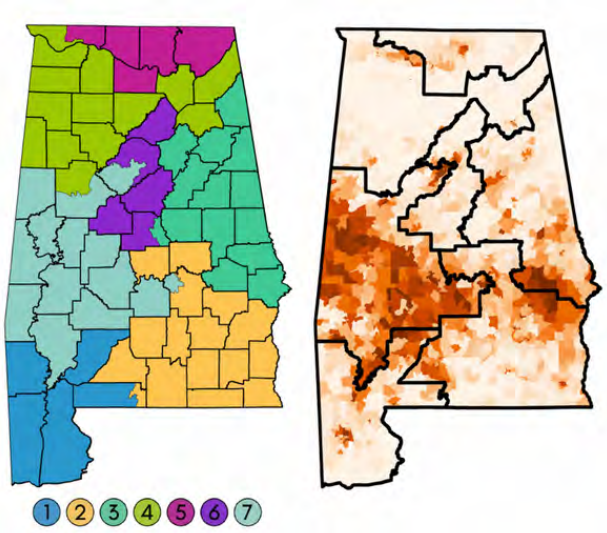
Suppression has also taken a digital form. In recent elections, coordinated disinformation campaigns on social media have targeted Black voters with false information about voting dates, registration deadlines, or eligibility (Howard et al., 2020). These campaigns often use culturally tailored messaging, fake grassroots pages, and bot amplification to appear credible within Black online communities. By mimicking trusted voices or community spaces, misleading content can spread quickly before corrections reach the same audiences.

While these tactics are less visible than physical intimidation, they echo past strategies by using fear, confusion, and information overload to discourage participation. The psychological impact is significant. When voters are repeatedly exposed to conflicting or false information, it can increase uncertainty about the voting process, reduce confidence in the system, and ultimately suppress turnout. In this way, digital misinformation represents a modern evolution of voter suppression, continuing a cycle of mistrust that disproportionately affects Black communities.

GERRYMANDERING AND REPRESENTATION

Voter suppression is not limited to preventing ballots from being cast. It also includes diminishing the impact of those ballots through gerrymandering. Politicians use "cracking" to split cohesive Black voting blocs across multiple districts, diluting their power, or "packing" to concentrate them into a single district, limiting their influence elsewhere.

The effects are profound. When Black voters consistently see their collective voices diminished, it fosters political disillusionment, reinforcing the perception that participation is futile. For example, in Allen v. Milligan (2023), the Supreme Court ruled that Alabama's congressional map violated the Voting Rights Act by intentionally weakening the voting strength of Black communities (NAACP Legal Defense Fund, 2023).



Source: Declaration of Moon Duchin filed by plaintiffs in Allen v. Milligan, formerly Milligan v. Merrill.

Independent redistricting commissions offer a promising solution. States like California and Michigan have successfully implemented these commissions, creating fairer and more competitive elections (Levitt, 2019). Such reforms can help rebuild trust by showing communities that their votes matter and will translate into meaningful representation.

THE PSYCHOLOGICAL LEGACY OF SUPPRESSION

Centuries of voter suppression have left behind more than structural barriers. They have created psychological wounds that persist across generations. Communities repeatedly subjected to disenfranchisement often develop political disillusionment, believing that voting will not lead to meaningful change (Cohen & Luttig, 2021).

This cycle of mistrust connects the past and present. The violent intimidation of Reconstruction, the legal manipulations of Jim Crow, and today's digital disinformation campaigns all send a similar message: Black voices are unwelcome in the political sphere. Such generational trauma lowers turnout, which in turn allows discriminatory policies to persist, creating a feedback loop of suppression and disengagement. Breaking this loop requires both policy reform and intentional efforts to rebuild trust at the community level.

CONCLUSION AND POLICY RECOMMENDATIONS

The ongoing struggle for voting rights in Black communities is deeply tied to the history of systemic racism in the United States. From violent suppression in the Reconstruction era to modern tactics like voter ID laws, polling place closures, digital disinformation, and gerrymandering, these barriers have continually evolved but remained effective.

To combat this, policymakers must address both structural inequities and psychological legacies by:

1. Restoring federal oversight of voting laws by strengthening the Voting Rights Act to prevent discriminatory policies.

2. Expanding access to voting, including automatic registration, extended early voting periods, and vote-by-mail options.

3. Implementing independent redistricting commissions to eliminate partisan and racial gerrymandering.

4. Regulating digital voter suppression by holding social media companies accountable for disinformation campaigns.

5. Investing in civic education and community engagement to rebuild trust and encourage participation among historically marginalized groups.

Voting is a mechanism for communities to shape their futures. Ensuring equal access to the ballot box is essential not only for Black civic engagement but for the survival of a truly representative democracy.

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POLICY BRIEF

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Restoring Representation: Combating Voter Suppression in the 21st Century

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EXECUTIVE SUMMARY

Despite decades of progress, voter suppression and inequitable redistricting continue to silence marginalized communities across the United States. The weakening of the Voting Rights Act and the rise of modern suppression tactics, such as strict voter ID laws, polling place closures, and racial gerrymandering, have created barriers that weaken democratic participation. To address these inequities, this brief outlines three policy recommendations: restoring federal oversight through updated voting rights legislation, expanding access to early and mail-in voting, and establishing independent redistricting commissions. These actions will help ensure that every citizen has equal opportunity to shape the laws and leaders that impact their lives

BACKGROUND

Voter suppression is intentional policies or practices that make it harder for certain groups, especially marginalized communities, to vote or have their votes fully counted. These tactics can include restrictive voter ID laws, polling place closures, voter roll purges, limited early voting, and racially biased redistricting. Although the Voting Rights Act of 1965 was created to combat racial discrimination in voting, recent court decisions and policy rollbacks have weakened its protections, allowing new forms of suppression to emerge.

The communities most impacted are Black, Latino, Native American, Asian American, and low-income populations, as well as students, elderly voters, and people with disabilities. These groups often face systemic barriers, such as lack of access to required identification, transportation challenges, and fewer polling locations, that make participation more difficult.

The fight for equitable voting access has deep historical roots, dating back to the Reconstruction Era and the passage of the 15th Amendment. Significant progress was made with the Voting Rights Act of 1965, which curbed discriminatory practices like literacy tests and poll taxes. However, major setbacks occurred after Shelby County v. Holder (2013), which weakened requiring federal approval of voting law changes in states with histories of discrimination. More recently, in Allen v. Milligan (2023), the Supreme Court reaffirmed that racial gerrymandering remains a violation of the Voting Rights Act, showing ongoing tensions in voting rights protection.

Lyndon B. Johnson Presidential Library and Museum/NARA

Ensuring fair and equitable voting access is essential for a healthy democracy. When marginalized communities face barriers to voting, their voices are underrepresented in policymaking, leading to inequitable outcomes in areas like housing, education, healthcare, and criminal justice. Continued voter suppression perpetuates systemic racism and diminishes trust in democratic institutions. Protecting and expanding access to the ballot is not only a legal responsibility but morally significant and necessary to uphold equal representation and civic participation.

Modern suppression occurs through both legal and structural means. After Shelby County v. Holder, many states enacted restrictive laws under “election security.” These include strict voter ID requirements, limits on absentee and early voting, and aggressive voter roll purges. Additionally, racial and partisan gerrymandering, as seen in Allen v. Milligan, manipulates district boundaries to dilute the voting power of communities of color. Together, these tactics reduce turnout, weaken representation, and reinforce systemic inequities. Reforms must therefore target both legislative loopholes and structural practices to restore equal access to the ballot.

POLICY PROBLEM

Voter suppression and racial gerrymandering have become powerful tools that continue to disenfranchise marginalized voters. The 2013 Shelby County v. Holder decision weakened federal oversight, allowing states to implement restrictive voting laws that disproportionately impact Black, Latino, and low-income voters. Additionally, partisan gerrymandering, such as the case in Allen v. Milligan (2023), has weakened the political influence of communities of color by manipulating district boundaries. Without comprehensive policy reforms, these practices will continue to undermine democratic legitimacy, exacerbate racial inequities, and silence millions of eligible voters.

POLICY RECOMMENDATIONS

1. **Restore Federal Voting Protections:** Reinstate and modernize the preclearance provisions of the Voting Rights Act to require federal review of voting law changes in jurisdictions with histories of discrimination. This will help to strengthen accountability and ensure equitable access to the ballot.

2. **Expand Access to Early and Mail-In Voting:** Mandate minimum early voting periods, no-excuse absentee ballots, and accessible mail-in voting systems nationwide. Early and mail-in voting increases turnout among low-income, minority, and rural populations, reducing barriers caused by long lines or limited polling sites. This increases participation and reduces structural barriers to voting.
3. **Establish Independent Redistricting Commissions:** Require nonpartisan or independent commissions to draw electoral district boundaries. States like California and Michigan show that independent redistricting leads to fairer maps, more competitive elections, and improved voter confidence (Allen v. Milligan, 2023). This promotes fair representation and prevents racial or partisan gerrymandering.

CALL TO ACTION

In order to address the financial and structural barriers to reproductive care, the federal government, states, AND local communities must work together. As a start, policymakers should:

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Increasing Black Voter Participation: Empowerment, Education, Change

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EXECUTIVE SUMMARY

Black voter participation in the United States remains below its full potential, which significantly limits the influence of Black communities on national and local policy decisions. This issue disproportionately affects two key demographic groups: middle-aged Black Americans and younger, first-time voters. While many in these groups are politically aware and deeply invested in their communities, a range of systemic and social barriers has contributed to lower turnout rates over time.

Historically, Black Americans have faced voter suppression through discriminatory laws and practices, and those challenges persist today in new forms. Modern obstacles such as strict voter ID laws, gerrymandering, limited access to polling places, and cuts to early voting disproportionately affect Black voters. Additionally, many schools lack comprehensive civics education, leaving young people unprepared to navigate the voting process or understand the impact of their participation. For some, especially younger voters, there is also a sense of disillusionment—a belief that their vote does not truly matter or change outcomes. This combination of structural and emotional barriers contributes to a cycle of disengagement.

The consequences of low Black voter turnout are far-reaching. When large segments of the population are underrepresented at the ballot box, policies often fail to reflect their needs and priorities. In today's political climate—where hard-won rights in areas like education, housing, health care, and reproductive freedom are being rolled back—the need for robust civic participation is more urgent than ever. A strong, representative democracy depends on the active engagement of all communities, especially those historically marginalized.

To address this issue, a two-pronged approach is necessary. First, there must be a renewed focus on civic education, particularly in underfunded schools and communities, to ensure young voters are equipped with the knowledge and confidence to participate. Second, reforming and strengthening the Voting Rights Act is essential to protecting against discriminatory laws and ensuring fair access to the ballot for all Americans. By combining education and policy reform, we can help empower Black voters and ensure their voices are fully heard in shaping the future of American democracy.

POLICY PROBLEM:

The persistent and systemic disenfranchisement of Black voters in the United States, resulting from both historical and modern voter suppression tactics, gerrymandering, and institutional barriers. This undermines equitable political participation and democratic representation.

POLICY RECOMENDATIONS:

- **RESTORE AND STRENGTHEN THE VOTING RIGHTS ACT:** Congress must pass legislation such as the John R. Lewis Voting Rights Advancement Act, which would restore the preclearance provision struck down in Shelby County v. Holder (2013). This law would require jurisdictions with histories of voter suppression to seek federal approval before implementing changes to voting laws—protecting against discriminatory practices targeting Black voters.
- **CIVIC EDUCATION AND COMMUNITY INVESTMENT:** There must be investment in grassroots civic education programs—particularly in historically disenfranchised communities—to rebuild trust in the electoral process. These programs should be led by trusted local organizations and focus on teaching not just the mechanics of voting, but the historical importance and power of Black civic participation.
- **COMBAT MISINFORMATION AND INTIMIDATION: S**tate and federal agencies must actively address misinformation campaigns and modern voter intimidation, both online and in-person. This includes enforcing existing laws against harassment at polling places and increasing transparency in social media algorithms that may disproportionately target disinformation toward Black communities.

CALL TO ACTION:

To address the persistent barriers to Black voter participation, a multifaceted approach that combines legal protections, community empowerment, and structural reforms is necessary. The recommendations aim to combat both historical legacies and contemporary obstacles that continue to disenfranchise Black communities.

CONCLUSION:

To truly ensure equitable civic participation, the United States must go beyond symbolic recognition of voting rights and confront the systemic structures that continue to disenfranchise Black voters. Protecting the right to vote must be treated not as a partisan issue, but as a moral and democratic imperative. Empowering Black communities to fully participate in the electoral process is not only a matter of justice, it is essential to the health of American democracy.

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POLICY BRIEF

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Unequal Access: The Evolution and Future of Reproductive Rights in the United States

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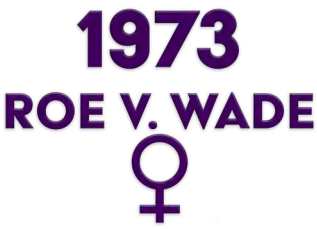
EXECUTIVE SUMMARY

Reproductive rights in the United States have shifted dramatically from a federally protected framework to a fragmented, state-based system. The Supreme Court's decision in Dobbs v. Jackson Women's Health Organization (2022) eliminated constitutional protections for abortion that had existed for nearly five decades, leaving regulation to individual states. This change has produced significant inequities in access to reproductive health care, with the greatest burdens falling on Black women, low-income communities, and those living in rural areas. (USC Center for Health Journalism) Federal action is urgently needed to restore equitable protections, strengthen public health infrastructure, and ensure that reproductive rights are consistently safeguarded across the nation.

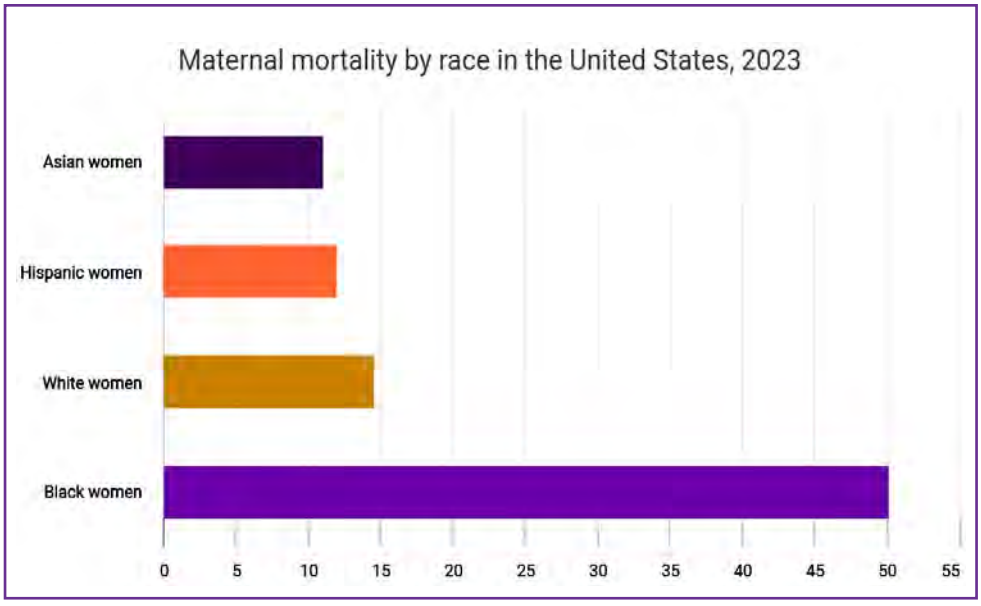
BACKGROUND: The Evolution of Reproductive Rights



For For nearly fifty years, the decisions in Roe v. Wade (1973) and Planned Parenthood v. Casey (1992) provided a constitutional foundation for abortion rights in the United States. These cases established abortion as a component of the right to privacy and prohibited states from imposing regulations that created an "undue burden" on individuals seeking care. Together, they created a national baseline of protection, attempting to balance individual autonomy with state interests in potential life and maternal health.

However, reproductive rights in the United States have never been limited solely to abortion access. They encompass a broader framework of healthcare services, including contraception, prenatal and postpartum care, fertility treatment, miscarriage management, and safe childbirth. Access to these services has long been shaped by geographic, economic, and racial disparities. Even before the overturning of Roe, many communities—particularly low-income individuals and people of color—faced significant barriers to comprehensive reproductive healthcare.

Maternal health outcomes in the United States reflect these inequalities. The U.S. has one of the highest maternal mortality rates among high-income nations, and racial disparities are especially stark. Black women are significantly more likely to die from pregnancy-related causes than white women, often at rates two to three times



higher. These disparities persist regardless of income or education level and are influenced by structural racism, unequal access to healthcare, implicit bias in medical treatment, and differences in insurance coverage and quality of care. Data reporting on maternal deaths has increasingly highlighted these inequities, drawing national attention to the intersection of reproductive rights and racial justice.

The constitutional framework established by Roe and Casey existed within this broader landscape of uneven healthcare access. While the decisions protected the legal right to abortion, they did not eliminate the practical and structural barriers that limited reproductive autonomy for many individuals.

That framework ended in 2022 when the Supreme Court issued its decision in Dobbs v. Jackson Women's Health Organization, overturning both Roe and Casey and returning regulatory authority to the states. The result was an immediate transformation of the national landscape: some states enacted near-total abortion bans, while others codified reproductive protections into law. This divergence has produced a patchwork system in which not only abortion access, but broader reproductive healthcare experiences—including emergency pregnancy care and maternal health services, are increasingly shaped by geography. In this new era, reproductive rights are determined less by constitutional guarantee and more by state policy, with significant implications for healthcare equity and maternal outcomes nationwide.

Unequal Access and the Human Impact

The post-Dobbs era has deepened existing disparities in health outcomes and access to care. Individuals in restrictive states often face extraordinary barriers—such as travel distances exceeding 100 miles, limited provider availability, and financial strain—just to obtain services that remain accessible elsewhere. These inequities are not evenly distributed. Black women and other women of color, who already experience maternal mortality rates two to three times higher than white women, are disproportionately affected.

Low-income and rural populations are also severely impacted, lacking the resources or flexibility to travel across state lines. For these communities, the combination of geographic and economic barriers effectively eliminates access to abortion care altogether. Health providers, meanwhile, must navigate contradictory and shifting laws that create uncertainty, legal risk, and administrative burdens, undermining the consistency and safety of care.

The consequences of the Dobbs decision are not theoretical—they are measurable and immediate. Research from Johns Hopkins University and the Guttmacher Institute shows that travel distances to abortion clinics have tripled on average in restrictive states, rising from 39 miles to over 110. States that have banned or severely limited abortion access are now reporting higher rates of unplanned births and infant mortality.

These restrictions also have cascading economic and social consequences. Women denied abortion care are more likely to fall into poverty, face unemployment, and experience long-term health complications. For Black women—who are already overrepresented among primary breadwinners—these challenges reinforce structural inequities in health, education, and economic mobility. Without federal intervention, these outcomes will continue to widen existing racial and gender gaps.

Legislative Landscape: What Has Been Done and What Is Missing

Historically, reproductive rights have been shaped through a combination of judicial rulings, state legislation, and advocacy efforts. Roe and Casey established federal protections; Dobbs dismantled them. In the absence of a federal standard, states have moved in opposing directions—some restricting abortion almost entirely, others expanding access and establishing legal protections for patients and providers.

Advocacy organizations, including the Center for Reproductive Rights and Planned Parenthood, have mobilized to mitigate these disparities through travel assistance, legal defense, and public health initiatives. However, these efforts are patchwork responses to a structural problem. Without a cohesive national framework, reproductive rights remain vulnerable to further erosion, and millions of Americans continue to face unequal access to care.

Policy Recommendations

1. **Codify Federal Protections for Reproductive Health Care.**

   Congress should enact legislation that guarantees nationwide access to abortion and related services. Federal protections would eliminate the state-by-state disparities that currently determine who can access care and who cannot. Research from the Center for Reproductive Rights indicates that comprehensive federal policies improve maternal health outcomes and reduce racial inequities.

2. **Expand Federal and State Funding for Reproductive Health Services.**

   Increased funding for Medicaid and Title X programs is essential to support low-income and underserved populations. According to the Guttmacher Institute, investing in reproductive health care reduces unintended pregnancies, strengthens preventive care, and improves long-term health outcomes.

3. **Strengthen Data Collection and Public Health Infrastructure.**

   Standardized reporting on maternal mortality, abortion access, and reproductive health outcomes across states would improve transparency and accountability. Research from The Lancet and Johns Hopkins University emphasizes that robust, consistent data are critical for identifying inequities and informing effective policy solutions.

Conclusion and Call to Action

The overturning of Roe v. Wade transformed reproductive rights in the United States from a federally guaranteed protection to a fragmented system defined by inequality. Millions of women—especially Black, low-income, and rural women—now face barriers that threaten their health, autonomy, and economic stability. Congress must act to restore equitable access to reproductive health care by codifying federal protections, expanding funding, and investing in data-driven public health infrastructure. Reproductive rights are fundamental human rights, and ensuring equal access is both a moral and national imperative.

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Revitalizing the Voting Rights of Marginalized Communities: Overcoming Suppression and Empowering Civic Participation

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EXECUTIVE SUMMARY

Voter suppression remains a persistent and evolving challenge in the United States, especially for marginalized communities such as Black, Latino, Native American, low-income, elderly, disabled, and formerly incarcerated voters. While historical barriers like literacy tests and poll taxes have been dismantled, modern tactics, such as strict voter ID laws and gerrymandering, continue to disenfranchise these populations. This issue is not only a legal problem but a moral one, as it undermines the democratic principles that are the foundation of our society. To address this, policy reforms, strengthened civic education, and proactive steps to counteract voter suppression must be prioritized.

BACKGROUND

Voter suppression remains a significant issue in the United States, continuing to disproportionately affect marginalized communities despite progress made since the Civil Rights Movement. Modern tactics such as voter ID laws, gerrymandering, and the systematic purging of voter rolls have made it increasingly difficult for people—particularly from Black, Latino, and Native American communities—to exercise their right to vote (Brennan Center for Justice, 2021). These disenfranchisement efforts not only limit political participation but also undermine the democratic principles of equal representation and fairness in elections. Historically, explicit discriminatory practices like Jim Crow laws restricted voting rights, but while many of these have been dismantled, subtler forms of disenfranchisement have emerged in the post-Civil Rights era. For example, the 2013 Supreme Court decision in Shelby County v. Holder rolled back key protections of the Voting Rights Act, enabling states to implement restrictive voting laws that disproportionately impact marginalized groups. The populations most affected include Black, Latino, and Native American communities, as well as low-income, elderly, disabled, and formerly incarcerated individuals, who face a combination of legal and logistical barriers that continue to suppress their political voice. The right to vote is fundamental to a functioning democracy, and when it is denied or diluted, the integrity of the democratic process is compromised. This issue is especially urgent today, as political decisions that affect marginalized communities are shaped by who has access to the ballot. Efforts to address voter suppression have included landmark legislation such as the Voting Rights Act of 1965, but ongoing challenges persist due to court rulings and legislative changes. Current initiatives, like the John R. Lewis Voting Rights Advancement Act, seek to restore federal oversight and strengthen protections to ensure equitable access to voting for all citizens.

POLICY PROBLEM

The systemic disenfranchisement of marginalized communities continues through both historical and modern voter suppression tactics. Laws like strict voter ID requirements, polling place closures, aggressive purging of voter rolls, and racial gerrymandering systematically exclude Black, Latino, Native American, and low-income voters. These practices not only perpetuate inequality in the political process but also erode public trust in elections and democratic institutions.

POLICY RECOMMENDATIONS

1. **REINSTATE AND STRENGTHEN THE VOTING RIGHTS ACT:** Congress must work to restore and update key provisions of the Voting Rights Act of 1965, especially the preclearance formula that was struck down in Shelby County v. Holder (2013). The John R. Lewis Voting Rights Advancement Act should be passed to require federal approval of voting law changes in jurisdictions with histories of voter suppression. This proactive measure is critical to preventing discriminatory laws from being enacted before they harm marginalized communities.

2. **CREATE COMPREHENSIVE CIVIC EDUCATION INITIATIVES:** Disenfranchisement is often compounded by a lack of understanding of the electoral process and the power of civic participation. Robust, community-driven civic education programs are essential to ensure that marginalized communities understand not only the mechanics of voting but also the historical context and ongoing significance of their participation. These programs, led by trusted local organizations, should focus on rebuilding trust in the electoral system and empowering individuals with the knowledge to advocate for themselves.

3. **COMBAT MODERN VOTER SUPPRESSION AND DISINFORMATION:** Modern voter suppression tactics, such as online disinformation campaigns and in-person intimidation, disproportionately target marginalized communities. The federal government must address these issues by enforcing existing voter protection laws, increasing penalties for voter harassment, and requiring greater transparency in social media algorithms that amplify false or misleading content. A coordinated effort to combat both digital and physical voter suppression will be key to protecting the integrity of future elections.

It's time to act decisively. Lawmakers must work to reinstate protections for voters that have been eroded in recent years. This means passing the John R. Lewis Voting Rights Advancement Act, funding civic education initiatives that empower marginalized communities, and taking concrete steps to combat modern voter suppression and disinformation. These changes require collaboration between legislators, advocacy organizations, and local communities, and they must be implemented with urgency.

Voter suppression remains one of the most significant threats to American democracy. The erosion of the Voting Rights Act and the rise of modern disenfranchisement tactics have weakened our electoral system, disproportionately harming marginalized communities. To ensure the right to vote is fully realized for all Americans, it is essential that we reinstate protections, fight back against voter suppression, and empower disenfranchised communities. This is not just a policy issue—it is a moral imperative that affects the future of our democracy.

NCNW

POLICY BRIEF

LACI WHITE
NCNW Advocacy & Policy Brief
Bethune Height Career Accelerator Program

Bridging the Gap: Federal Policy Solutions for Equitable Reproductive Healthcare Access

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EXECUTIVE SUMMARY

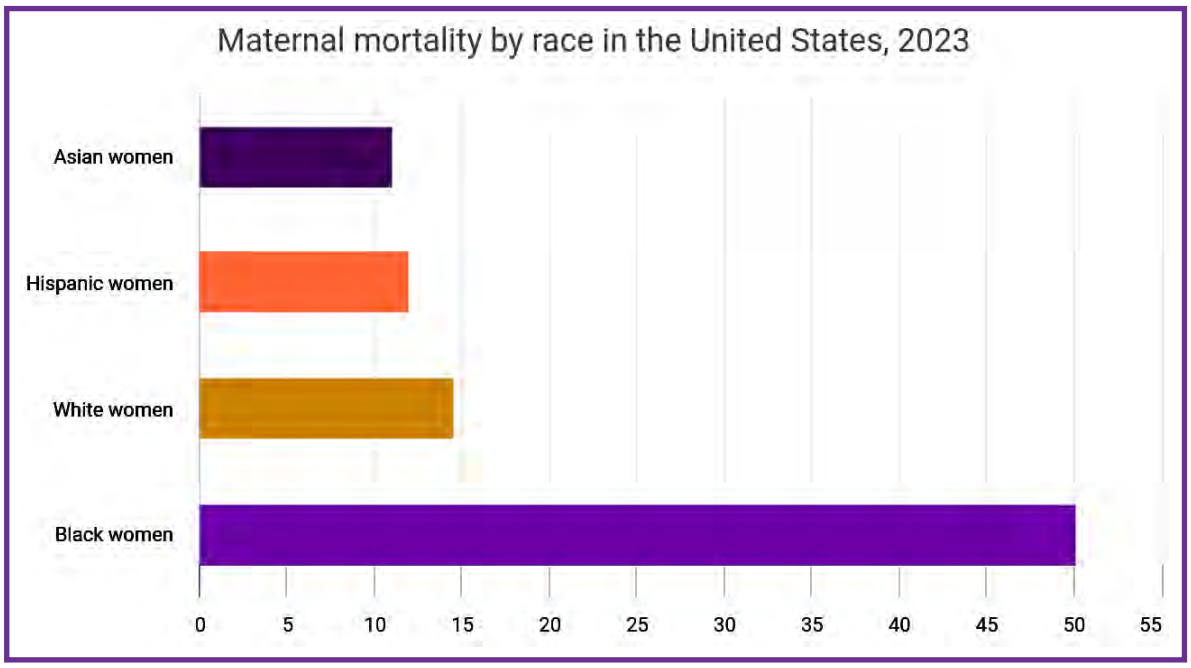
Reproductive healthcare in the United States is increasingly fragmented, with access dependent on state-level laws and socioeconomic factors. The overturning of Roe v. Wade has intensified disparities in abortion access, contraception, and maternal care, disproportionately affecting low-income women and women of color. Federal inaction has left significant policy gaps that perpetuate structural inequities. This brief examines the historical, legal, and social context of reproductive rights, identifies key policy gaps, and proposes three research-backed recommendations to ensure equitable access nationwide.

BACKGROUND

Reproductive rights in the United States have shifted dramatically from a federally protected framework to a fragmented, state-based system. The Supreme Court's decision in Dobbs v. Jackson Women's Health Organization (2022) eliminated constitutional protections for abortion that had existed for nearly five decades, leaving regulation to individual states. This change has produced significant inequities in access to reproductive health care, with the greatest burdens falling on Black women, low-income communities, and those living in rural areas. (USC Center for Health Journalism) Federal action is urgently needed to restore equitable protections, strengthen public health infrastructure, and ensure that reproductive rights are consistently safeguarded across the nation.

Reproductive rights in the United States encompass access to abortion, contraception, maternal healthcare, and family planning– core elements of women's health and autonomy. Historically, these rights have been shaped by ongoing legal, political, and social debates. Early advocacy in the early 20th century, led by figures such as Margaret Sanger, established contraception as a cornerstone of women's independence. However, meaningful legal protections did not emerge until Roe v. Wade (1973), which recognized the constitutional right to abortion. This was later refined by Planned Parenthood v. Casey (1992), which introduced the "undue burden" standard, balancing state regulation with individual rights. In 2022, the Dobbs v. Jackson Women's Health Organization decision overturned Roe, returning abortion regulation to the states and intensifying existing disparities in access (Flores, 2014; Rodman, 2023).

The impact of these shifts is not evenly distributed. Low-income women, women of color, rural residents, and others reliant on public healthcare programs experience the most severe barriers. Black women, for example, face maternal mortality rates more than three times higher than White women (CDC, 2023). Rural populations often confront geographic and logistical barriers to clinics and providers, with some traveling hundreds of miles for basic reproductive care (Jones, Witwer, & Jerman, 2023). These disparities reflect the intersection of race, class, and geography, revealing systemic inequities deeply embedded in healthcare access.



Unequal access to reproductive healthcare has far-reaching social and economic consequences. Marginalized populations face higher rates of maternal morbidity, unintended pregnancies, and financial strain, further widening the gap in health and economic stability. The divergence of state policies following Dobbs has created a patchwork system where access depends on one's zip code rather than one's rights. Without federal intervention, these disparities will continue to deepen, leaving millions without essential healthcare options.

Legal and policy frameworks have contributed both progress and limitation. While landmark cases like Roe and Casey established legal precedents, federal measures such as the Hyde Amendment have restricted abortion funding through Medicaid, disproportionately burdening low-income communities (Guttmacher Institute, 2024). Title X remains the primary federal program for family planning services, yet underfunding in several states limits its reach and effectiveness (Planned Parenthood Action Fund, 2023). Some states have enacted protective "shield laws" or expanded Medicaid coverage to fill these gaps, but their reach remains inconsistent nationwide (Jones, Witwer, & Jerman, 2023; KFF, 2024). These inconsistencies underscore the urgent need for cohesive federal policy to ensure equitable reproductive healthcare access for all.

POLICY PROBLEM

Despite legal protections, reproductive healthcare access is uneven across states and populations due to federal inaction, funding restrictions, and state-level variability. This patchwork leaves marginalized communities disproportionately affected, perpetuating health disparities, economic inequities, and systemic injustice.

POLICY RECOMMENDATIONS

1. **Enact Comprehensive Federal Legislation Protecting Reproductive Healthcare Access**
    a. Pass the Women's Health Protection Act (WHPA) to codify the right to abortion and prevent restrictive state-level laws.
        i. Research shows codified federal protections reduce geographic disparities and improve equitable access (Rodman, 2023).
2. **Expand Federal Funding for Reproductive Health Services**
    a. Remove restrictions like the Hyde Amendment and increase Title X funding to ensure low-income populations can access contraception, abortion, and maternal healthcare.
        i. Evidence demonstrates that increased funding improves outcomes for women of color and low-income individuals, reducing maternal mortality and unintended pregnancies (KFF, 2024; Planned Parenthood Action Fund, 2023).
3. **Implement National Standards for Reproductive Healthcare Access and Data Reporting**
    a. Establish federal guidelines for clinic accessibility, service coverage, and healthcare provider availability, especially in rural and underserved areas.
        i. Collect and publish comprehensive data on reproductive healthcare disparities to inform evidence-based policy decisions (Jones, Witwer, & Jerman, 2023; CDC, 2023).

CALL TO ACTION

Congress should immediately prioritize the passage of the WHPA, repeal federal funding restrictions like the Hyde Amendment, and allocate resources to expand Title X and maternal healthcare programs. Additionally, the Department of Health and Human Services should implement national standards and reporting requirements to ensure equitable access across states.

CONCLUSION

Reproductive healthcare access in the United States remains uneven, with marginalized communities facing the greatest barriers. Federal action is essential to bridge the gaps created by state-level variability, funding restrictions, and systemic inequities. By codifying protections, increasing funding, and establishing national standards, policymakers can ensure that reproductive rights are not only legally recognized but equitably accessible to all Americans.

NCNW

POLICY BRIEF

SAMAURIA EASON
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Beyond Survival: Protecting Black Mothers Through Advocacy & Accountability

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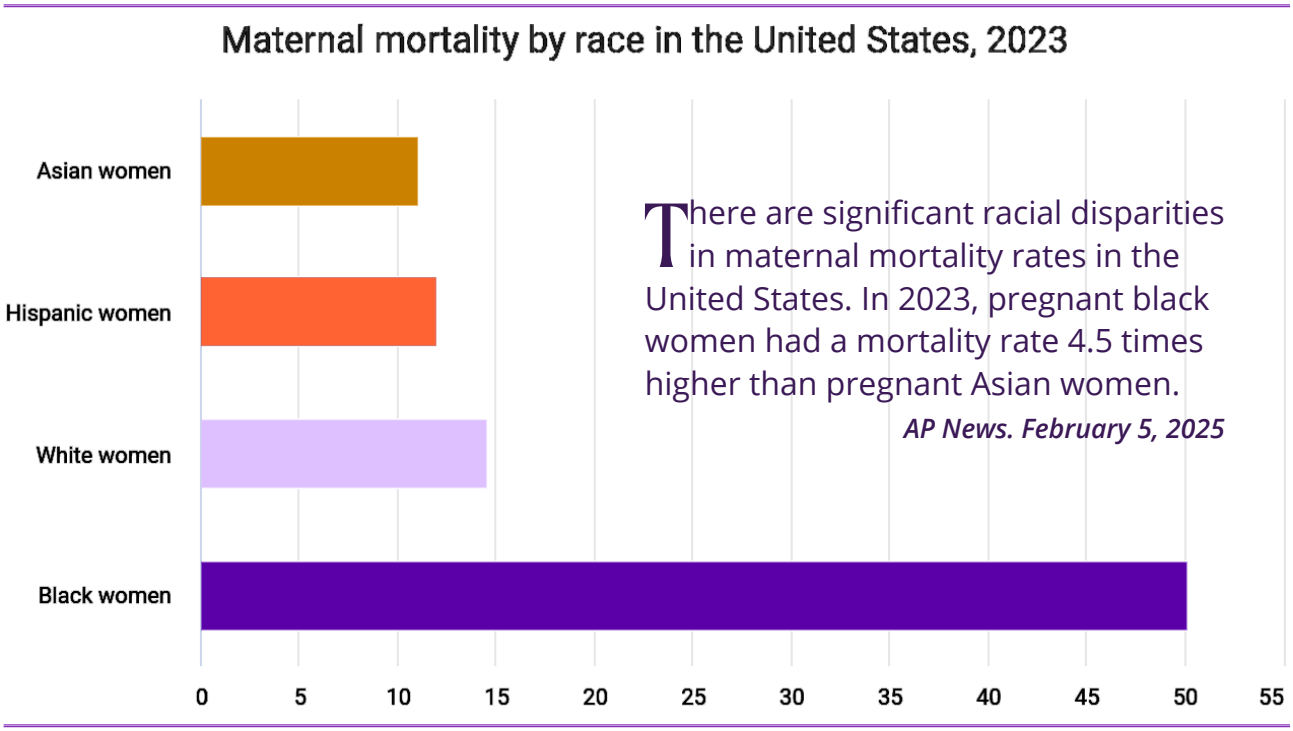
EXECUTIVE SUMMARY

Although nearly **80% of pregnancy-related deaths are preventable**, **Black mothers in the United States continue to die at alarming rates**, especially those living in low-income communities. Pregnancy and childbirth, moments that should be defined by care and safety, too often become life-threatening for Black women navigating a healthcare system that repeatedly fails to protect them. **Black mothers experience a maternal mortality rate nearly three times higher than that of White mothers.** In 2020 alone, non-Hispanic Black women died at a rate of 55.3 deaths per 100,000 live births, compared to 19.1 deaths per 100,000 among non-Hispanic White women (Hoyert). These deaths are not inevitable; they are the result of systemic racism, implicit bias, inadequate patient advocacy, and a lack of institutional accountability within medical settings.



There are significant racial disparities in maternal mortality rates in the United States. In 2023, pregnant black women had a mortality rate 4.5 times higher than pregnant Asian women.

AP News. February 5, 2025

This policy brief argues that the implementation of maternal care advocates in hospitals serving low-income Black mothers is an urgent and necessary policy intervention. These advocates would serve as trained, independent advocates embedded within care teams to ensure informed consent, elevate patient voices, and intervene when concerns are dismissed or overlooked. By providing continuous support across pregnancy, labor, and the postpartum period, medical care advocates would not only safeguard patient autonomy and dignity but also create a structural mechanism for accountability within healthcare systems. Implementing medical care advocates represents a tangible, evidence-informed step toward dismantling preventable inequities and ensuring that Black mothers are heard, respected, and most critically able to survive childbirth.

BACKGROUND

Despite years of research that document racial disparities in maternal health and multiple policy efforts aimed at expanding access to care, Black maternal mortality remains the most persistent and preventable crisis in the United States. The continued loss of Black mothers, especially those living in low-income communities, reflects not a failure of medicine but instead a failure of systems to protect, listen to, and advocate for black women within healthcare settings. While federal initiatives such as the Medicaid postpartum extensions and the Black Maternal Momnibus Act reflect meaningful progress, these initiatives alone won't sufficiently address the everyday clinical experiences where implicit bias, dismissal of patient concerns, and lack of accountability continue to shape maternal outcomes.

The roots of this crisis are deeply embedded in the history of medical racism and reproductive injustice. From forced sterilization and unethical medical experimentation, including the Tuskegee Syphilis Study and the exploitation of Henrietta Lacks, to discriminatory reproductive policies and restrictive legislation, Black women's reproductive autonomy and health have been repeatedly undermined by institutions charged with their care.

Current maternal health policies often focus on access and coverage, yet they overlook the most critical moments of care where preventable complications are escalated due to communication breakdowns, inadequate advocacy, or delayed intervention. Because of this, Black mothers remain vulnerable during pregnancy, labor, and the postpartum period, the time where consistent support and patient-centered advocacy are needed most. The persistence of these gaps highlight a fundamental disconnect between policy frameworks and the lived experiences of Black women navigating maternal healthcare systems. These historical injustices have eroded trust in healthcare systems, constrained access to quality maternal services, and normalized disparities in treatment that persist today.

Though there has been a multitude of research being done, racial disparities within maternal mortality have been most consistent. Beginning in the 1980s and 1990s, studies revealed significantly higher risks of pregnancy-related death for Black women. Despite advances in obstetric care and medical technology, the United States has seen a troubling rise in maternal mortality since the early 2000s. Why is this most alarming? Because as a nation we rank ourselves as being the most advanced, yet the maternal mortality of Black women is the most alarming trend that isn't observed in other high-income nations. In 2018, the Centers for Disease Control and Prevention confirmed that Black women were three to four times more likely to die from pregnancy-related causes than White women. The COVID-19 pandemic further exacerbated these inequities, as Black women faced disruptions in prenatal care, heightened exposure risks, and increased rates of severe complications.

In response, federal and state policymakers have introduced measures aimed at improving maternal health outcomes, including the Affordable Care Act's expansion of prenatal coverage, the Black Maternal Health Momnibus Act, and state-level extensions of Medicaid coverage to twelve months postpartum. While these initiatives represent important progress, they have not sufficiently addressed the conditions within healthcare settings where many preventable maternal deaths occur. Hospital accountability gaps, inconsistent tracking of outcomes by race and income, and the continued presence of implicit bias leave Black mothers vulnerable during pregnancy, labor, and the postpartum period.

This issue is particularly urgent given that **approximately 80% of pregnancy-related deaths in the United States are preventable**. Yet Black mothers continue to face barriers such as delayed diagnosis, dismissal of pain and symptoms, inadequate communication, and lack of patient-centered advocacy during critical moments of care. The consequences extend far beyond individual mothers, affecting children, families, and entire communities. Preventable maternal deaths contribute to emotional trauma, economic instability, and intergenerational health challenges, reinforcing cycles of inequity and mistrust in healthcare institutions.

Maternal health is not solely a medical concern; it is a measure of health equity, civil rights, and institutional accountability. The United States has the highest maternal mortality rate among developed nations, and Black women bear the heaviest burden of this failure. Addressing Black maternal mortality therefore requires structural interventions that move beyond access alone and directly confront inequities within healthcare delivery. Without targeted, system-level solutions that prioritize accountability, advocacy, and respect for Black mothers, preventable maternal deaths will continue to reflect not isolated tragedies, but a sustained public health emergency rooted in structural injustice.

POLICY PROBLEM

Despite the growing awareness and increased research on racial disparities in maternal health, the current policies fail to adequately address the systemic barriers that place Black women at the highest risk of pregnancy-related complications and death. While Black mothers experience disproportionately poor outcomes across income, education, and geographic lines, access to comprehensive and continuous maternal care remains inconsistent and deeply fragmented.

Medicaid, one of the biggest payers of nearly half the U.S. births, does not provide uniform coverage nationwide, and many women lose insurance just sixty days after childbirth. This gap leaves mothers without access to care during the postpartum period, a time when medical complications, mental health challenges, and chronic conditions are most likely to emerge. These coverage disruptions disproportionately harm Black women, who are more likely to rely on Medicaid and less likely to have access to alternative insurance options.

Within healthcare settings, implicit bias and structural racism continue to influence clinical decision-making, pain assessment, and patient-provider communication. Black women's symptoms are more likely to be dismissed or undertreated, contributing to delayed diagnoses and preventable complications. At the same time, maternal health data collection remains insufficient and inconsistently disaggregated by race, income, and insurance status, limiting the ability to track disparities or hold hospitals accountable for inequitable outcomes.

Finally, community-based maternal health programs, many of which have demonstrated success in improving outcomes through culturally responsive care and advocacy, remain chronically underfunded and lack sustainable policy support. Without enforceable, equity-centered policies that address coverage gaps, provider bias, and institutional accountability, maternal health disparities will persist. Addressing these failures is essential not only to improving health outcomes, but to advancing reproductive justice and restoring trust in healthcare systems.

POLICY RECOMMENDATIONS

A critical and immediate policy intervention is the extension of Medicaid coverage for mothers to twelve months postpartum. Currently, many women lose health insurance just sixty days after delivery, despite facing heightened health risks during the first year after childbirth. Research published in Health Affairs found that states expanding Medicaid eligibility experienced a 17% reduction in postpartum hospitalizations within the first sixty days after birth, particularly among low-income mothers (Daw et al.). Additional evidence from Colorado demonstrates that expanded postpartum coverage improves continuity of care and reduces insurance gaps (Searing et al.). Extended Medicaid coverage has also been associated with increased treatment for perinatal mood and anxiety disorders and reduced out-of-pocket costs for vulnerable families (Kranz et al.). Together, these findings underscore that postpartum Medicaid extensions are a proven, equity-driven solution to prevent avoidable maternal morbidity and mortality.

In addition to coverage expansion, policymakers must require standardized and enforceable implicit bias training across maternal healthcare settings. Research consistently shows that racial bias regardless of socioeconomic status contributes to worse outcomes for Black mothers (Taylor). A review by the Robert Wood Johnson Foundation found that nearly all studies evaluating implicit bias training reported positive outcomes, including improved provider awareness, attitudes, and skills for recognizing and mitigating bias ("Implicit Bias Training"). Making such training mandatory, paired with monitoring and accountability mechanisms, would help ensure respectful, patient-centered care for all mothers. Addressing provider bias directly confronts one of the most persistent drivers of maternal health inequities.

Finally, hospitals should be required to publicly report maternal health outcomes disaggregated by race, income, and insurance status, with financial incentives tied to demonstrated improvements. Transparent data reporting enables policymakers, researchers, and communities to identify disparities and demand accountability. Studies examining Medicaid expansion under the Affordable Care Act found that increased coverage and improved data visibility were associated with narrowed disparities in access to care and outcomes (Daw et al.; Eliason). By linking Medicaid reimbursement rates or federal funding to measurable improvements in maternal outcomes, policymakers can incentivize hospitals to implement effective interventions, including patient advocacy programs, enhanced care coordination, and stricter informed consent practices.

Black maternal mortality is not a failure of medical knowledge or technological capacity however, it is a failure of accountability. The evidence is undeniable: Black mothers die at nearly three times the rate of White mothers, not due to biological differences, but because of systemic neglect, bias, and inadequate safeguards within healthcare institutions. Incremental reform is no longer sufficient.

Meaningful progress requires bold, coordinated policy action that prioritizes equity at every level of maternal care. By expanding postpartum Medicaid coverage, enforcing transparent reporting of maternal outcomes, standardizing implicit bias training, and investing in maternal care advocacy, policymakers can transform hospitals into spaces of protection rather than harm. Every delay in action costs lives. The choice before us is clear: continue tolerating preventable deaths or build a healthcare system that values Black mothers' lives as deeply as it values their children's. The time for rhetoric has passed and the time for policy is now.

CONCLUSION

Black maternal mortality is not just a health crisis, it's a justice issue. By enforcing accountability, expanding advocacy, and centering equity, we can save lives and rebuild trust. Every mother deserves safe, respectful, and equitable care. No exceptions.

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NCNW

POLICY BRIEF

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How State Heartbeat Laws Force Physicians into an Ethical Dilemma Between Medical Judgement and Legal Compliance

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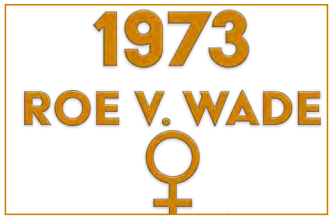
EXECUTIVE SUMMARY

"**HEARTBEAT**" statutes prohibit abortion once fetal cardiac activity is detected, often around six weeks, before many women know they are pregnant. These laws are forcing clinicians to choose between evidence based care and legal compliance, with avoidable harms concentrated among Black, Indigenous, rural, and low income patients. The case of Adriana Smith–an Atlanta nurse, who was declared legally brain dead at nine weeks pregnant, maintained on physiological support for months and delivered her baby by cesarean at 32 weeks—illustrates how fear of prosecution, legal expectations, and politicized mandates can override medical futility standards and patient autonomy. This policy brief analyzes how the United States can realign practice with medical ethics and reproductive justice.

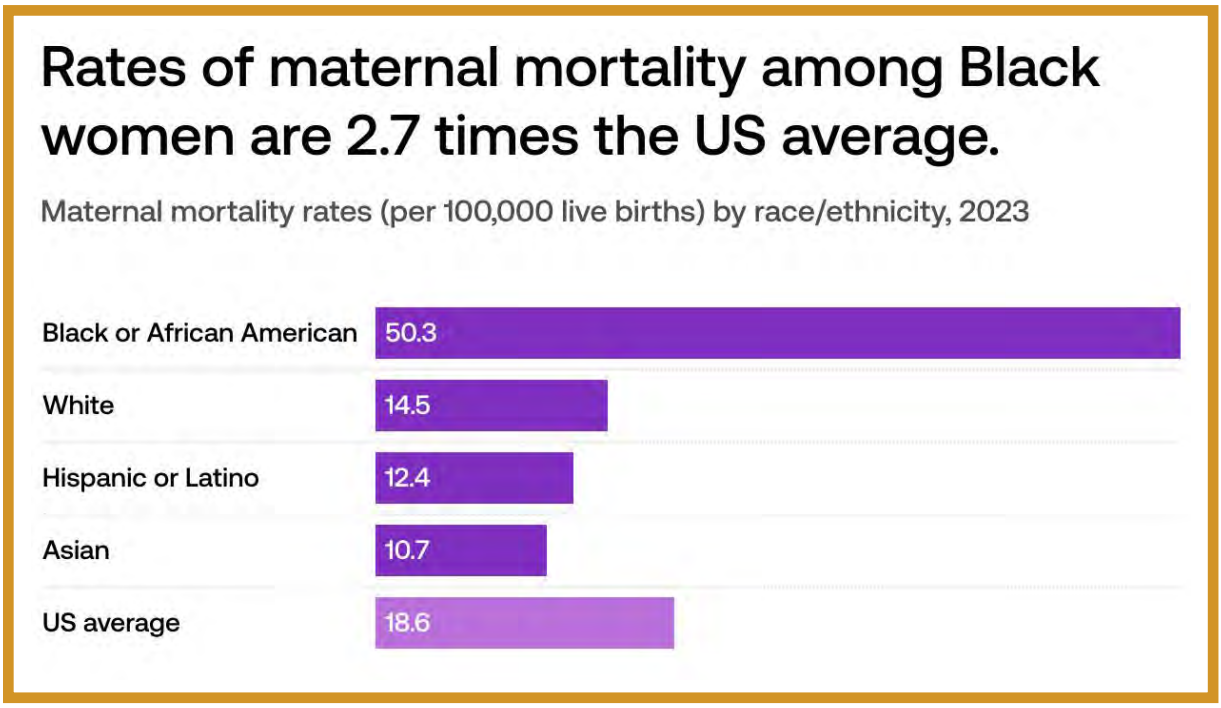
BACKGROUND



For over 50 years after Roe V. Wade (1973), abortion before viability was protected as a constitutional liberty. Even then, access was uneven and shaped by targeted regulations of providers, funding limits, and geography. This left low-income women and women of color to navigate the steepest barriers. In Planned Parenthood v. Casey (1992), the Court replaced Roe's trimester framework with an "undue burden" standard, inviting states to layer restrictions that, in practice, delayed care and narrowed clinical options. The landscape shifted decisively with Dobbs v. Jackson (2022), which removed federal constitutional protection and returned authority to those states. In the aftermath, a wave of heartbeat bans and gestational limits took effect across large regions of the country—some with narrow, ambiguous, or inconsistently applied 'medical emergency" exceptions.

These statues do more than narrow access; they reconfigure the ethics of everyday practice. Clinicians in restricted states report "moral injury," delayed consultations with hospital counsel, and hesitancy to treat miscarriages, ectopic pregnancies, previable preterm rupture of membranes, and septic complications—conditions that often require pregnancy termination as stabilizing care. Ambiguity around exceptions, coupled with civil and criminal penalties, reframes urgent medical judgement as legal risk management, Training pipelines are shifting as applicants avoid ban states, threatening capacity where need is greatest.

The impact is disproportionately borne by Black, Indigenous, rural, and low-income women who already face unequal access to primary care, contraception, and prenatal services. In the United States, maternal mortality stands at approximately 22 deaths per 100,000 live births—one of the highest mortality rates among wealthy nations—with Black women nearly three times more likely to die from pregnancy related causes. Heartbeat laws compound these inequities by forcing women to carry nonviable pregnancies, increasing financial strain, and undermining physician autonomy. The reproductive justice framework—founded by women of color—emphasizes that true freedom requires the ability to make your own reproductive decisions. Under this lens, current policies not only restrict abortion but also deepen systemic inequities that endanger marginalized communities.



Within this context, Adriana Smith's case is not an anomaly but a warning. Brain death is legally recognized as death in all fifty states, and maintaining life support to meet statutory abortion prohibitions subordinates the medical definition of death to a legal fiction, undermining standards of medical futility, non-maleficence, and respect for persons. When law disrupts accepted clinical definitions and emergency care pathways, patient safety and clinician integrity are both threatened.

POLICY PROBLEM

State heartbeat laws, as currently drafted and enforced, force conflicts between medical ethics and legal mandates, producing avoidable morbidity, eroding trust in institutions, and exacerbating racial and socioeconomic disparities in maternal health

EVIDENCE OF HARM *(Selected Findings from Sources, No New Claims Added)*

The cumulative evidence illustrates how heartbeat laws endanger both patients and providers. After the overturning of Roe V. Wade, millions of women lost access to timely and safe reproductive care, with many forced to travel hundreds of miles or carry pregnancies to term despite severe health risks. Hospitals in states with abortion bans have reported increased delays in emergency treatment for complications such as sepsis and incomplete miscarriage, as clinicians must first consult legal counsel before providing life saving care. These delays have led to measurable increases in preventable morbidity and mortality.

Physicians in restrictive states report heightened anxiety, moral distress, and fears of prosecution for performing procedures that align with established standards of care. This chilling effect is reshaping medical education and training, as applicants increasingly avoid residencies in ban states, further depleting the healthcare workforce in regions that already face provider shortages. From a public health standpoint, these laws exacerbate racial and socioeconomic disparities. Black and Indigenous women, who already suffer disproportionate maternal mortality, are now at even greater risk due to restricted access to contraception, abortion, and comprehensive prenatal care. Collectively, these effects erode trust in the healthcare system, undermine professional ethics, and place marginalized communities at the center of reproductive injustice.

POLICY RECOMMENDATIONS, IMPLEMENTATION, AND METRICS

To reconcile medical ethics with legal structures and ensure safe, equitable care, the following policy framework is proposed:

Federal Safe Harbor Protections

Congress should enact safe harbor laws shielding clinicians and hospitals from criminal or civil liability when providing evidence-based emergency care under accepted medical standards, including cases involving brain death, sepsis, or nonviable pregnancy. The Department of Health and Human Services (HHS) and the Department of Justice (DOJ) should jointly issue guidance affirming that physicians acting within established definitions of medical futility and brain death are protected from prosecution. States would be required to integrate these standards into legislation and hospital procedures. Compliance can be measured for hospital adoption of internal protocols and a measurable reduction in reported treatment delays for obstetric emergencies.

Equity Centered Access and Oversight

To address disparities, Congress and federal agencies must fund travel assistance, contraception access, and maternal health programs for communities most affected by restrictions, particularly Black and Indigenous women. States should be mandated to publish transparent reports on maternal morbidity and mortality, emergency transfer times, and care denial rates. Success can be measured by improved same day stabilization rates for emergency obstetrics cases, reductions in racial disparities in maternal outcomes, and enhanced residency recruitment and retention in previously restricted states.

CONCLUSION AND CALL TO ACTION

Heartbeat laws are not only a political issue, they represent a profound ethical and human crisis that redefines the practice of medicine. These laws distort accepted clinical definitions of death, threaten physician integrity, and perpetuate racial and socioeconomic inequities in maternal health. Adrian Smith remains an example of how statutory rigidity can override compassion, science, and patient dignity.

The National Council of Negro Women (NCNW) must amplify the reproductive justice framework, which places race, gender, and class at the forefront of healthcare advocacy. NCNW chapters across the nation should collaborate with clinicians, legal scholars, and policymakers to champion evidence based reproductive policy reform. This includes educating communities on reproductive rights, advocating for safe harbor legislation, and mobilizing collective action to demand laws that respect both patients and providers.

Protecting reproductive autonomy is not solely about preserving abortion access, it is about ensuring that all women, particularly those most marginalized, can receive compassionate, competent, and ethical care. Aligning law with medical evidence, ethics, and human rights is not only a moral imperative but also essential to building a just and equitable healthcare system for all.