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RESTRICTING CHOICE: THE INTERSECTION OF LAW, POLICY, AND PUBLIC OPINION ON ABORTION RIGHTS

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RESTRICTING CHOICE: THE INTERSECTION OF LAW, POLICY, AND PUBLIC OPINION ON ABORTION RIGHTS

By

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Abstract

Abortion access has long been a contentious issue in the United States, subject to changing social values, new scientific findings, and public policies. This project examines how historical, political, and cultural forces have shaped abortion law and abortion access in the United States through an analysis of the Supreme Court decisions in *Roe v. Wade* (1973) through *Dobbs v. Jackson Women's Health Organization* (2022). Using a multidisciplinary literature review, I analyze abortion policy through legal, public health, and sociological scholarship to examine the dynamics of abortion policy development and dispute resolution. The research pinpoints legal and policy solutions that enable better access to reproductive healthcare under existing system constraints. The paper uses a comparative case study – with California as an abortion-access state and Texas as an abortion-restricted state –to show how various legal and political systems control post-*Dobbs* abortion access. My findings suggest that funding restrictions like the Hyde Amendment (1976) and state-level abortion regulations permitted under the "undue burden" standard established in *Planned Parenthood v. Casey* (1992) have restricted access to abortion for disadvantaged groups. These policies show that legal systems control both access to abortion services and the overall results of reproductive health services. The study demonstrates how legal access mechanisms, ideological barriers, and institutional frameworks create health disparities, which, in turn, affect healthcare access and the practice of reproductive justice

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Introduction and Significance

This paper analyzes abortion access in the United States following the ruling of *Roe v. Wade* (1973) and subsequent restrictions, ending with the Court decision *Dobbs v. Jackson Women's Health Organization* (2022). This research starts from the understanding that abortion is a critical component of women's health care. As is the case with many medical situations, patients should make abortion decisions in consultation with their healthcare practitioners, without excessive intervention from third parties. A woman's decision to undergo an abortion occurs for a variety of reasons, including but not limited to fetal abnormalities, illness, exposure to teratogenic drugs, intimate relationship violence, rape, incest, obstacles to accessing and using contraceptives, or choosing not to carry a pregnancy to term. (American College of Obstetricians and Gynecologists, n.d.)

In the ongoing fight for the right to make their own health care decisions, American women face numerous obstacles. While reproductive rights help expand the legal right to abortion, it does not guarantee access to people who already face barriers to healthcare. Reproductive rights deal with autonomy and the capacity to make decisions about reproduction. Reproductive justice goes beyond this and also takes socioeconomic status, social class, and race into account. The idea of reproductive justice is fundamentally focused on societal inequalities in access to abortion treatment. Reproductive justice acknowledges that underprivileged communities may not have the means and support system necessary to exercise their legal right to an abortion (Luna & Luker, 2013). Reproductive justice is important to this research as it focuses on sociocultural disparities in access to abortion care. This helps to not only increase access but also to provide and expand meaningful access.

This research investigates how various political ideas influence public policy concerning women's access to abortion, as well as the historical background of reproductive justice movements in the United States since the passage of *Roe v. Wade* in 1973 and through its overturning with *Dobbs* in 2022. To contribute to discussions on expanding access to abortion, my project analyzes how access to abortion has evolved in the past 50 years, the influence of public opinion and policy on this changing access, and the broader implications of reproductive justice for the reproductive autonomy of women across racial and class lines. Furthermore, this study will perform a policy comparison between an abortion-access state, California, and a state with a complete abortion ban, Texas. This shows how different post-*Dobbs* legal systems create barriers to abortion access, depending on a person's location, financial status, and capacity to travel.

Rather than treating abortion rights as only a legal issue, this paper connects abortion access to public health, gender equality, and reproductive justice. The interdisciplinary research reveals how reproductive rights need protection and how abortion services need to be distributed fairly. This is necessary to highlight evidence-based policy solutions and their long-term effects on marginalized communities. The following sections examine the historical development of abortion rights and the emergence of restrictive abortion policies, and the current state of abortion access in different states.

Methodology and Approach

My methodology is a multidisciplinary literature review that draws from law, public health, sociology, and policy analysis. This strategy is crucial since abortion restrictions impact healthcare institutions, public opinion, and uneven access, in addition to operating through legislation. A purely legal analysis provides only a partial understanding of the issue, while

studies focusing exclusively on public opinion and sociological perspectives deal with the ways reproductive rights are constructed by legal mechanisms. This study uniquely assesses how court decisions affect many communities in the real world since it crosses the boundaries between politics, law, and social impact. The method combines case law with institutional response mechanisms to analyze different policies and their intersectional impacts. The reproductive justice framework assesses both formal legal rights and actual access to reproductive healthcare resulting from existing structural disparities. When combined, these sources offer a more comprehensive knowledge of abortion availability than would be possible with only a legal review.

Key methods of this study include an examination of landmark abortion-related legal decisions and legislation: *Roe v. Wade* (1973), the Hyde Amendment (1976), *Planned Parenthood v. Casey* (1992), and *Dobbs v. Jackson Women's Health Organization* (2022). Through examining the short-term and long-term policy changes that emerged from those court rulings, this paper evaluates the legal arguments and established precedents that have evolved (Greenhouse & Siegel, 2012). An additional method includes a comparative case study analysis at the state level after the *Dobbs* (2022) decision. It compares California as an abortion-access state, and Texas as an abortion-restricted state. These states were chosen as they reflect different policy contexts in the post-*Dobbs* era. It is imperative to analyze how both protective and restrictive legislative frameworks affect access. Furthermore, this comparison examines disfavored interstate travel for care, economic, and health outcomes. Analyzing California and Texas will further demonstrate how diverse legislative circumstances shape reproductive healthcare (Kaplan, 2023). This ensures that legal judgments are understood through a broader

political and cultural lens. This comparison reveals how these policies translate into tangible implications for abortion access and reproductive health.

Additionally, the research investigates how governments and citizens react to important decisions that establish new abortion legislation. The study will analyze how different states and the national government responded to legislative changes while showing how public opinion evolved through media coverage and activist activities from different geographical areas. The research shows how government policies affect public opinion to explain how legal reforms connect to ongoing social and political movements (Siegel, 2015).

The study will investigate how restrictive abortion policies impact multiple marginalized groups who experience intersectional discrimination. The accessibility of reproductive healthcare services in the United States is determined by three main factors: economic barriers, racial disparities, and geographic inequalities. These factors are important to look at as it creates obstacles for low-income individuals, women of color, and people living in rural areas to obtain safe and legal abortion services (Luna & Luker, 2013). Instead of concentrating only on legal considerations, this method makes sure that policy discussions take into account the entire extent of disparity in access to reproductive healthcare.

The methodology creates policy reforms based on scientific evidence. The recommendations will include supporting legal protections that secure reproductive rights and developing policies to improve abortion access for marginalized groups. The approach provides an extensive examination of abortion access, going beyond ideological borderlines to study the actual effects and potential solutions through its incorporation of legal and sociological elements. The study's methodological approach does not require Institutional Review Board (IRB)

approval, given that it analyzes government reports, published legal writings, and scholarly articles.

History of Abortion Access in the U.S.

With the passage of *Roe v. Wade* (1973), the U.S. Supreme Court established a new legal standard by granting women the constitutional right to abortion and changing American society (Rose, 2007). However, three years after *Roe*, the U.S. Congress approved the Hyde Amendment in 1976. The Hyde Amendment restricted abortion access by prohibiting the federal funding of abortion services except for situations where a woman's life was in danger or a pregnancy resulted from rape or incest (Hyatt et al., 2022). This was the beginning of an impact on low-income women who depended on government-funded healthcare services such as Medicaid (Hyatt et al., 2022).

The 1992 Supreme Court case *Planned Parenthood v. Casey* confirmed *Roe* at the same time that it allowed for state regulation of abortion. States gained authority to establish abortion restrictions, often creating excessive obstacles for women who wanted abortions. The ruling changed abortion rights as it gave states more authority to control abortion laws. In many states, new regulations established mandatory waiting periods and parental consent requirements, together with clinic operation standards. The push for state authority control reached its peak at *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe*. All states received complete power to develop their own abortion laws. This ruling overturned 50 years of established precedent that had safeguarded the nation's constitutional right to an abortion (Kaufman et al., 2022)

New abortion laws and restrictions after both *Casey* and *Dobbs* have stigmatized women's reproductive health. They have reshaped abortion from a procedure that is both a

normal part of reproductive life and, at times, medically necessary to preserve a patient's life or health into a highly politicized issue. The lives of expectant mothers across the United States are in danger due to increased stigmatization and lack of access.

The Reproductive Justice Framework

Abortion access discussions in the United States often revolve around legal matters and individual decision-making. The reproductive rights framework has played a significant role in getting constitutional protections like those given by *Roe v. Wade* (1973). However, people from different groups still experience major barriers that prevent them from accessing abortion services. The reproductive justice framework originated as a response to these restrictions, and it offers an extensive intersectional approach, showing how reproductive choices connect to broader patterns of power and inequality and system boundaries. (Ross & Solinger, 2017).

Reproductive justice was a term introduced in the 1990s by Black women activists who aimed to expand beyond the limited perspective of the prevailing reproductive rights campaigns, which focused on individual choice and legal access to abortion. Reproductive justice criticized these liberal feminist tactics, which considered women to be a uniform group and dealt with reproductive freedom solely through legal rights and market-based "choices" (Morison, 2021). With that in mind, reproductive justice establishes ties between reproductive rights and social justice. It demonstrates that rights become unachievable when people lack the required social, economic, and institutional resources needed to exercise their rights (Ross & Solinger, 2017). Reproductive justice fundamentally consists of three interconnected principles: the right to bear a child, the right not to bear a child, and the right to raise children in environments that are safe, healthy, and sustainable. The framework understands reproductive freedom through overlapping systems of inequality, including racism, sexism, classism, heterosexism, and ableism. By

utilizing an intersectionality approach, reproductive justice moves the analytical spotlight from separated personal decision-making to the structural settings that allow or restrict reproductive lives (Morison, 2021)

The main point of reproductive justice defines abortion access as more than a moral and legal matter. It should be treated as both a public health concern and a human rights violation. Research shows that when abortion access is restricted, serious health and financial problems can contribute to higher maternal death rates (Hall et al., 2023). The Turnaway Study provides strong evidence that supports these findings. Starting in 2008, the study tracked almost 1,000 women over a five-year period to assess two groups of women who experienced different outcomes. One group of women received abortions while the other group lost access to medical services because they passed the gestational limit for abortion in their respective locations. The results demonstrated that women who underwent abortion procedures showed no development of depression or anxiety symptoms. On the other hand, those who wanted to have an abortion but were denied access experienced economic difficulties. This included higher poverty rates and an increased risk of health problems that originated from their pregnancy condition. The study found that women who were denied an abortion experienced enduring physical health issues and reduced contentment throughout their lives. (ANSIRH, n.d.)

Reproductive justice places abortion rights within a clinical and public health context and holds that the refusal of treatment worsens the already existing racial and economic disparities in health conditions. By using empirical medical evidence to support reproductive justice, Hall et al. not only strengthen the movement's relevance in the areas of advocacy and theory but also set it up as a crucial health policy and clinical practice perspective (Hall et al., 2023).

The importance of reproductive justice in the clinical realm is more clearly demonstrated by research that has highlighted that while abortion access through law is essential, it is not enough to secure equal reproductive outcomes (Gilliam et al., 2009). Research shows that federal and state governments impose greater burdens on economically disadvantaged people, women of color, undocumented immigrants, and other minority groups. This includes policies such as the Hyde Amendment, parental involvement laws, and funding restrictions. Moreover, marginalized communities often have their treatment postponed, face more stigma, and have greater medical risk. This, in turn, makes it imperative to have a framework that considers both legal status and lived experience (Gilliam et al., 2009).

Reproductive justice provides the vital perspective for grasping stigma and reproductive coercion. Reproductive decision-making is inseparably linked to sociocultural discourses that define "desirable" and "undesirable" reproducers. The historical surveillance of marginalized communities' reproduction, together with coercive sterilization practices and state-led population control efforts, has created current reproductive policies that identify specific groups as unfit and irresponsible while denying them reproductive rights (Morison 2021). The stigma surrounding abortion, which is backed by religious beliefs and political discourse, acts as a form of social control that prevents people from seeking medical help and causes them to feel ashamed, even in states where abortion is legally permitted.

By focusing on structural inequality instead of legal rights, the reproductive justice framework makes it possible to compare the effects of different policy regimes, like those in Texas and California, on the health, economic, and social aspects of the populace. Consequently, the concept of reproductive justice provides a theoretical basis that is indispensable for the comprehension of the interplay between abortion laws, stigma, healthcare infrastructure, and

socioeconomic inequity. Together, these factors shape whether reproductive rights can actually be exercised.

Reproductive justice is the major principle that guides this research and consideration of abortion policy as a problem consisting of multiple dimensions. With this lens, we not only consider the question of legality but also investigate if reproductive freedom is truly available to people of different statuses. This concept is also the premise for the next analyses of stigma, media portrayal, and policy-making influences based on values, along with suggested solutions grounded in evidence that are directed towards the goal of reproductive equity.

Stereotypes, Stigma, and the Media

The stigma surrounding abortion has a significant impact on how the public views the procedure, as well as the experiences of people who either seek out or perform abortion care. Beyond official legal limitations, stigma affects how people perceive and react to abortion. It affects women's roles in society and justifies the existence of policies that prevent access to abortion. From the viewpoint of reproductive justice, stigma is not just an individual feeling but a structural power that limits reproductive freedom. This can be seen through the effect of media stories, discussions in churches, policies and laws, and political discourse (Sorhaindo & Lavelanet, 2022).

Abortion stigma is characterized as a negative social attribute that labels individuals who seek abortion as morally inferior or deviant. Stigma influences prevailing ideals such as womanhood, sexuality, and motherhood (Hanschmidt et al., 2016). Researchers found abortion stigma as a phenomenon that plays out in three intermingled domains: perceived stigma, internalized stigma, and enacted stigma. Perceived stigma describes how people forecast their social treatment, while internalized stigma describes the process of accepting negative societal

views about oneself. Enacted stigma refers to situations where individuals face direct discrimination and mistreatment because they have undergone an abortion. (Hanschmidt et al., 2016). Studies show that those who seek abortion experience stigma from a variety of sources, such as their own family, church or religious community, doctors or medical personnel, and the general public.

Media portrayal is one of the major factors that keep these stigmatizing narratives alive. Public discussion often portrays abortion as a morally controversial, tragic, or psychologically damaging practice rather than a routine healthcare procedure. The print and electronic media connect abortion to people being irresponsible, feeling regret, and living outside social norms, even when no evidence proves women suffer from long-term negative mental health consequences after having an abortion (Hanschmidt et al., 2016). These depictions foster a culture where abortion is seen as socially wrong, which makes it more likely that people would hide their experiences and put off getting treatment.

Religion and religiosity also affect stigma. Sociologists have demonstrated that religion has always been an important factor influencing people's attitudes towards abortion in the U.S. Studies show that the level of opposition to legal abortion is closely correlated with religious affiliation, degree of belief, and the frequency of attending religious services (Barringer et al., 2020). Among the different types of Christianity, conservative Protestantism is the most likely to see abortion as a moral issue and thus prohibited. On the other hand, nonreligious people and those associated with Jewish or more liberal religious traditions are more likely to support abortion when controlling for factors including educational attainment, socioeconomic status, racial background, and political beliefs (Barringer et al., 2020). These moral considerations,

rooted in religion, not only influence individual beliefs but also impact the public's perception of abortion access and the cultural arguments that arise around it.

Conservative Christian religious discourse views abortion as a major breach of the moral order and, therefore, views women who have abortions as irresponsible, sinful, or deviant. Following Michel Foucault's concept of governmentality, Ghatak and Abel (2013) assert that religion works as an exemplary disciplinary institution that influences moral conscience through ritual, discourse, and collective norms. Thus, religious circles do not simply vocalize moral beliefs but also play a vital role in controlling conduct by fostering inner discipline and voluntary submission among their followers (Ghatak & Abel, 2013). Applying this framework to abortion reveals how religious narratives dictate reproductive conduct even in the absence of direct legal prohibition. The negative stigmas associated with religion are also solidified via political action and media coverage. Since *Roe*, anti-abortion campaigns in the United States have framed abortion as the taking of "innocent life" by using fetal imagery and biblical allusions. The catchphrase "pro-life" was coined to present abortion as a danger to social order and family values by declaring it a form of murder (Barringer et al., 2020). The mass media, political campaigns, and advocacy organizations distribute these religious narratives to further create a public perception of abortion that uses moral standards to affect individual belief systems.

The stigma surrounding abortion has measurable effects on mental health and well-being. Abortion stigma is linked to anxiety and depression. This makes individuals feel a need to keep their abortion decisions private. People who experience religious-based stigma might feel more shame and moral conflict, especially when their fertility choices do not align with the main religious values. The practice of secrecy, which is commonly done to escape

judgment or social punishment, has been found to increase emotional pain and decrease the possibility of receiving social support (Hanschmidt et al., 2016).

Stigma also occurs in the medical field, where it has an impact on abortion care regarding quality and accessibility. A scoping review commissioned by the World Health Organization found that stigma surrounding abortions has an overall negative impact on the quality of care in terms of accessibility, acceptability, equity, and safety. Care that is faith-based or influenced by a hospital's culture may result in moral judgment, withdrawal of service, extra procedural difficulties, or one-sided advice. This undermines patient-centered care (Sorhaindo & Lavelanet, 2022). Most importantly, the negative perception of abortion continues to exist even in regions where it is legal. The legality of abortion does not itself erase stigma. Through excessive monitoring requirements and a lack of funding, abortion services often receive special treatment. This separates them from other reproductive health services. The perception of abortion as a moral problem shapes the healthcare industry.

The reproductive justice framework reveals that abortion stigma operates as a social force that maintains existing power structures between different racial, gender, and social class groups. The practice of abortion stigma functions as an extension of reproductive control systems. Governments, religious institutions, and other authorities use stigma in the form of moral beliefs and economic practices to manage human reproduction through their legal and regulatory frameworks (Morgan & Roberts, 2012). Groups that are usually at the margins of society, such as low-income women, women of color, adolescents, and undocumented individuals, face even more stigma, control, and severe penalties, especially where political power and social norms highly favor religious ideologies (Morison, 2021).

Stigmas and stereotypes that are connected with abortion exist as people hold personal beliefs that media outlets and religious groups propagate. As religious discourse often defines abortion as an immoral and socially unacceptable practice, the resulting stigma creates laws that limit reproductive rights and medical access. By examining religious stereotypes and their effects, this research will develop more meaningful solutions to enhance reproductive health care access.

Impact of Values on Policy: A Comparative Case Study

Abortion policy in the United States exists as a result of both judicial interpretation and other non-judicial factors. The legislators who create laws about reproductive rights do so by using established cultural, religious, and political values. The state-level differences that emerged after *Dobbs* (2022) show how different value systems create legislative frameworks that restrict or protect abortion access. The states of Texas and California make this contrast especially clear. Comparing Texas and California shows how different political values produce different legal systems and different access outcomes.

Texas abortion policy restrictions currently stand among the most severe in the United States (Guttmacher Institute, 2026a). Before *Dobbs*, Texas prohibited abortion after six weeks' gestation, restricted particular abortion procedures, required mandatory ultrasounds, a 24-hour waiting period, biased counseling, and parental consent for minors, limited telemedicine access, and enforced targeted regulations for abortion providers (Center for Reproductive Rights, 2026). The state enforcement of its trigger ban, which established a complete abortion ban and allowed both civil and criminal enforcement of that ban, began after the *Dobbs* decision on August 25, 2022 (Center for Reproductive Rights, 2026). Texas does not provide any specific constitutional or legal rights that protect abortion rights. The legislative framework establishes abortion as an

activity under complete state control and moral evaluation instead of as a safeguarded medical practice.

The demographic context in which these policies operate is significant. Texas has approximately seven million women of reproductive age (15–49) (Guttmacher Institute, 2026a). The population structure reveals that 33% of people live under 200% of the federal poverty level, while 24% lack health insurance. The study shows that 19% of Texas women who can have children were born outside the United States. The racial and ethnic composition of this population of women of reproductive age shows demographic diversity: 43% Hispanic identification, 12% Black identification, and 36% White identification (Guttmacher Institute, 2026a). This demographic and socioeconomic diversity indicates that many people of reproductive age will encounter difficulties when trying to obtain medical care that exists outside the boundaries of legal restrictions. The people who lack financial resources and/or health insurance and face immigration restrictions will encounter greater difficulties in accessing medical services, given that the state criminalizes all abortions.

In 2020, before the overturning of Roe, 58,030 abortions occurred in Texas among women aged 15–44, a rate of 9.5 abortions per 1,000 women aged 15–44 (Guttmacher Institute, 2026a). This data shows that abortion existed as a clear part of reproductive healthcare services before Texas prohibited abortion. Following the implementation of these limits, the number of abortions fell to 12,420 in 2023 before rising to 34,520 in 2024 and 42,270 in 2025 (Guttmacher Institute, 2026). This pattern suggests that although the overall number of abortions decreased after placing restrictions, the number of abortions is steadily rising. People are continuing to seek abortion care even after laws against the procedure are established. Texas's situation demonstrates that when local abortion services become unavailable, people still require abortion

services. They then must seek different methods to obtain healthcare that will result in more challenging and costly service access.

California serves as a contrasting policy framework. The state is classified as one of the most protective with respect to abortion rights (Guttmacher Institute, 2026a). California's Supreme Court acknowledged abortion rights as a constitutional right in 1969, four years before *Roe v. Wade* (Center for Reproductive Rights, 2026). State law protects the right to personal reproductive decisions, and in November 2022, voters approved Proposition 1. This explicitly amended the state constitution to protect abortion and contraception rights. The law in California prohibits abortion at viability and recognizes abortion as a basic right that exists through privacy safeguards (Center for Reproductive Rights, 2026).

California has enacted policies that extend access beyond what the Constitution recognizes. For instance, the Medicaid program finances abortion services, private insurance providers must include abortion coverage in their plans, and selected advanced practice clinicians have permission to deliver first-trimester medication and aspiration abortion services. The state has enacted interstate shield laws to protect healthcare providers and their patients from legal claims brought by people from other states. The state has implemented data privacy protections for reproductive healthcare services. California established an Abortion Practical Support Fund, which provides 20 million dollars in funding, together with a Los Angeles County Abortion Access Safe Haven Pilot Program that will help increase service capacity (Center for Reproductive Rights, 2026). California's regulatory framework includes insurance requirements and financing sources intended to reduce the cost of accessing abortions. These policies reflect a governance structure that views abortion as a medical service that is included in larger commitments of access and privacy.

Looking at the state of California demographics compared to Texas, there are approximately 9.2 million females who can have children between the ages of 15 and 49. The population shows that 28% of individuals who earn less than 200% of the federal poverty level receive Medicaid benefits, while 9% of the population lacks health insurance. The study found that 28% of participants had international origins, while 44% of the state population identified as Hispanic, 5% as Black, and 30% as White. (Guttmacher Institute, 2026).

In 2020,154,060 abortions were performed in California, which resulted in a rate of 19.2 abortions per 1000 women aged 15 to 44 (Guttmacher Institute, 2026). The higher rate relative to Texas reflects differences in access to infrastructure and service availability. After *Dobbs*, California has become a destination state, allowing people from restrictive jurisdictions to access its legal protections, demonstrating how state laws impact regional access to services.

The abortion regulations in Texas and California show how different policies express fundamental value systems. The Texas government uses its laws against abortion to create a system that severely punishes reproductive freedom offenses while controlling abortion procedures. The legal system in California protects citizens through privacy rights, healthcare access, and reproductive justice rights. The different values each state carries produce different legal results, although they operate in similar demographic contexts. Reproductive justice further emphasizes that legal rights do not provide equal access and that structural conditions determine how people experience their rights (Hyatt et al., 2022). Therefore, state-level fragmentation after *Dobbs* emphasizes how moral and ideological commitments get ingrained in legislation. It directly reflects how those values influence the geography of reproductive healthcare in the United States.

Solutions and Advocacy

The preceding sections demonstrated that legal doctrine, moral values, institutional structures, and material inequalities together define abortion access in the United States. The fragmentation that started with *Casey* and expanded dramatically after *Dobbs* has not eliminated abortion needs; rather, it has redistributed access unevenly across state lines. The evidence presented in this study suggests that effective reform requires both legal protection and structural implementation. The solutions include financial coverage, telehealth growth, provider workforce change, stigma reduction, and constitutional protection. The reproductive justice framework requires more than the restoration of legal rights because it is based on equitable access to sustainable services that must be protected from political changes.

A long-term sustained protection of abortion rights requires constitutional and statutory protections from both state and federal governments. The California case shows that states can protect reproductive rights more effectively when they establish those rights through constitutional laws like Proposition 1 (Center for Reproductive Rights, 2026). States like Texas, on the other hand, lack these safeguards and have enacted overlapping prohibitions and enforcement strategies (Center for Reproductive Rights, 2026). Based on this comparison, constitutional entrenchment is not merely symbolic, as it functions as a permanent protection system. Where politically feasible, states should adopt explicit constitutional amendments protecting abortion and contraception rights. Further, legislation creating a baseline right to abortion at the federal level would lessen disparities between states and bring back some degree of uniformity across the country (Baden et al., 2025).

The current political situation underscores the need for future protective abortion regulations. U.S. Health Secretary Robert F. Kennedy Jr. proposed that federal authorities should

reassess mifepristone (an FDA-approved drug that can end pregnancies up to 10 weeks' gestation when used with misoprostol) access in 2025 despite established evidence proving the drug's safety and effectiveness (Sherman, 2025). This development illustrates that medication abortion access is vulnerable not only to state bans but also to federal regulatory shifts. The Food and Drug Administration (FDA) governs pharmaceutical products through its distribution rules; therefore, any modifications to these rules will establish new distribution limitations that impact the entire United States. States that support abortion rights should establish legal frameworks that define and protect medication abortion access and create additional pathways for pharmacies to distribute this medication, while maintaining telehealth services as protected under state regulations.

However, written rights need enforcement systems for their full protection. Guttmacher's 2025 policy analysis shows that people have increasingly used interstate travel as their main method to obtain abortion services. In 2024, 154,900 individuals traveled between states to receive medical treatment (Baden et al., 2025). Thus, preserving the fundamental right to travel and fortifying interstate shield legislation are crucial elements of reform. State-level rules known as "interstate shield legislation" are intended to cover medical professionals, patients, and assistants from investigations conducted outside of their state. Shield protections must extend explicitly to telehealth provision of medication abortion to those assisting patients and to digital privacy safeguards. For instance, the shield laws of California establish a protective framework that extends protection to both healthcare providers and their patients through their defense against all out-of-state civil and criminal claims. The absence of these protections creates legal risks that control and suppress the actual implementation of rights.

The process of reducing disparities in healthcare also requires organizations to expand their medical services while implementing patient-centered healthcare practices that incorporate the reproductive justice framework. The majority of abortions in states without total bans are performed through medication (Baden et al., 2025). Expanding telehealth and pharmacy distribution of medication abortion can significantly reduce logistical barriers, particularly for rural and low-income populations (Jekel, 2023). The evidence supports a policy framework that requires both the removal of nonessential medical restrictions on telemedicine services and the elimination of regulations that prevent pharmacies from distributing mifepristone. Federal and state policymakers should prioritize telehealth reimbursement parity and invest in broadband infrastructure to ensure that telemedicine expansion does not reproduce digital inequality (Jekel, 2023). The system should consider telehealth expansion as a permanent access improvement instead of a temporary solution.

The expansion of provider workforce capacity will also create essential medical access for patients. Analyzing the years 2020 to 2024, the Guttmacher Policy Review identified clinician shortages and geographic concentration as persistent barriers to abortion care (Baden et al., 2025). Hurdles to abortion care predated *Dobbs*, yet in certain areas of the country, they have worsened after 2022. This emphasizes the need for an expanded abortion-care workforce. The states that permit advanced practice clinicians (APCs) to deliver early abortion services show patient safety results that match those of physician-provided services. The existing evidence supports a proposal for expanded scope-of-practice regulations that would permit certified nurse practitioners and physician assistants to perform medication and aspiration abortion procedures during early pregnancy. The proposed changes will enhance service delivery through improved

capacity while decreasing waiting times in states that face increased demand from patients who come from other states.

Furthermore, the existing insurance system needs reform as cost has become the main obstacle. Guttmacher's data show that patients in states where Medicaid covers abortion are far more likely to pay little or nothing out of pocket compared to patients in states that enforce Hyde-like restrictions (Baden et al., 2025). Although politically unfeasible under the current presidential administration, repealing Hyde through federal legislation is essential to aligning abortion policy with principles of healthcare equity. The Equal Access to Abortion Coverage in Health Insurance (EACH) Act functions as federal legislation requiring insurance providers to cover abortion services. In the long term, state legislators must require all public and private insurance plans to include abortion coverage while establishing reimbursement rates that support provider operations. Legal rights exist only for those who can afford them because financial resources create barriers to access.

Solutions must also address stigma and public discourse. The media maintains abortion stigma through its narratives that combine religious rhetoric and traditional stereotypes to create a damaging effect. Guttmacher's policy analysis shows that complete sexual and reproductive health education enables young individuals to comprehend their alternatives while learning to identify pregnancy at earlier stages (Baden et al., 2025). States should mandate comprehensive, evidence-based sexual health education. A reproductive justice perspective is also important to teach to the youth in order to encourage education about meaningful access.

Finally, the implementation of reproductive justice demands that abortion be examined within its complete healthcare system context. Restrictive policies also block people from obtaining contraception and force clinics to shut down as they decrease the effectiveness of Title

X programs that offer these vital health services and more, such as STI and pregnancy testing (Baden et al., 2025). Funding boosts for programs like Title X, together with the safeguarding of person-centered counseling services, form an essential component of a unified reproductive health program. The establishment of a policy framework that enables simultaneous access to contraception and maternal health services and abortion rights creates a more stable and equitable system than one that treats abortion as an exceptional case.

The proposed solutions follow a basic principle: abortion access should be assessed through both its legal status and its equitable access. The reproductive justice framework requires examination of both sides of abortion rights. People must possess actual conditions that enable them to exercise those rights under their given conditions. The five strategies that include constitutional protection, financial coverage, telehealth expansion, provider workforce reform, and stigma reduction will create interconnected benefits. Reproductive justice advocacy needs to adopt a comprehensive approach that combines multiple elements instead of working on individual issues through separate solutions.

Conclusion

This capstone research demonstrates that abortion access in the United States depends on the combined effects and intersection of legal frameworks, policy decisions, and public opinion. The period from *Roe v. Wade* (1973) until *Dobbs v. Jackson Women's Health Organization* (2022) shows how abortion law developed from public discussions about the relationship between state and federal power and individual freedom rights. The Supreme Court's decision to overturn Roe v. Wade was not the first time legal or geographic inequality was created in abortion access. Instead, it amplified an already disparate system, allowing states to restrict or ban abortion more aggressively. This, in turn, makes reproductive justice geographically

dependent. Access to abortion care is determined by the laws, resources, and political values of the state where people live.

Research shows how different value systems become institutionalized through state policies. Through a comparative analysis of Texas and California, this project has shown that Texas has implemented multiple bans and enforcement laws that make abortion illegal. Moreover, these regulations stem from the state's moral opposition to abortion. In California, abortion has received constitutional and statutory protection as a fundamental aspect of privacy rights and healthcare accessibility. The two states have similarly diverse populations, but they create distinct realities that affect both patients and healthcare providers. The contrast shows that abortion policy extends beyond constitutional law, involving both political traditions and ethical authority in governance.

The analysis shows that to ensure meaningful access to abortion treatment, legal protection is necessary but insufficient. Factors like economic inequality, geographic access differences, and social and racial inequality prevent people from exercising their reproductive rights. To help represent marginalized groups, the reproductive justice framework investigates access to abortion through an examination of the various factors mentioned. Abortion policy, therefore, serves as a platform to display all the existing disparities that exist throughout the entire U.S. healthcare system.

The Solutions and Advocacy section proposed a multi-layered approach to reform, which included constitutional and statutory protections for stabilized access and interstate travel protections, together with protective measures against interstate travel restrictions and telehealth services and medication abortion services. The implementation of these reforms will enable

people to access their rights in a meaningful way. The establishment of sustainable change needs to connect legal protections with the implementation of structural requirements.

Future research should continue to monitor how state-level policies shape reproductive healthcare, particularly focusing on medication abortion and telehealth. Research also needs to examine how different state policies affect public health outcomes, economic development, and public perception, with a focus on maternal health results and healthcare worker distribution. Moreover, data privacy, interstate enforcement, and healthcare federalism make abortion an ongoing issue that requires interdisciplinary research.

The post-*Dobbs* landscape demonstrates that abortion access in the United States exists as a dynamic process that depends on judicial decisions and other factors. The system operates through changing value systems, institutional structures, and policy decisions. The reproductive justice framework shows that abortion policy assessment needs to consider two main issues: abortion's legal status and actual protective measures for reproductive rights for all social and racial groups. Addressing this issue requires continued attention to law, public health, and social inequality.

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