Cultural Competency at a Crossroads: The Role of Government Policies in Women's Reproductive Healthcare

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On my honor as a University student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments.

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Introduction

Access to healthcare in the United States (U.S.) has never been equal. While policy reform and medical advancements have expanded overall access to healthcare services, significant disparities persist, specifically in reproductive healthcare. These disparities are not accidental; rather, biases are perpetuated and reinforced within the U.S. healthcare system through discriminatory policies. But what is reproductive health care, and what services are included in this umbrella term? The American College of Physicians (ACP) defines reproductive healthcare as any care that relates to an individual's reproductive system and its functions and processes (*American College of Physicians | Internal Medicine | ACP*, 2025). Additionally, the ACP uses “healthcare” as a broad term for services that range from contraception, pre- and postnatal counseling and screening, diagnostic therapies, fertility and infertility treatments, and pregnancy management (*American College of Physicians | Internal Medicine | ACP*, 2025). While reproductive healthcare is not inherently a women’s issue, laws and regulatory bodies in the U.S. have historically targeted women’s reproductive healthcare services.

The presence of socio-economic disparities in reproductive healthcare is due to a lack of cultural competency. Cultural competency is the ability of healthcare institutions and professionals to provide services that respect and meet patients' diverse cultural, personal, and linguistic needs (Montalmant & Ettinger, 2023). It influences every aspect of healthcare, from patient-provider communication to how and when medical decisions are made, directly impacting health outcomes. When healthcare systems and government policies fail to consider cultural diversity, patients, specifically women, people of color, and gender-nonconforming individuals, face increased rates of misdiagnoses and inadequate treatment, leading to mistrust of medical institutions.

Historically, U.S. legislation has directly impacted the services providers can administer and to whom they can be administered. They often prioritize certain populations while systemically excluding others. Throughout this research paper, I will argue that the U.S. government has actively reinforced healthcare biases, created barriers to equitable reproductive care, and failed to incorporate and enforce culturally competent practices in reproductive services. My goal is to examine the role of government policies in shaping healthcare access and the implications these policies have for marginalized groups through a historical and systems analysis. A historical lens will form a general picture of cultural and political attitudes towards women's health. At the same time, Actor-Network Theory (ANT) will point to the actors that drove these socio-political changes and attitudes. The actors include, but are not limited to, sociopolitical parties, healthcare providers, government agencies, women, persons of color, and healthcare systems.

Problem Definition

As the U.S. population continues to become more diverse, reproductive healthcare policies need to be adjusted to address the unique needs and socioeconomic barriers that minority populations face. According to the U.S. Census Bureau (2023), over 40% of the population identifies as part of at least one ethnic or racial minority group. However, the reproductive health care system in the U.S. has been based on Eurocentric standards and models, which have led to disparities in access to culturally diverse care, specifically in maternal health care and contraceptive services (Dehlendorf et al., 2016).

According to the Centers for Disease Control and Prevention (CDC), approximately 613,383 abortions were recorded across 48 U.S. states from 2021 to 2022 (Ramer, 2024). Of these abortions during this period, approximately 31.9% of women who obtained an abortion identified as white women, 39.5% identified as Black women, 21.2% identified as Hispanic women, and 7.3% identified as non-Hispanic women, as shown in Figure 1 (Ramer, 2024). Additionally, 92.8% of the abortions were performed at ≤ 13 weeks of gestation (Ramer, 2024). Another major barrier to equitable reproductive health care is access to insurance (Hill et al., 2025; Jindal et al., 2023): "Racially/ethnically minoritized populations are more likely to be uninsured; 14% of Black, 25% of Hispanic, and 24% of American Indian/Alaska Native (AI/AN) adults are without insurance, whereas only 8% of White, non‑elderly adults are uninsured" (Hill et al., 2025; Jindal et al., 2023). Figure 2, generated by KFF's Hill et al. (2025), depicts the change in insurance coverage based on race from 2010 to 2023. In addition to these systemic inequalities, provider biases and lack of standardized cultural sensitivity/ competency training among reproductive health care providers contribute to perpetuating disparities in the reproductive health care industry.

Despite national efforts like Title X for family planning and training programs, many institutions struggle to fully implement practices due to a lack of government funding, insufficient policy enforcement, and a lack of cultural humility among health care providers (Jindal et al., 2023; *Title X Statutes, Regulations, and Legislative Mandates | HHS Office of Population Affairs*, n.d.). While many studies point to the benefit of culturally competent reproductive health care, including increased contraceptive adherence, reduced maternal mortality, and increased patient satisfaction (Coleman-Minahan et al., 2019; Dehlendorf et al., 2016), determining ways to legislatively enforce these principles nationally remains unclear.

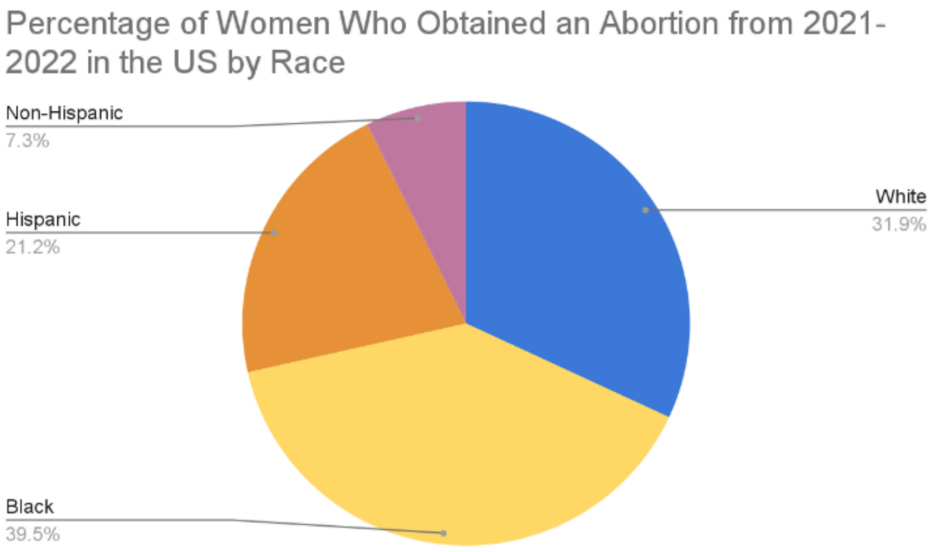

Figure 1: Breakdown of the racial profiles of women who received an abortion between 2021 and 2022 according to data from the CDC's Morbidity and Mortality Weekly Reports (MMWR) (Ramer, 2024). Pie chart was generated by author.

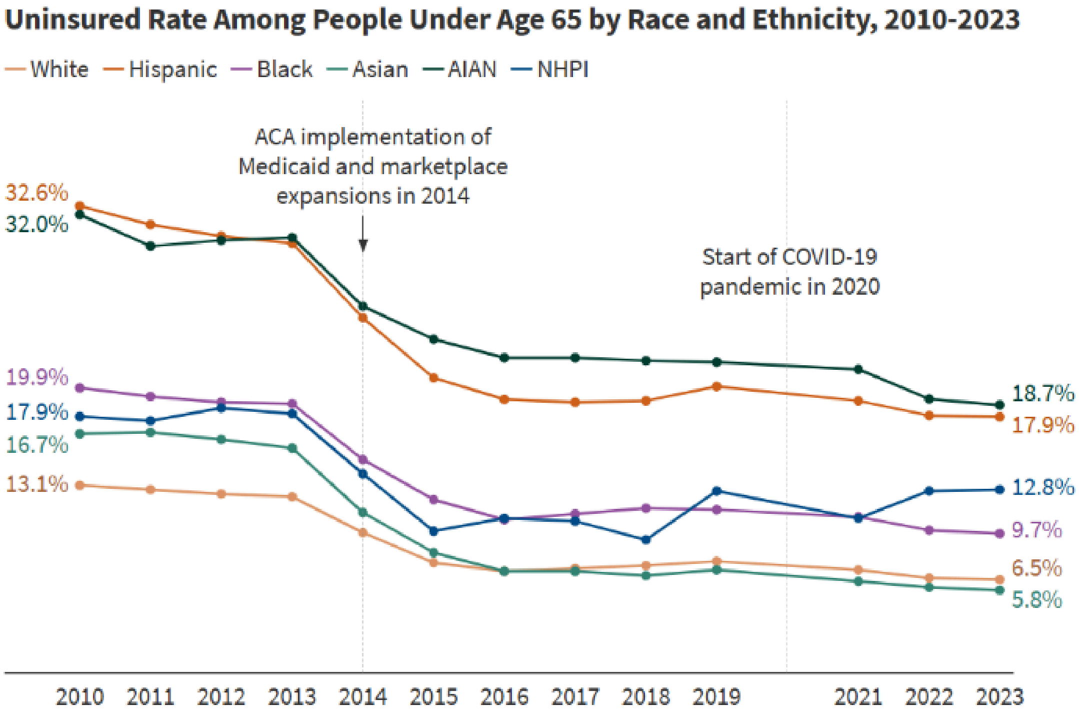

Figure 2: "Differences between Black and White people as of 2023 were statistically significant at the p<0.05 level. Includes individuals ages 0 to 64. AIAN refers to American Indian or Alaska Native. NHPI refers to Native Hawaiian or Pacific Islander. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. 2020 data excluded because the American Community Survey did not release the 1-year estimates for 2020 due to significant disruptions to data collection brought on by the coronavirus pandemic." (Hill et al., 2025)

A complex network of federal and state policies, healthcare institutions, and judicial rulings shapes reproductive healthcare. While some policies expanded access to care, such as the Affordable Care Act's contraceptive mandate and increase in insurance coverage (Daw & Sommers, 2019), others reinforced cultural and social disparities. Laws that restrict access to abortion and Medicaid coverage, like the Global Gag Rule, demonstrate how inequities can be exacerbated rather than alleviated through government intervention. A more current legal protection like Roe v. Wade (1973) and its subsequent overturning in Dobbs v. Jackson Women's Health Organization (2022) emphasize how access to reproductive healthcare remains a deeply politicized issue. Additionally, it shows how decisions made by the U.S. government continue to dictate who has access to care, the specific conditions for care, and at what cost (Madlock Gatison, 2016).

Lack of culturally competent reproductive healthcare policies significantly contributes to healthcare disparities that disproportionately affect minority groups (Figure 2). As described by Montalmant et al. and other studies, data shows that Black and Indigenous women in the U.S. experience the highest maternal mortality rates, two to three times higher when compared to White women. This is largely due to structural racism, provider bias, and unequal access to pre- and postpartum care ("Eliminating Racial Disparities in Maternal and Infant Mortality," 2019). Furthermore, language barriers serve as a major limiting factor, as Limited English Proficiency (LEP) patients are less likely to obtain proper counseling on family planning resources and general healthcare services (*Implications of Language Barriers for Healthcare: A Systematic Review - PMC*, n.d.). The economic costs of these disparities are substantial, as poor maternal health outcomes can lead to increases in medical expenses, decreased productivity, and intergenerational cycles of poverty (Montalmant & Ettinger, 2023). The destabilizing condition is clear: current legislative efforts are fragmented and inconsistently applied and enforced, leaving a gap in providing equitable reproductive healthcare for all individuals in the U.S..

Destabilizing Condition: The Gap in Current Research

The existence and prevalence of reproductive healthcare inequalities are widely acknowledged in the U.S.. Still, the extent to which government policies have been and are currently being used to drive and exacerbate these inequalities is less understood. Many questions still need to be answered, including the following: How have patterns of exclusion throughout history impacted and shaped modern healthcare laws? How have judicial rulings been used to reinforce and amplify biases in reproductive healthcare? Who has/ who continues to benefit from, restrictive healthcare policies? Similarly, who is harmed? What is the role of government funding? – These are just a few crucial questions plaguing the women, researchers, clinicians, and politicians.

Current studies focus on theoretical frameworks and specific case studies rather than evaluating how effective specific policies have been implemented systemically (Brach & Fraser, 2000). Additionally, limited studies show the impact of patient outcomes and institutional change; thus, determining the best way to integrate cultural competency into reproductive healthcare policies and systems remains a critical gap.

Research Approach

This research paper will use historical analysis and the Actor-Network Theory (ANT) to evaluate how past U.S. reproductive healthcare policies have been developed, implemented, and impacted access to culturally competent care. Historical analysis will illustrate how past reproductive healthcare policies have hindered or facilitated cultural competency. This will be done by examining legal decisions, public health campaigns, and government initiatives to discern patterns that have shaped current disparities in healthcare. ANT will complement this approach by tying together non-human and human actors. The non-human actors include but are not limited to legislation, technological intervention, and protocols implemented by institutions. The human actors include policymakers, healthcare providers, and U.S. citizens.

The key steps to the dual analysis will include a chronological mapping of reproductive healthcare legislation, groups, and initiatives. These will be examined through three overarching lenses: policy-driven disparities, social-political factors leading to culturally insensitive healthcare policies, and economic costs and the role of technology (Figure 3).

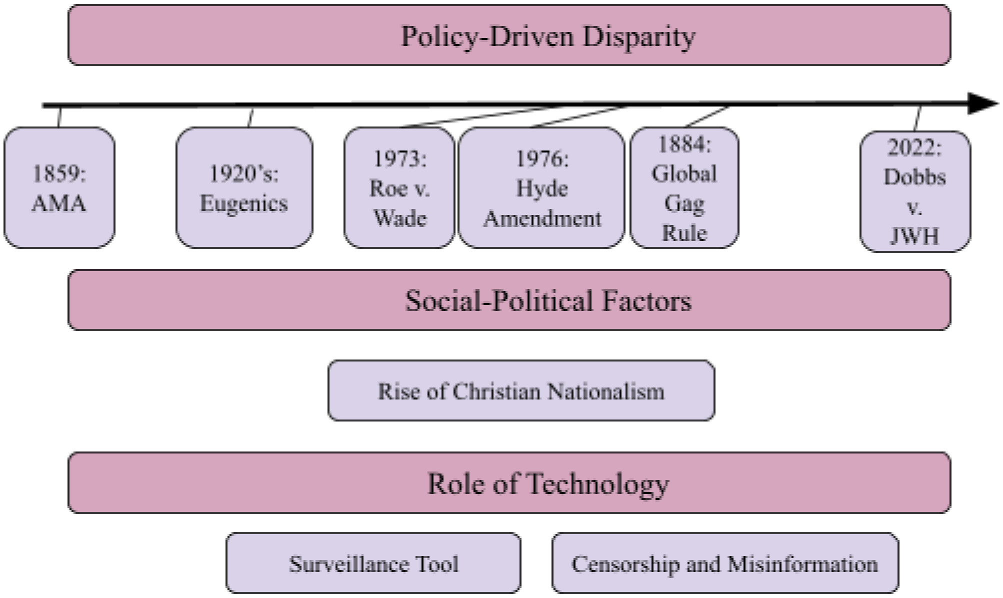

Figure 3: Research process flowchart for historical and systems analysis. Created by author.

Results and Insights: Policy-Driven Disparities

The American Medical Association's Report on Criminal Abortion of 1859

U.S. policies have played a decisive role in determining who has access to reproductive healthcare and what that access looks like throughout history. Starting in the late 19th and early 20th centuries, committees like the American Medical Association's (AMA) Report on Criminal Abortion in the *Transactions of the American Medical Association for 1859* (American Medical

Association, 1848) have served as the foundation for restrictive abortion regulations. The “resolutions”, which were unanimously put in place, were not signed by “the physicians responsible for the antiabortion effort” (*The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.). Rather, they were put in place by Horatio Robinson Storer and other male anti-abortion activists and physicians (*The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.).

The AMA challenged the socially and legally accepted notion that abortion would be acceptable until the “quickening” of a woman’s pregnancy, which was typically around the fourth or fifth month (*The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.). This timeframe was typically when pregnant people would begin feeling fetal movements; at this point, the fetus would be considered to be viable. Instead, Storer and his counterparts argued that life began at conception, making abortion morally wrong at any stage of pregnancy (American Medical Association, 1848; *The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.). Additionally, the AMA’s “resolutions” sought to publicly shame and criminalize women seeking abortions and those advertising abortions, which were primarily midwives – many of whom were poor women of color, through their “...notion of women’s liability, and anti-advertising principles” (American Medical Association, 1848; *The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.).

Impact of the American Medical Association’s Report on Criminal Abortion of 1859

Over the next two decades, abortions and those who sought or promoted them were criminalized as strict abortion laws were put in place across the U.S.. This movement served as the foundation for strict abortion laws and the long-time moral debate of when a fetus should be considered viable (The AMA Documents That Led to the Laws Overturned by Roe v, n.d.). Due to inconsistent record-keeping in the late 19th century, there is limited data that reflects the immediate effects of some of the first strict abortion laws. However, the AMA's push to criminalize abortions and those who seek one underscores the dangers of one-size-fits-all reproductive health laws, as they disproportionately impact marginalized communities, specifically, poor women and women of color (*The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.).

The criminalization of abortion does not prevent abortions from happening; rather, it makes the procedure more dangerous. Before Roe v. Wade in 1973, 17% of maternal deaths were linked to illegal abortions (*Maternal Mortality Surveillance, United States, 1980-1985*, n.d.). Enacting stricter abortion laws enforced the white, middle-class ideals of motherhood, serving as a way for the government to control the role women played in society. This was especially prevalent during slavery, when Black women were often forced to reproduce for the economic gain of their slave masters. The impact of the AMA's anti-abortion movement continues to riddle Black women, as they have one of the highest maternal mortality rates, particularly in southern states where abortion laws remain strict (*Maternal Mortality Surveillance, United States, 1980-1985*, n.d.).

The Eugenics Movement and Forced Sterilization

The Eugenics Movement, which took shape in the early 20th century in the U.S., sought to "improve" the genetic quality of marginalized communities (University of Michigan Library, 2012). Those in support of the Eugenics Movement, most notably Charles Davenport and Harry Laughlin, advocated for forced sterilization for those who were deemed "unfit" to reproduce– including impoverished people, marginalized racial groups, girls who were thought to be feeble-minded, and those with disabilities (mental or physical) (University of Michigan Library, 2012). These ideologies were upheld through various judicial rulings, and discriminatory policies were implemented across the U.S. over the next few decades. Supporters of the Eugenics Movement believed that, rather than continuous sterilization, imprisonment/ institutionalization, and the perpetuated cycle of poverty of future generations, sterilization up front would prevent future “defectives” (University of Michigan Library, 2012).

Between the 1900s and the 1940s, recognized as the peak influence of the Eugenics Movement, the first eugenic laws that were racially and socially targeted were being rolled out. In 1907, the first eugenic sterilization law was passed in Indiana, allowing state institutions to forcibly sterilize anyone they deemed “unfit” to reproduce (Paul A. Lombardo, 2008). This law served as a guide for 30 other states that would enact similar legislation (Figure 4). Additionally, U.S. immigration was impacted, specifically by the Immigration Act of 1924 or the Johnson-Reed Act. This policy set strict quotas on immigrants from specific backgrounds, including Southern and Eastern Europe and nearly all immigrants from Asian countries(Paul A. Lombardo, 2008; University of Michigan Library, 2012). The belief that certain races and ethnic groups were inferior served as the basis of these discriminatory laws.

One of the most notorious judicial rulings that would legitimize forcible sterilization was *Buck v. Bell* (1927). Carrie Buck was a young woman who was institutionalized in the Virginia State Colony for Epileptics and Feebleminded when she was selected to be a test case for Virginia’s sterilization law. Buck was a low-income white woman with limited access to education. Supreme Court Justice Oliver Wendell Holmes Jr. justified sterilization by stating, “Three generations of imbeciles is enough” (*Eugenics in Virginia*, n.d.; University of Michigan Library, 2012). Holmes viewed sterilization as a “sacrifice” that was “nothing” when compared to soldiers who laid down their lives to fight during times of war– Holmes had previously fought in three battles and was wounded in each (University of Michigan Library, 2012). Additionally, the court used the smallpox vaccine as evidence to support sterilization as a public health measure, as "mental deficiency" was deemed to be hereditary (Paul A. Lombardo, 2008; University of Michigan Library, 2012).

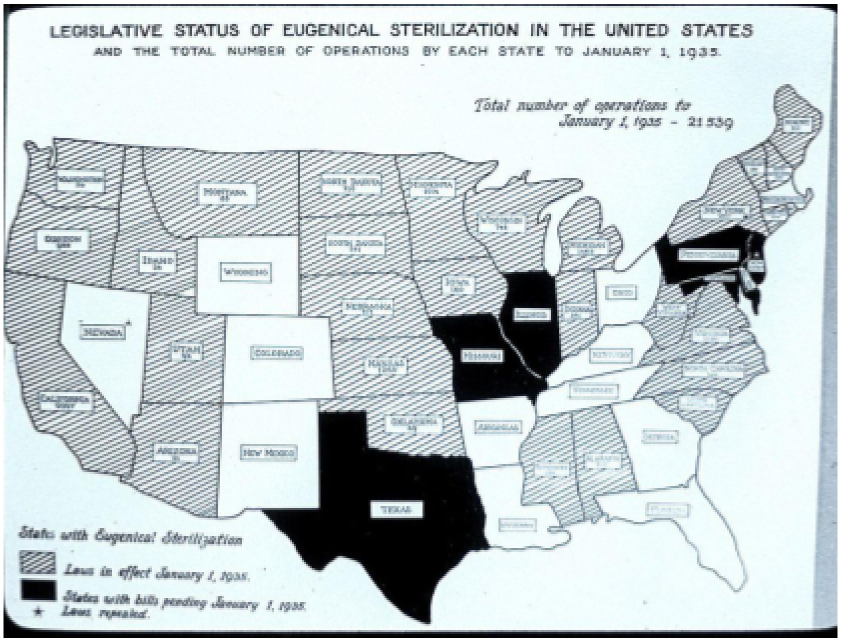

Figure 4: 1935 Map of current number of forced eugenical sterilization that shows the growing implementation of discriminatory legislation (1935sterilization-Map-1024x778.Jpg (1024×778), n.d.)

Impact of The Eugenics Movement and Forced Sterilization

After the ruling of the Buck v. Bell (1927) case in support of state-issued sterilization of anyone deemed "unfit" to reproduce, nearly 60,000 people would be sterilized throughout the 20th century (Stern, 2005). These sterilization laws disproportionately affected women who were poor, disabled, and of racial/ethnic minorities, particularly Black, Indigenous, or Mexican American (Stern, 2005). Undoubtedly, the effects of the Eugenics Movement still impact reproductive care in the U.S.. According to the Minnesota Journal of Law and Equity, "Between 1997 and 2010, California paid doctors $147,460 to perform sterilization procedures on inmates. Medical staff at the prison specifically targeted pregnant inmates and repeat offenders, and coerced them into being sterilized" (jlieditors, 2021). Furthermore, the 2020 ICE detention center whistleblower report cited 57 detained women who were coerced into undergoing hysterectomies and other "unnecessary gynecological surgeries" (jlieditors, 2021). The ICE hysterectomy scandal displays how the impact of the Eugenics Movement is still prevalent today and continues to target those with limited bodily autonomy and the means to fight back. It also shows the lasting impact of the discriminatory U.S. policies.

Roe v. Wade (1973)

The 1973 Roe v. Wade case was a pivotal moment for reproductive health policy, as it legalized abortion nationwide as a constitutional right under the Fourteenth Amendment's Due Process Clause (*Roe v. Wade*, n.d.; *The AMA Documents That Led to the Laws Overturned by Roe v*, n.d.). "Jane Roe" challenged Texas state laws that criminalized abortion except when a woman's life was at risk. In a 7-2 decision in favor of Roe, it was ruled that restrictive abortion laws violated the right to privacy (*Roe v. Wade*, n.d.). This effectively overturned state bans and set up a trimester framework that would be used to dictate the extent of state regulation. This case came about in part due to the increased maternal mortality rates due to unsafe and illegal abortion procedures (Reagan, 1997). Furthermore, the *Roe v. Wade* ruling reflected legal trends toward expanding bodily autonomy and integrity, civil rights, and feminist activism (Reagan, 1997).

Impact of Roe v. Wade (1973)

The national legalization of abortion through the Roe v. Wade case functioned as an inflection point from a regulatory standpoint. It altered how legal, social, and medical networks operated with one another in the reproductive healthcare space. State health departments had the responsibility to implement these new systems, while medical institutions needed to generate new protocols for abortion services. Meanwhile, the rise of religious and conservative groups/ organizations began to form and mobilize against the ruling, ultimately setting the tone for future political and legal challenges.

Hyde Amendment (1976)

The Hyde Amendment, introduced by Representative Henry Hyde in 1976, is a legislative provision that prohibits the use of federal funds for abortions. The only exceptions include cases or incest, rape, or when the woman's life is at risk. Initially, the Hyde Amendment only affected those with Medicaid. Still, over the 40 years of its implementation, funding limitations have spread to federal employees, incarcerated women, military personnel and veterans, Native Americans, and Peace Corps volunteers (Goldberg, 2010; *The Hyde Amendment*, 2021). Medicaid is a federal/ state health insurance program for low-income individuals; thus, restricting Medicaid access disproportionately affects the most vulnerable women (Salganicoff et al., 2024; *The Hyde Amendment*, 2021).

Impact of the Hyde Amendment (1976)

The Hyde Amendment has had a profound impact on reproductive healthcare, especially for low-income women. Before its implementation, federally funded Medicaid covered approximately one-third of abortions: "Today, 35% (5.5 million) of women ages 15 to 49 covered by Medicaid live in states where abortion remains legal, but the program will not cover the service except for limited Hyde circumstances. 21% live in a state where abortion is banned" (Salganicoff et al., 2024). Furthermore, in 2019, it was estimated that about 29% of Black women, 25% of Hispanic women, 15% of White women, and 12% of Asian women of reproductive age (15 to 49 years old) were covered by Medicaid (*The Hyde Amendment*, 2021). Sixty-two percent of Black women between 15 and 49 years old who are covered by Medicaid had incomes below the federal poverty line in 2019 (*The Hyde Amendment*, 2021). Overall, the Hyde Amendment was successful in decreasing the amount of funds allocated towards abortions; however, it has caused systemic barriers in access to care and has exacerbated inequalities in the healthcare system.

Global Gag Rule (1984)

The Global Gag Rule (GGR), or the Mexico City policy, is “a dangerous anti-abortion policy that risks the health and lives of women and girls around the world” (*What Is the Global Gag Rule?*, n.d.). Implemented in 1984 by President Ronald Reagan, this policy prohibited foreign non-governmental organizations (NGOs) that receive federal aid from providing funded counseling, information and advocacy, and referrals for abortion services, even if the NGO used their funds (*What Is the Global Gag Rule?*, n.d.). Under the Reagan administration, the goal of the GGR was to reduce the number of abortions, however, there has been no evidence to support that cutting family planning resources and advocacy about abortions preformed by professionals reduces the instance in which abortions occur (*The Foreseeable Harms of Trump’s Global Gag Rule - Bingenheimer - 2017 - Studies in Family Planning - Wiley Online Library*, n.d.). Since its first implementation, it has been rescinded and reinstated multiple times, the conditions changing according to the administration in power. In 2017, with the Trump administration, the GGR was expanded to all U.S. global health assistance, not just family planning (*The Foreseeable Harms of Trump’s Global Gag Rule - Bingenheimer - 2017 - Studies in Family Planning - Wiley Online Library*, n.d.).

Impact of the Global Gag Rule (1984)

The GGR has had significant direct impacts on reproductive health services globally by reducing access and advocacy on contraception, HIV/ AIDS prevention, and maternal healthcare.

However, the indirect impact on cultural competency in the U.S. reproductive healthcare system is equally harrowing (Figure 5). Since the GGR was enacted, it has led to the reinforcement of Western-centric health structures, loss of funding for culturally tailored care, reduction of care for immigrants and refugees, erosion of trust, and conflation in family planning education (*The Foreseeable Harms of Trump's Global Gag Rule - Bingenheimer - 2017 - Studies in Family Planning - Wiley Online Library*, n.d.).

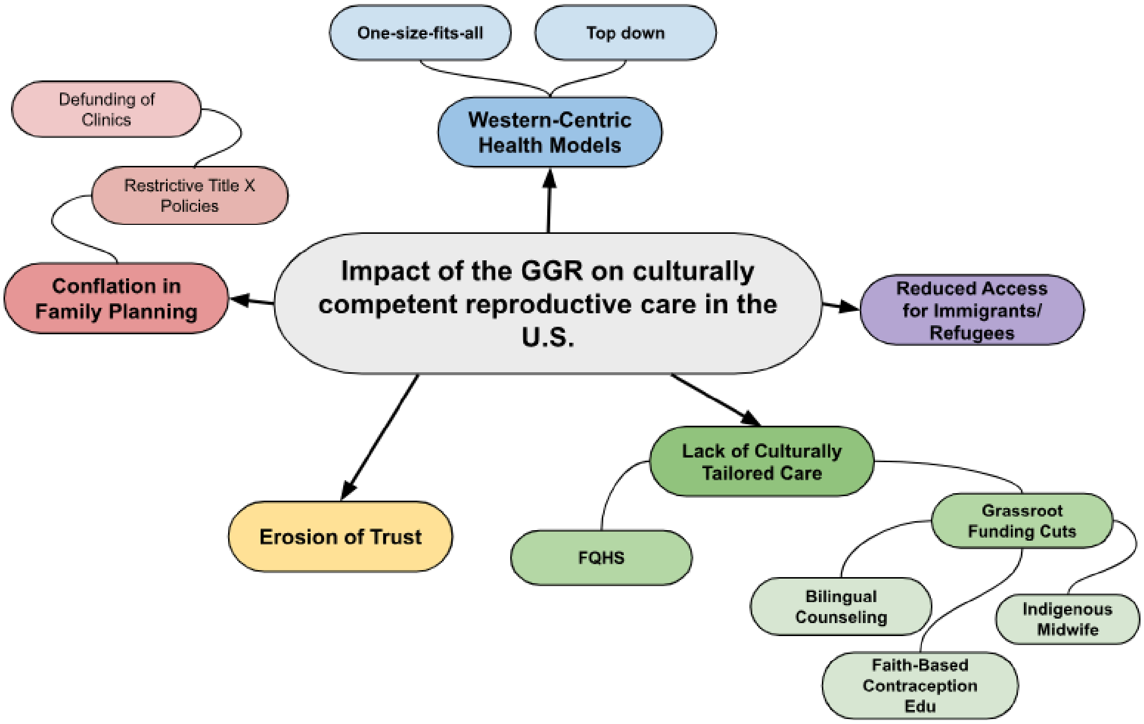

Figure 5: Mind map of the impact the Global Gag Rule has had on culturally competent care in the U.S. healthcare systems. Created by author.

Conditioning foreign and domestic NGOs to comply with restrictive policies forces organizations to align with American health models rather than the local and cultural medical practices. This creates a one-size-fits-all approach that is not sensitive to different ideologies and practices. A parallel of this top-down approach is visible in how government agencies create reproductive policies without considering the unique cultural, linguistic, and religious needs of minority groups. Grassroots and federally qualified health centers (FQHCs) have lost funding due to their association with comprehensive reproductive healthcare services. This meant that translation services, counseling, and faith-based family planning education were cut, hurting immigrants and culturally diverse regions the most (Giorgio et al., n.d.). With the inability to access timely, affordable, and necessary care comes feelings of mistrust.

Additionally, the Trump expansion of the GGR meant that rather than the $600 million USD that was allocated towards funding family planning services annually in 2019, $7.4 billion USD annually would now be in jeopardy (Giorgio et al., n.d.). In addition to family planning, this funding is largely used for vaccines (malaria, tuberculosis, HIV/ AIDS, etc.), water, nutrients, and many other services and practices (Giorgio et al., n.d.; *What Is the Global Gag Rule?*, n.d.). Blurring the lines between what is considered family planning creates mass confusion and is harmful, as it threatens those who rely on federal funding to access care in the U.S. and globally.

Dobbs v. Jackson Women's Health Organization (2022)

As mentioned in a prior section, under *Roe,* abortion was ruled to be a constitutional right, protected by the Fourteenth Amendment's Due Process Clause, and set up the trimester scheme (Roe v. Wade, n.d.; The AMA Documents That Led to the Laws Overturned by Roe v. n.d.). In 1992, the *Planned Parenthood v. Casey* trial took place, and the Court determined that "states were forbidden to adopt any regulation that imposed an 'undue burden' on a woman's right to have an abortion" as the State could not protect the life of a fetus before it was deemed viable under the Constitution. The ruling of the Planned Parenthood v. Casey case was meant to act as a "final settlement of the question of the constitutional right to abortion" with judges "call[ing] for the contending sides of a national controversy to end their national division"

(*Dobbs v. Jackson Women's Health Organization | Constitution Center*, n.d.). However, the Court's request was unsuccessful. In 2022, the *Dobbs v. Jackson Women's Health Organization* case would serve as a landmark decision for the American healthcare system, as the Supreme Court determined that the right to abortion was not protected under the U.S. Constitution, leading to the overturning of both *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992).

Impact of Dobbs v. Jackson Women's Health Organization (2022)

Overturning the decisions of *Roe v. Wade* and *Planned Parenthood v. Casey* did not settle the 50-year debate on the morality of abortion services. Rather, the Dobbs decision allowed U.S. politics to reflect the attitude of the anti-abortion supporters as early as the actors involved in developing the AMA, in both law and policy. In 2020, a study was conducted to estimate the potential impacts of a complete abortion ban. They estimated that within a year, there would be a 24% increase in maternal mortality rates. They also found that maternal mortality rates would be highest for non-Hispanic Black mothers, who would account for 39%. (*Clear and Growing Evidence That Dobbs Is Harming Reproductive Health and Freedom | Guttmacher Institute*, 2024; Stevenson et al., 2022). Additionally, within the first 30 days of *Dobbs* being decided, 43 clinics across 11 states stopped providing abortion services, and there was a 5% decline in brick-and-mortar clinics between 2020 and 2024 (*Clear and Growing Evidence That Dobbs Is Harming Reproductive Health and Freedom | Guttmacher Institute*, 2024).

In the six months after *Dobbs*, there were 32,360 fewer abortions performed in formal clinic settings across the U.S.; however, self-managed abortions in the form of mailed medications increased by 27,838 (Aiken et al., 2024). Furthermore, as of the 2024 Analysis report conducted by the Institute for Women's Policy Research, abortion has been banned in 17 states across the US, which will cost approximately sixty-one billion dollars annually

(Administrator, 2024). As of July 1, 2024, women represent 50.5% of the US population according to the 2024 United States Census Bureau, which equates to approximately 171,756,049 people (U.S. Census Bureau QuickFacts, n.d.). According to studies conducted in 2023 by Guttmacher:

> Half of US abortion patients live with incomes below the federal poverty threshold, compared with only 14% of the full population of US women aged 15–44. Black women account for more than one-quarter (28%) of abortion patients but only 14% of all US women aged 15–44. Latinas account for one-quarter (25%) of abortion patients but 21% of US women aged 15–44. Asian and Pacific Islander women are more proportionately represented, making up 6% of abortion patients and 7% of US women aged 15–44. White women, on the other hand, account for 39% of abortions but make up 54% of US women aged 15–44.

The evidence provided by Guttmacher indicates that while there is a diverse range of people who seek abortions in the U.S., restrictive abortion bans impact those who already face systemic racism and economic injustice. This further emphasizes the need for reproductive healthcare policies that are sensitive to how intersectional social barriers limit access to equitable care.

Results and Insights: Social Political Factors

Rise of Christian Nationalism

A leading factor in developing culturally competent reproductive healthcare systems is creating policies and practices that respect the needs and values of all religions. The increasing influence of Christian nationalism, the belief that the U.S. was originally founded as a Christian nation and should remain so, has led to a decline in care that is receptive to other religions

(Swihart et al., 2025). Christian nationalism has manifested through both rhetoric and policy, with its influence peaking during the Reagan administration and continuing into today. In political discourse, there is often a call for both "God and country". Visualized through pushes for Christian prayer in school, opposition to abortions, LGBTQ+ rights, comprehensive sex education, and rejection of the absolute separation of church and state (*Religious Right*, n.d.; Whitehead & Perry, 2020). The Religious Right and Christian nationalism often overlap. The Religious Right is a coalition group that began in the 1970s; they advocate for "social and political conservatism" (*Religious Right*, n.d). A prominent manifestation of Christian nationalism is the push for abortion restrictions. Both Christian nationalists and Religious Right members supported and celebrated the overturning of *Roe v. Wade* in the *Dobbs v. Jackson Women's Health Organization (2022)*. This decision was heavily influenced by the Supreme Court, a Court that was shaped by conservative Christian legal ideologies (Gorski, 2020)

Impact of the Rise of Christian Nationalism

Framing certain reproductive healthcare services– specifically abortion and contraception– as "morally unacceptable" with little to no regard for other cultures' views on the subjects is exceptionally harmful. The Pew Research Center surveyed 36,000 respondents across the U.S. between 2023 and 2024 to determine the current landscape of religion; 62% identified as Christian, 29% as non-religious, and 7% as belonging to other faiths. The Hyde Amendment, state-level abortion bans, and health-conscious clauses allow medical professionals to refuse care if it does not align with their religious affiliations. The disregard of reproductive needs based on religious beliefs threatens autonomy and inclusivity for those who identify as Muslim, Jewish, Indigenous, or secular (Sherman, 2024).

Furthermore, the rise of Christian nationalism emphasizes a narrow moral and religious framework that excludes racial, gender, and cultural diversity in healthcare. As a result, communities of color, LGBTQ+ individuals, and low-income communities become the target of insensitive laws. Financial burden is also associated with strict religious frameworks. “According to Altarum, health disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year and additional economic losses due to premature deaths” (Gordon, 2024). Therefore, not only do strict religious frameworks harm individuals who do not conform to their narratives, but they also create a financial burden. This is why there is a dire need to provide diverse services and research how best to serve women with different religions and ethnic backgrounds.

Results and Insights: Role of Technology

Technology plays a paradoxical role in the perception of reproductive healthcare in the U.S., both enabling and exacerbating limiting factors, especially in marginalized communities. When it comes to limiting culturally responsive reproductive care, technology has been used as a surveillance tool and has pushed specific stigmas. These limitations pose threats to people of color, immigrants, LGBTQ+ communities, and low-income individuals.

Technology as a Surveillance Tool

Digital privacy has been a growing concern for Americans. There have been increased concerns over where people's data is going and who it is being shared with. In a study conducted by the Mozilla Foundation (2021), they found that fertility and menstrual tracking apps, like Flo and Period Tracker, were sharing their users' data with third parties, specifically, Facebook and Google. These companies did so without the users’ consent and often without them knowing entirely (**Privacy Not Included Review*, n.d.). In a post-*Roe* society, there is growing concern over whether this data could be used by law enforcement in states where abortion has already been criminalized, exacerbating the danger for vulnerable groups in these states (Spector-Bagdady & Mello, 2022). While the Health Insurance Portability and Accountability Act (HIPAA) of 1966 was put in place to protect the privacy of individuals' sensitive information, there has been an increase in lawsuits against the 2024 HIPAA Privacy Rule to Support Reproductive Healthcare Privacy (2024 HIPAA Privacy Rule) (*Seventeen States Attack HIPAA and Reproductive Health Privacy*, n.d.). According to the National Partnership for Women and Families (2025), the 2024 HIPAA Privacy Rule was put in place:

> To prohibit the use or disclosure of protected health information for the purpose of investigating or criminalizing anyone for lawful reproductive care. This means that HIPAA-covered entities like doctors are barred from complying with law enforcement requests and legal process – including court orders, subpoenas, and warrants – if officials are seeking out medical records to prosecute someone for seeking, assisting with, or providing lawful reproductive care.

Ultimately, overturning this Rule would erode the trust between patients and providers, by exposing and criminalizing patients' sensitive information to non-medical personnel/ data systems. The lawsuits act as a way to scare and threaten individuals seeking necessary reproductive care, and they use vulnerabilities in data as a means to do so.

Censorship and Misinformation

Social media platforms and major technology companies play a pivotal role in how technology has limited culturally competent reproductive health care in the U.S., specifically through censorship and the spread of misinformation. According to Amnesty International, after the *Dobbs* decision (2022), social media platforms began removing and restricting access to crucial content related to contraception, abortion, and culturally tailored reproductive services with vague and minimally transparent reasoning. Two of the most well-known platforms that have done this are TikTok and Meta, which have removed or banned content and/ or creators who made accurate and informative content that guided users on seeking medical abortions (*United States*, 2024). This form of censorship disproportionately affects marginalized communities that rely on free digital platforms for medical advice, specifically younger generations. Limiting the availability of educational resources that account for cultural and linguistic differences exacerbates mistrust towards medical systems. Additionally, the conflation of reproductive health information surrounding sexual wellness, family planning, abortion, etc., as sensitive or strictly regulated content, dilutes culturally specific messaging (*United States*, 2024). Furthermore, the mass landscape of misleading reproductive information across digital platforms harmfully impacts patients' decisions.

Conclusion

The intricate relationship between the influence of American politics and culturally competent reproductive healthcare represents a vast landscape of challenges and opportunities. Throughout this analysis, it became increasingly apparent that government policies and political movements have not only shaped accessibility to medical services but have also been used to perpetuate systemic biases that disproportionately affect marginalized groups. The social and economic barriers in healthcare are not accidental; rather, they have been embedded within historical and modern policy frameworks that have failed to address and recognize U.S. populations' diverse cultural, social, and linguistic needs. Cultural competency, which is defined by Montalmant and Ettinger (2023) as the ability for healthcare providers, systems, and policies to provide care that aligns with the needs of diverse patient populations, has emerged as a crucial mechanism to minimize healthcare disparities. Still, American politicians continue to undermine these efforts by enacting legislation and funding restrictions to limit abortion, contraceptive, vaccination, and family planning access. Additionally, there has been an insufficient enforcement of culturally sensitive policies, all of which impact low-income women of color the most.

Improving cultural competency is not just a matter of improving how patients and providers communicate; it extends into how policies are developed, where social justice, protection of reproductive autonomy, and access to equitable healthcare should be at the forefront. To achieve a smaller gap in reproductive healthcare disparities, systematic changes need to be made. Increases in funding for programs that offer comprehensive training programs for medical providers emphasizing structural awareness and cultural humility, and the inclusion of the voices of marginalized groups in both research and policy are necessary to foster environments of trust, to improve healthcare outcomes, and decrease current barriers social-political forces have instilled. Healthcare programs, like Medicaid, also need to be adjusted to address insurance-related problems. With an overwhelming majority of low-income women of color using Medicaid/ Medicare as their insurance source, incorporating culturally sensitive policies will ensure these communities receive the care they need.

While there is no one simple solution to solving structural and systemic inequities enacted by American politicians and socio-political groups, enacting cultural competency initiatives will help to mend some of the deep-rooted divisions while fostering better understanding, inclusivity, and equity among individuals and institutions. However, acknowledging limitations in current and past policies and systems is essential. This is a complex problem where intersectional identities, including race, socioeconomic status, geographic location, and the political environment, play crucial roles in how patients receive care. Thus, a comprehensive approach needs to be taken. This approach requires a focus on advocating for policy changes, strict policy enforcement, continuous research, government funding, and social justice. Only then will culturally competent reproductive healthcare serve all women equitably.

<u>**References**</u>

Aiken, A. R. A., Wells, E. S., Gomperts, R., & Scott, J. G. (2024). Provision of Medications for Self-Managed Abortion Before and After the Dobbs v Jackson Women's Health Organization Decision. *JAMA*, *331*(18), 1558–1564. https://doi.org/10.1001/jama.2024.4266

American College of Physicians | Internal Medicine | ACP. (2025, March 4). https://www.acponline.org/

American Medical Association (with New York Botanical Garden, L. T. M. L.). (1848). *The Transactions of the American Medical Association*. Philadelphia : The Association. http://archive.org/details/transactionsofam01amer

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review: MCRR*, *57 Suppl 1*(Suppl 1), 181–217. https://doi.org/10.1177/1077558700057001S09

Clear and Growing Evidence That Dobbs Is Harming Reproductive Health and Freedom | Guttmacher Institute. (2024, May 29). https://www.guttmacher.org/2024/05/clear-and-growing-evidence-dobbs-harming-reproductive-health-and-freedom

Coleman-Minahan, K., Stevenson, A. J., Obront, E., & Hays, S. (2019). Young Women's Experiences Obtaining Judicial Bypass for Abortion in Texas. *The Journal of Adolescent*

Health: Official Publication of the Society for Adolescent Medicine, *64*(1), 20–25. https://doi.org/10.1016/j.jadohealth.2018.07.017

Daw, J. R., & Sommers, B. D. (2019). The Affordable Care Act and Access to Care for Reproductive-Aged and Pregnant Women in the United States, 2010–2016. *American Journal of Public Health*, *109*(4), 565–571. https://doi.org/10.2105/AJPH.2018.304928

Dehlendorf, C., Henderson, J. T., Vittinghoff, E., Grumbach, K., Levy, K., Schmittdiel, J., Lee, J., Schillinger, D., & Steinauer, J. (2016). Association of the quality of interpersonal care during family planning counseling with contraceptive use. *American Journal of Obstetrics and Gynecology*, *215*(1), 78.e1-9. https://doi.org/10.1016/j.ajog.2016.01.173

Dobbs v. Jackson Women's Health Organization | Constitution Center. (n.d.). National Constitution Center – Constitutioncenter.Org. Retrieved April 3, 2025, from https://constitutioncenter.org/the-constitution/supreme-court-case-library/dobbs-v-jackson-womens-health-organization

Eliminating Racial Disparities in Maternal and Infant Mortality. (2019, May 2). *Center for American Progress*. https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/

Eugenics in Virginia: Buck v. Bell and Forced Sterilization. (n.d.). Eugenics: Three Generations, No Imbeciles: Virginia, Eugenics & Buck v. Bell. Retrieved March 6, 2025, from http://exhibits.hsl.virginia.edu/eugenics/

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

Goldberg, J. (2010, September 17). *Whose Choice: A Timeline of the Hyde Amendment and Its Impact on Abortion Funding*. Center for Reproductive Rights. https://reproductiverights.org/whose-choice-a-timeline-of-the-hyde-amendment-and-its-impact-on-abortion-funding/

Gordon, T. M. (2024). Charting the Course for Inclusive and Equitable Health Innovation in the Wake of the COVID-19 Pandemic. *International Journal of Health, Wellness & Society*, *14*(2). Academic Search Complete. https://doi.org/10.18848/2156-8960/CGP/v14i02/127-150

Gorski, P. S. (2020). *American Babylon: Christianity and Democracy Before and After Trump* (Internet materials). Routledge. https://proxy1.library.virginia.edu/login?url=https://www.taylorfrancis.com/books/9780429318146

Hill, L., Ndugga, N., Artiga, S., & Published, A. D. (2025, February 13). Health Coverage by Race and Ethnicity, 2010-2023. *KFF*. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

Implications of Language Barriers for Healthcare: A Systematic Review—PMC. (n.d.). Retrieved April 1, 2025, from https://pmc.ncbi.nlm.nih.gov/articles/PMC7201401/

Jindal, M., Chaiyachati, K. H., Fung, V., Manson, S. M., & Mortensen, K. (2023). Eliminating health care inequities through strengthening access to care. *Health Services Research*, *58*(Suppl 3), 300–310. https://doi.org/10.1111/1475-6773.14202 jlieditors. (2021, June 7). The Long Scalpel of the Law: How United States Prisons Continue to Practice Eugenics Through Forced Sterilization. *Minnesota Journal of Law & Inequality*. https://lawandinequality.org/2021/06/07/the-long-scalpel-of-the-law-how-united-states-prisons-continue-to-practice-eugenics-through-forced-sterilization/

Madlock Gatison, A. (editor). (2016). *Communicating Women's Health: Social and Cultural Norms That Influence Health Decisions* (Internet materials). Routledge. https://proxy1.library.virginia.edu/login?url=https://www.taylorfrancis.com/books/9781315732077

Maternal Mortality Surveillance, United States, 1980-1985. (n.d.). Retrieved March 6, 2025, from https://www.cdc.gov/mmwr/preview/mmwrhtml/00001754.htm

Montalmant, K. E., & Ettinger, A. K. (2023). The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-023-01816-x

Paul A. Lombardo (with Internet Archive). (2008). *Three generations, no imbeciles*. Johns Hopkins University Press. http://archive.org/details/threegenerations00lomb

**Privacy Not Included review: Period Tracker*. (n.d.). Mozilla Foundation. Retrieved April 18, 2025, from https://foundation.mozilla.org/en/privacynotincluded/period-tracker/

Ramer, S. (2024). Abortion Surveillance—United States, 2022. *MMWR. Surveillance Summaries*, *73*. https://doi.org/10.15585/mmwr.ss7307a1

Reagan, L. J. (with Internet Archive). (1997). *When abortion was a crime: Women, medicine, and law in the United States, 1867-1973*. Berkeley : University of California Press. http://archive.org/details/whenabortionwasc00reag

Religious Right. (n.d.). The Free Speech Center. Retrieved April 16, 2025, from https://firstamendment.mtsu.edu/article/religious-right/

Roe v. Wade. (n.d.). Oyez. Retrieved April 2, 2025, from https://www.oyez.org/cases/1971/70-18

Salganicoff, A., Sobel, L., Gomez, I., & Published, A. R. (2024, March 14). The Hyde Amendment and Coverage for Abortion Services Under Medicaid in the Post-Roe Era. *KFF*. https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services-under-medicaid-in-the-post-roe-era/

Seventeen States Attack HIPAA and Reproductive Health Privacy. (n.d.). National Partnership for Women & Families. Retrieved April 18, 2025, from https://nationalpartnership.org/report/attacks-on-repro-privacy/

Sherman, C. (2024, March 2). What Alabama's IVF ruling reveals about the ascendant Christian nationalist movement. *The Guardian*. https://www.theguardian.com/world/2024/mar/02/christian-nationalism-alabama-ivf-ruling-politics

Spector-Bagdady, K., & Mello, M. M. (2022). Protecting the Privacy of Reproductive Health Information After the Fall of *Roe v Wade*. *JAMA Health Forum*, *3*(6), e222656. https://doi.org/10.1001/jamahealthforum.2022.2656

Stern, A. M. (2005). Eugenics and Historical Memory in America. *History Compass*, *3*(1), **-**. https://doi.org/10.1111/j.1478-0542.2005.00145.x

Stevenson, A. J., Root, L., & Menken, J. (2022). *The maternal mortality consequences of losing abortion access*. OSF. https://doi.org/10.31235/osf.io/7g29k

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2025). Cultural Religious Competence in

Clinical Practice. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK493216/

The AMA Documents that Led to the Laws Overturned by Roe v. (n.d.). Retrieved March 6, 2025, from https://www.priory.com/homol/abortionhist.htm

The Foreseeable Harms of Trump's Global Gag Rule—Bingenheimer—2017—Studies in Family Planning—Wiley Online Library. (n.d.). Retrieved April 3, 2025, from https://onlinelibrary.wiley.com/doi/full/10.1111/sifp.12030

The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion | Guttmacher Institute. (2021, April 23). https://www.guttmacher.org/fact-sheet/hyde-amendment

Title X Statutes, Regulations, and Legislative Mandates | HHS Office of Population Affairs. (n.d.). Retrieved April 1, 2025, from https://www.opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates

United States: Social media companies' removal of abortion-related content may hinder access to accurate health information. (2024, June 11). Amnesty International. https://www.amnesty.org/en/latest/news/2024/06/united-states-social-media-companies-removal-of-abortion-related-content-may-hinder-access-to-accurate-health-information/

University of Michigan Library (Director). (2012, March 8). *Legacy of American Eugenics: Buck v. Bell in the Supreme Court* [Video recording]. https://www.youtube.com/watch?v=sGofQX15qp8

What Is the Global Gag Rule? (n.d.). Retrieved March 6, 2025, from https://www.plannedparenthoodaction.org/communities/planned-parenthood-global/end-global-gag-rule

Whitehead, A. L., & Perry, S. L. (2020). *Taking America Back for God: Christian Nationalism in the United States* (Internet materials). Oxford University Press. https://proxy1.library.virginia.edu/login?url=https://dx.doi.org/10.1093/oso/9780190057886.001.0001