BRIDGING THE GAP

IMPROVING ACCESS TO MATERNAL AND REPRODUCTIVE HEALTHCARE FOR STRONGER FUTURES

LEGISLATIVE AGENDA

A REPORT BY
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Executive Summary

Despite decades of progress in maternal and reproductive health policy, systemic inequities persist, and in many cases, are worsening.[1] High maternal mortality rates, barriers to quality prenatal and postpartum care, and a chronic lack of accessible providers all reflect a national failure to provide equitable and comprehensive healthcare for all. The Advisory Coalition on Health Equity (ACHE) was established under the leadership of Congresswoman Bonnie Watson Coleman to confront these challenges head-on and holistically, starting in New Jersey's 12th Congressional District (NJ-12).

ACHE is a reproductive health working group composed of researchers and advocates from NJ-12 committed to leveraging data and lived experience to craft equity-centered policy solutions. The coalition has researched the structural failures embedded in the current maternal and reproductive healthcare system and compiled their findings to better inform legislative policy proposals that directly reflect the needs of those most impacted. This report examines critical aspects of maternal and reproductive healthcare, focusing on areas where systemic inequities are most acute. These areas include:

Improving Access to Prenatal and Perinatal Care

Access to early and consistent prenatal care is a key determinant of maternal and infant health outcomes.[2] Yet, many low-income families and women of color face insurmountable barriers. Whether it be financial, geographic, or systemic, action must be taken to ensure all populations, especially marginalized communities, obtain adequate care.

Improving Medicaid's Role in Reproductive Health

Medicaid covers over 40% of births in the U.S.[3] This means that the ongoing threats to eliminate state health insurance funding is putting reproductive health in danger. This report explores how Medicaid expansion and protection can serve as a cornerstone for equitable maternal care.

Strengthening Midwifery and Doula Support

Midwives and doulas established birthing practices long before their techniques were adopted into modern medicine.[4] However, these historically rooted, culturally competent providers have been systematically undervalued, stigmatized, and dismissed as invalid medicine by the Western world. Reintegrating these supports systems can significantly reduce complications and racial disparities in birth outcomes.

Lowering Maternal Mortality Rates

With the highest maternal mortality rate among wealthy nations, especially for Black women, the U.S. must implement targeted, data-informed strategies to reverse this trend.[5] This report suggests that policy recommendations center racial equity and community-led care models to reverse and prevent these morbid outcomes.

Reducing Racial and Linguistic Disparities in Care

Language access, cultural competency, and implicit bias persist and remain barriers to quality care. This coalition advocates for provider training, interpretation services, and accountability structures to address these disparities that is supported by the evidence cited in this report.

Expanding Postpartum and Mental Health Care

Postpartum recovery and mental health are too often excluded from maternal health policy. This report emphasizes the importance of ongoing, integrated care for new mothers and pregnant people, including behavioral health support, lactation services, and family-centered care models to establish and build trust in our healthcare system.

Throughout this report, ACHE sought to amplify the voices of NJ-12 residents in maternal and reproductive healthcare while drawing from national data. Each section outlines concrete policy recommendations that reflect a vision for reproductive healthcare that is equitable, accessible, and grounded in justice to ensure that meaningful, long-term change can be achieved.

The path forward is clear and urgent: the United States must confront the historical injustices embedded in its healthcare system and boldly legislate in support of families and future generations. Piecemeal reform has been unsuccessful and subpar in impact for our most affected communities. Through Congresswoman Bonnie Watson Coleman's leadership, overseeing the work of ACHE, reproductive healthcare can be reimagined as a right, not a privilege. We must build a healthcare system that delivers dignity and care for all. We must carry our mothers and parents to success the same way they carried us.

Introduction

Various institutional challenges in care disproportionately affect women of color across the country, especially related to reproductive and maternal health. As a society, we must understand the challenges preventing thousands of women from experiencing healthy and safe pregnancies or from receiving adequate reproductive care throughout their lives. As president and CEO of the Institute for Women's Policy Research, Dr. Jamila K. Taylor suggests that complete reproductive freedom can be achieved if researchers and advocates "emphasize the interconnectivity of reproductive rights, human rights, and economic justice."[6] For this reason, it is important to acknowledge the racial and cultural prejudices that heavily impact women's experiences. Addressing less recognized problems, such as linguistic barriers, insufficient lactation support, and demand for family mental and behavioral support, may also improve outcomes for mothers and infants. The Advisory Coalition on Health Equity (ACHE) aims to identify patterns of systemically insensitive institutional practices and present possible recommendations for policy improvement in these areas.

Before medical regulation and care advancement, women relied on natural or at-home remedies usually provided by midwives, health guides, as well as recipes passed from other women.[7] Most women gave birth with the help of female relatives, midwives, and other women; however, as male physicians began to receive training in the field of obstetrics, these customary practices began to decline. This, alongside excessive campaigning against midwives and advocacy from health professionals for the use of Western medicine and certified training, changed labor practices for the future.[8] This shift was not without reason and was a strategically rooted in classist and racially prejudiced beliefs against historically significant practices like midwifery.[9] Intervention continued to increase during these later years, and by 1980, midwives attended only 1.1.% of births.[10] Early methods of care heavily relied on the help of other women.

As medical intervention was normalized, physicians and charitable hospitals began opening services for women in new cities with dense populations of diverse communities during the early 20th century.[11] Alongside the developments in labor assistance and maternal care, prenatal care experienced significant changes since many professionals furthered their understanding of health and the importance of routine visits during the prenatal stages.[12] Despite the increase in families seeking professional medical care, the early 20th century was also characterized by high mortality rates, particularly among women located in these urban areas, a pattern which is still heavily present today.[13] The women's health movement, which gained momentum shortly after during the mid-20th century, attempted to address these discrepancies in maternal health through legislation, research, and community education. For example, women successfully encouraged hospitals to move away from traditional maternity care to a more family-centered approach during labor, advocating for mothers to have greater self-autonomy during childbirth.[14] Additional landmark events during these years include Medicaid's mandated coverage of pregnant women up to 100% of the federal poverty level in 1986, and the *New Mothers' Breastfeeding Promotion and Protection Act (H.R. 3531)* in 1988, a revolutionary piece of legislation protecting lactation under the *Civil Rights Act*. [15,16]

Despite notable legislation and changes to maternal and reproductive care, various systemic issues have persisted and have grown more intense today. High mortality rates are continuously reported—especially amongst Black women—despite greater technological advancements than ever. The U.S. has the highest rates of maternal mortality, with 22 deaths reported for every 100,000 live births.[17] Black women are at an even higher risk due to additional systemic challenges in the healthcare system.[18] Other current reproductive and maternal health issues in America are also the result of inefficient institutional designs. For example, many Black communities and/or rural communities lack accessible obstetric units.[19] Since 2022, over 100 hospitals across the country have closed their obstetric units, and over 35% of counties in the U.S. are considered maternity care

deserts.[20] Across the country, many families face barriers to accessible quality services and providers.

Beyond insufficiency, the quality of maternal and reproductive care in the U.S. is below standard. Although heavily beneficial, the lack of prenatal care visits reported during the first and second trimesters suggests possible gaps in accessibility, like financial coverage.[21] A study from 2019 found that mistreatment in health care for expecting and recent mothers who give birth in hospitals is significantly higher for Indigenous, Latina, and Black women, younger aged women, and for women who experience some economic, and health hardships.[22] Overall, more than 15% of families in the U.S. experience inadequate maternal care, which not only leads to higher rates of maternal mortality, but also poor outcomes for mothers and children in their long-term lives.[23] These alarming systemic disparities and gaps in maternal care for women of all groups across America exemplify the need to improve existing legislation as well as push for effective policy implementation. ACHE seeks to use research to support effective legislation that will improve patient outcomes for marginalized groups affected by poor reproductive healthcare systems.

In this report, we will explore and identify present reproductive and maternal health issues in America using data from New Jersey's 12th Congressional District as an example. Additionally, this report will propose meaningful policy recommendations that advocate for a family-centered community, drawing from previous evidence of effective legislative and institutional changes, and placing special importance on the mother's physical, emotional, and economic well-being. The coalition seeks to address critical healthcare issues within New Jersey's 12th Congressional District that will serve Congresswoman Bonnie Watson Coleman's priorities for the country.

Policy Pathways

Improving Access to Prenatal Care

Led by Nyeilla Veale

Introduction

Understanding the challenges surrounding access to prenatal care in the United States requires acknowledging the nation's long-standing history of racial and social injustice. For centuries, communities of color have faced deeply rooted inequities across nearly every aspect of life. These disparities are not incidental—they stem from deliberate policies and systemic structures that have disadvantaged entire populations.

From the legacy of slavery and the impact of discriminatory housing laws to the consequences of underfunded schools and generational poverty, structural inequality continues to shape the conditions in which many Americans live. Black and Brown communities are more likely to live in areas with inadequate healthcare facilities, fewer clinics and fewer providers, especially culturally competent ones. In states like New Jersey, which was the last northern state to abolish slavery, these inequities are often reinforced by outdated policy choices and priorities. Improving care is more than simply expanding services; it is a reassessment of societal values and long-term commitments to the people who call these communities home.

When gender is considered alongside race, the barriers become even more severe.[24] Women have long been undervalued, dismissed, and marginalized, and these experiences often carry into their healthcare journeys.[25] The voices, knowledge, and pain of women, especially

Black women, have historically been overlooked or ignored.[26] These same systemic patterns are clear in healthcare, particularly in prenatal care.

A History of Challenges in Access to Prenatal Care

Access to prenatal care has become a critical public health issue because of its direct connection to the well-being of both mothers and infants.[27] Over the past century, medical advances have shown that early and consistent prenatal care helps prevent complications during pregnancy and childbirth.[28] But this type of care has never been equally available to everyone. While such obvious forms of discrimination have become less visible, disparities persist through more subtle means: structural racism, geographic isolation, economic hardship, and implicit bias within the healthcare system.[29]

The worsening maternal mortality crisis, especially among Black women, has brought national focus on these issues.[30] What was once considered a medical concern is now recognized as a civil rights issue and a reflection of deep societal failings. Because of this shift in understanding, access to prenatal care is now viewed as a key part of the movement toward health equity and social justice.

Despite our nation’s wealth and position as a leader in healthcare, we continue to face a sobering maternal health crisis, one that disproportionately harms women of color and their babies, which in turn impacts generations to come.[31] In New Jersey, Black women are seven times more likely to die from pregnancy-related complications than White women, even when factors like income and education are considered. These statistics are not isolated; they further reveal this nation's deeply rooted systemic problems.

Added to this are the long-term effects of historical trauma and a lingering mistrust of the medical system, which continue to discourage many from seeking care. These issues reflect broader societal failures and a lack of urgency towards addressing disparities in one of the most critical areas of public health: maternal and infant health. Improving access to prenatal

care involves more than expanding Medicaid or increasing clinic hours.[32] It requires strategic and thoughtful reshaping of how society values maternal health, especially the health of those who have historically oppressed.[33] This means addressing inequities head-on and ensuring that every mother and their child have a fair chance to live healthy, thriving lives.

The Health Case for Prenatal Care

Access to prenatal care plays a central role in shaping maternal and infant outcomes.[34] Prenatal care is not simply a schedule of appointments; it is often the first line of protection against preventable complications.[35] It also includes education and screening that support healthy fetal development and overall maternal well-being.[36] Within this broader framework, oral health offers one example of how minor health issues can influence pregnancy outcomes. Untreated conditions such as gum disease, which can progress into periodontal disease, can increase inflammation and heighten the risk of complications like preterm birth, low birthweight, pre-eclampsia, and gestational diabetes. Although this is an often overlooked but crucial aspect of care, when it is not prioritized or able to be accessed, the consequences become even more pronounced.[37] Limited access magnifies small health concerns into significant risks, further emphasizing how essential comprehensive prenatal care truly is.[38]

Health Equity and Prenatal Care Disparities

Recent data highlights how unequal access continues to shape outcomes. According to the 2025 March of Dimes Report Card, the national preterm birth rate is 10.4%, rising to 14.7% among Black mothers.[39] Almost a quarter of pregnant individuals did not begin prenatal care in the first trimester, continuing a four-year pattern of delayed entry into care. A study of more than 33 million live births from 2014 to 2022 found that 36.8% of births involved fewer than the recommended number of visits, 22.7% began care after four months, and 1.8% received no prenatal care at all. Inadequate care was far more common among those insured through Medicaid.[40] Maternal mortality remains a major concern, yet preventable. The U.S. rate is

18.6 deaths per 100,000 live births, with Black, Native American, and Pacific Islander mothers experiencing mortality rates two to three times higher than those of White mothers.[41] More than one-third of U.S. counties lack obstetric units or clinicians who provide maternity care, contributing to higher rates of preterm birth and infant mortality.[42] Workforce representation also plays a role. Only 6% of physicians and 3.8% of dentists identify as Black, while 5% of physicians and 6% of dentists identify as Hispanic/Latino.[43] These professionals are more likely to serve marginalized communities, so limited representation contributes to ongoing gaps in culturally informed care.[44] Together, these patterns point to access as a defining factor in maternal and infant health outcomes.

Federal Context

Federal programs such as Medicare, the *Affordable Care Act*, and maternal health initiatives provide an important foundation, but gaps in eligibility, reimbursement, and implementation leave many families without continuous care.[45] Even with insurance, challenges such as clinic shortages, transportation barriers, and limited availability of culturally competent providers, often hinder what programs can accomplish. States like New Jersey show how federal policies and local realities intersect. Without federal investment in local health systems, maternity care deserts remain a threat to maternal and infant health, particularly in marginalized communities.[46] Federal programs can reduce disparities, but only when coupled with the access needed for families to use them.

Policy Recommendations

1. Expanded Insurance Coverage

Why it matters: Inadequate prenatal care increases the likelihood of preterm birth, low birthweight, maternal complications, and developmental delays. Insurance gaps and high costs are some of the barriers that limit access to this care.

Recommendations: Provide continuous coverage for all individuals, including prenatal and postpartum services, that include oral health care, knowing its direct relationship to health outcomes for mothers and their babies, with reimbursement rates that support provider participation.

2. Investment in Community Health Clinics and Community-Based Programs

Why it matters: Sustainable improvement requires policies that center access, remove barriers, and ensure that all mothers, especially those in marginalized communities receive timely, comprehensive prenatal care.

Recommendations: Expand public health-focused clinics, establish more obstetric units in underserved areas, and support mobile prenatal services with linkage to reproductive care providers for continuity of care. Address transportation, childcare, and scheduling needs that interfere with appointments. Fund doulas, community health workers, and home-visiting services that provide culturally responsive care, advocacy, and education.[47] Meet families where they are in the process.

3. Diversified Workforce and Training Programs

Why it matters: Expanding clinic hours, transportation options, and insurance coverage is essential, but these efforts must be supported by a diverse and culturally competent workforce to deliver effective and trusted care.

Recommendation: Increase diversity across medical, nursing, midwifery and doula programs and incorporate training in public health, social determinants of health, and equity. Encourage service in communities with greatest need.

4. Data Reporting Accountability

Why it matters: Maternal health outcomes have long-term consequences for families and communities. The consequences of these outcomes disproportionately affect Black and Brown families, raising serious questions about equity in a country with advanced medical resources.

Recommendation: Require detailed reporting of maternal and infant outcomes by race, insurance type, and location to guide resource allocation.

Conclusion

Addressing the maternal health crisis requires long-term solutions that strengthen access at every step of care. It all starts with mom, the matriarch of households. Lack of transportation, inflexible work schedules, and experiences of bias within the healthcare system, make timely care difficult for many women. If these barriers are not addressed or removed, disparities will persist. Across research, policy, and lived experience, the message is consistent: maternal and infant outcomes depend on access and prioritization. Ensuring that every mother can obtain prenatal care remains the foundation of maternal and infant health equity.

Improving Access to Reproductive Healthcare Through Medicaid

Led by Brianna Paden-Williams

With Contributions from Maxilia Desir

Introduction

Since 1965, Medicaid, a federal and state-mandated program, has provided health coverage for millions of low-income adults, children, and people living with a disability in the United States. As the largest source of health coverage in the United States, roughly 1 in 5 Americans are enrolled in Medicaid.[48] NJ FamilyCare, New Jersey's Medicaid program, insures over 1.8 million New Jerseyans and serves as the primary payer for over 50% of births state-wide.[49]

Medicaid plays a key role in providing access to reproductive care and maternal health services for millions of pregnant women, including contraception, abortion care services, prenatal and postpartum care. Through NJ FamilyCare, pregnant people are guaranteed coverage throughout their pregnancy and coverage for 12 months postpartum with benefits such as community doula care, mid-wifery, and lactation or breastfeeding services.[50]

Nonetheless, clinics and hospitals serving a high proportion of Medicaid patients often face challenges that contribute to lower overall quality of care, stemming from broader structural and systemic financial constraints like reimbursement disparities, implicit bias, shortage of staff, and administrative burdens. For Black and Brown women, health inequities and structural racism continue to further the gap in adverse outcomes and disparities in maternal and infant health. In Mercer County, while the overall infant mortality rate has decreased, Black women remain almost three times higher in mortality rates compared to their White counterparts.[51]

Context of the Changing Medicaid Landscape

Medicaid is experiencing unprecedented changes after the passage of *H.R.1-One Big Beautiful Bill Act (OBBBA)*. The law includes substantial cuts to Medicaid—reaching nearly $1 trillion over the next decade—and dozens of other life-changing Medicaid-related provisions. Key provisions in *H.R.1-OBBBA* include increased eligibility check—from every

12 months to 6 months—and new adult work requirements under the *Affordable Care Act* (ACA) expansion group. With nearly 29% of New Jersey Medicaid recipients being part of the ACA expansion group, and with a projected 50,000 residents expected to lose Medicaid due to more frequent eligibility checks, the bill proposes major lapses in healthcare coverage across the state.[52] While pregnant and postpartum Medicaid enrollees are exempt from the work requirements, the indirect effects may threaten the safety net that provides crucial prenatal and maternal health care to pregnant women who receive Medicaid.

Additionally, *H.R.1-OBBBA* endangers crucial abortion-related services, eliminating Medicaid reimbursements for abortion providers and threatening over $800,000 in Medicaid funding. Roughly one-third of Planned Parenthood's patients in New Jersey use Medicaid as their primary form of insurance, cutting this funding will put thousands of clinics at risk of closing their doors, threatening essential reproductive and maternal health care for Medicaid members.[53]

Health Equity and Maternal Care Access Disparities in Medicaid Utilization

In 2021, NJ FamilyCare offered a new doula care benefit to support Medicaid members during pregnancy and postpartum to improve birth outcomes and experiences.[54] However, less than 1% of pregnant Medicaid recipients in Central New Jersey reported using the doula benefit in 2024, according to Trenton Health Team (THT). Through interviews with women receiving Medicaid, community doulas, and key stakeholders in the Greater Trenton area, THT identified key barriers and challenges to better understand the community doula benefit's low use rates, including lack of awareness and uncertainty on how to access it, demonstrating a greater need for community outreach and education.

Nonetheless, it is critical to acknowledge how doula participation in Medicaid billing is constrained. In community conversations, doulas expressed difficulty in navigating the Medicaid community doula certification pathway. Insufficient reimbursement rates further reduced their participation. Through Horizon, a major insurance provider, only 15

community doulas serve Mercer County as of 2025, with figures reflecting an even greater insufficiency in preceding years.

Additionally, midwives, licensed healthcare providers who are standard providers of care in many countries, attend fewer than 10% of births in New Jersey.[55] However, unlike the community doula benefit, midwifery services have seen substantial increases in usage among Medicaid recipients in Mercer County and Central New Jersey. In Mercer County, 84% of eligible Medicaid recipients used midwifery benefits in 2024, a large increase compared to 2022, according to a data analysis conducted by Trenton Health Team through the Regional Health Hub initiative.

While midwifery is covered under NJ FamilyCare, barriers to its access persist. Through interviews with Medicaid members, THT observed a lack of knowledge about the differences between midwives and doulas, uncertainty about seeing midwives during prenatal visits, and unawareness that a midwife can be requested through Medicaid. Beyond community doulas and midwives, breastfeeding, or lactation support, is an essential service covered by NJ FamilyCare that provides breastfeeding equipment and supplies with a prescription from a provider, or access to lactation counseling. In Mercer County, 1 in 4 Medicaid recipients who gave birth utilized breast pump services through Medicaid, with higher usage among Black and Hispanic populations. Compared to the available doula benefit or midwifery services, Medicaid enrollees knew more about available breastfeeding equipment or supplies through their coverage. However, some participants were not aware that lactation support or consultation could be provided for additional care through their benefits. This underscores the importance of educational awareness on catalyzing the change needed to improve reproductive and maternal health outcomes of Medicaid recipients.

Policy Recommendations

1. Diversify the Perinatal Workforce in New Jersey

Why it matters: It's evident that midwives and doulas during pregnancy, birth, and the postpartum period improves birth outcomes, increases childbirth care quality and patient satisfaction.[56]

Recommendations: Build a workforce pipeline through programs, policies and certifications to recruit new doulas and midwives into the workforce.

2. Improve Medicaid Certification Pathways and Doula Reimbursement Rates

Why it matters: Low Medicaid reimbursement rates for doulas remain a barrier to workforce growth and sustainability.[57]

Recommendations: Increase the reimbursement rate for doulas. Streamline credentialing and billing processes to ensure doulas can enroll as providers for NJ FamilyCare and managed care organizations.[58]

3. Increased Access to Perinatal Care

Why it matters: For most Americans, access to health care starts with health insurance.[59] Although health coverage before and after pregnancy is linked to better outcomes, pregnant Medicaid enrolled members are more likely to report having no postpartum visits, receiving less emotional and practical support at home after birth, and lacking decision-making autonomy during labor and delivery.[60]

Recommendations: Create clear pathways to increase utilization of perinatal care including intentional targeting of Medicaid benefits to Black, Brown, and Indigenous people who experience alarming racial disparities in maternal health outcomes.

4. Address Systematic Barriers that Cause Disparities for People of Color

Why it matters: Racism is embedded in the New Jersey maternity care system and significantly contributes to the poor outcomes seen in pregnant women of color.[61] In Mercer County, Black mothers have a much higher likelihood of experiencing pregnancy-related complications compared to White mothers.

Recommendation: We cannot improve maternal and infant health outcomes without addressing the systemic racism and social determinants of health that are important factors in one's health outcomes.

5. Expand Member Education and Outreach to Medicaid Recipients

Why it matters: It's important for Medicaid members to understand how to access and utilize benefits covered through their health plan, including doula care, midwifery, and lactation support.

Recommendations: Raise awareness of the unique role and distinction of doulas and midwives compared to physicians and other healthcare providers in perinatal care.[62]

Conclusion

In New Jersey, Black women are seven times more likely to die from maternity-related complications compared to their counterparts.[63] From expanding postpartum Medicaid coverage to 365 days per year for mothers and infants, to the new Nurture NJ-borne Maternal and Infant Health Innovation Center, New Jersey has made significant progress in advancing access to reproductive healthcare. To build on this progress in improving health outcomes for Medicaid recipients, we offer key policy recommendations that envision a future where everyone in New Jersey can access the healthcare they deserve. From the looming federal

cuts to Medicaid, to the ever-changing landscape of reproductive healthcare, the state can turn the tide with significant investments to ensure we protect Medicaid members and improve access to perinatal care and health outcomes for all women in New Jersey.

Midwives

Led by Julie Blumenfeld

With Contributions from Erin-Ellen Dillon-Fink

Introduction

Since 2000, the maternal mortality rate in the United States has been rising. The most current data indicates there were 18.6 maternal deaths per 100,000 live births, more than double the rate in comparison with other high-income countries.[64] Additionally, in the U.S., access to care during pregnancy, childbirth, and the postpartum period is limited; greater than one-third of counties are maternity care deserts.[65] This shortage of perinatal care providers, which leads to poor quality of care, is exacerbated by racial and socioeconomic inequities, resulting in even greater disparities in perinatal outcomes for people of color.[66] There is an immediate need to mobilize evidence-based, actionable change to impact the unacceptable maternal mortality ratio and stark health disparities in the U.S.

Historical Context of Perinatal Care in the United States

Maternal health care has gone through dramatic shifts throughout history from power dynamics, social attitudes, medical innovation, and policy. In the early 19th century, childbirth was overseen by women of color and immigrants, who predominantly were enslaved or indentured.[67] The critical role of midwives, particularly granny midwives, who

were traditional African American women in the southern U.S. and provided most of the perinatal care for much of early American history, is often overlooked. However, African American, Indigenous, or immigrant women provided skilled, community-based maternal care, long before the advent of modern obstetrics. Through apprenticeship and intergenerational knowledge, granny midwives attended births across rural and underserved communities, contributing to improved maternal outcomes despite limited access to formal medical resources.[68]

At the start of the 20th century, perinatal care started becoming increasingly medicalized, and granny midwives were intentionally portrayed as dangerous. Tides turned with the influence of the *1910 Flexner Report*, where midwives were falsely represented as outdated, and dangerous births increasingly began to take place in the hospital setting as a result.[69] Interventions like forceps and twilight sleep became increasingly popular despite their lack of proven safety.[70] Then with the *1921 Sheppard–Towner Maternity and Infancy Protection Act*, which regulated the practice of perinatal care and increasingly regulated midwifery licensure and practice, the ability of granny midwives to care for patients was starkly reduced.[71] This act also focused on shifting care into prenatal clinics and hospitals and out of the community, which restricted access for patients to community birth settings.[72]

Despite the evidence that midwifery-attended births in any setting had lower rates of maternal sepsis than physician-attended births in New York in 1913 (22% vs. 69%), the public health campaign continued to encourage pregnant women to seek physician-led care in hospitals.[73] By the mid-20th century, most births were occurring in hospitals, and while maternal mortality had dropped from 47 in 100,000 live births to 8 per 100,000 by 1982, the data does not accurately reflect all the changes in hygiene, infection control, and overall screening of pregnant and postpartum patients rather simply tells the story of hospital birth versus community.[74] However, the dramatic decline in community birth rates during this period significantly limits the availability of comparative data, making it difficult to draw

definitive conclusions about maternal mortality outcomes in community-based midwifery settings versus hospital-based care.

The Health Case for Midwives

Research supports that midwives both improve perinatal health outcomes and reduce health disparities including reduced rates of neonatal mortality, preterm birth, and increased breastfeeding success, which could confer important long-term health benefits specifically for Black women.[75] Midwifery is not only associated with improved clinical outcomes; it is also cost-effective. Data shows that holistic midwifery-led care, focusing on patient autonomy and education, yields comparable or better health, cost, and quality outcomes when compared to physician-led care.[76] Despite this evidence supporting the value added of midwifery-led care, certified nurse midwives (CNMs) and certified midwives (CMs) attend only approximately 11% of vaginal births in the U.S. with extremely limited access.[77] In contrast, in many countries with far better perinatal health outcomes, midwives are well-integrated and are the majority perinatal care provider.[78]

Comparison of Certified Nurse Midwives, Certified Midwives, and Certified Professional Midwives[79]

Clarifying the distinctions among professional midwifery credentials in the United States

National Midwifery Credentials in the United States of America	Certified Nurse-Midwife (CNM)	Certified Midwife (CM)	Certified Professional Midwife (CPM)
EDUCATION			
Minimum Degree required for Certification	Graduate Degree		Certification does not require an academic degree but is based on demonstrated competency in specified areas of knowledge and skills.
Minimum Education Requirements for Admission to Midwifery Education Program	Bachelor's Degree or higher from an accredited college or university AND		High School Diploma or equivalent
	Earn RN license prior to or within midwifery education program.	Successful completion of required science & health courses and related health skills training prior to or within midwifery education program.	Prerequisites for accredited programs vary, but typically include specific courses such as statistics, microbiology, anatomy and physiology, and experience such as childbirth education or doula certification. There are no specified requirements for entry to the North American Registry of Midwives (NARM) Portfolio Evaluation Process (PEP) pathway: an apprenticeship process that includes verification of knowledge and skills by qualified preceptors.
Clinical Experience Requirements	Attainment of knowledge, skills, and professional behaviors as identified by the American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Education. Clinical education must occur under the supervision of an American Midwifery Certification Board (AMCB)-certified CNM/CM or other qualified preceptor who holds a graduate degree, has preparation for clinical teaching, and has clinical expertise and didactic knowledge commensurate with the content taught; >50% of clinical education must be under CNM/CM supervision.		Attainment of knowledge and skills, identified in the periodic job analysis conducted by NARM. NARM requires that the clinical component of the educational process must be at least two years in duration and include a minimum of 55 births in three distinct categories. Clinical education must occur under the supervision of a midwife who must be nationally certified, legally recognized and who has practiced for at least three years and attended 50 out-of-hospital births post certification. CPMs certified via the PEP may earn a Midwifery Bridge Certificate (MBC) to demonstrate they meet the International Confederation of Midwives (ICM) standards for minimum education.
EDUCATION PROGRAM ACCREDITING ORGANZATION			

	The Accreditation Commission for Midwifery Education (ACME) is authorized by the U.S. Department of Education to accredit midwifery education programs and institutions. Midwifery education programs must be located within or affiliated with a regionally accredited institution.		The Midwifery Education Accreditation Council (MEAC) is authorized by the U.S. Department of Education to accredit midwifery education programs and institutions. The scope of recognition includes certificate and degree-granting institutions, programs within accredited institutions, and distance education programs.
SCOPE OF PRACTICE			
Range of care provided	Midwifery as practiced by CNMs and CMs encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan and care for the healthy newborn during the first 28 days of life. CNMs/CMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; independently prescribe medications; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order medical devices, durable medical equipment, and home health services. Midwifery care as practiced by CNMs and CMs includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling. These services are provided in partnership with individuals and families in diverse settings such as ambulatory care clinics, private offices, telehealth and other methods of remote care delivery, community and public health systems, homes, hospitals, and birth centers.		Midwifery as practiced by CPMs offers care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. CPMs provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period, as well as maternal and well-baby care through the 6-8 week postpartum period. CPMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment. CPMs are educated to recognize conditions requiring consultation with and/or referral to other healthcare professionals. They conduct physical examinations, administer medications, and use devices as allowed by state law, order and interpret laboratory and diagnostic tests.
Practice Settings	All settings - hospitals, homes, birth centers, and offices. The majority of CNMs and CMs attend births in hospitals.		Homes, birth centers, and offices.
Prescriptive Authority	All US jurisdictions	Maine, Maryland, New York, Rhode Island, Virginia, Washington DC	CPMs do not maintain prescriptive authority; however, they may obtain and administer certain medications in select states.
Third Party Reimbursement	Most private insurance; Medicaid coverage mandated in all states; Medicare, TRICARE	Most private insurance; Medicaid coverage in Maine, Maryland, New York, New Jersey, Rhode Island, and Washington, DC	Private insurance mandated in 6 states; coverage varies in other states; 13 states include CPMs in state Medicaid plans
CERTIFICATION			

NATIONAL MIDWIFERY CREDENTIALS IN THE UNITED STATES	CERTIFIED NURSE-MIDWIFE (CNM)	CERTIFIED MIDWIFE (CM)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)
Certifying Organization	American Midwifery Certification Board (AMCB)		North American Registry of Midwives (NARM)
	AMCB and NARM are accredited by the National Commission for Certifying Agencies		
Requirements Prior to Taking National Certification Exam	Graduation from a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME); AND Verification by program director of completion of education program AND Verification of master's degree or higher *CNMs must also submit evidence of an active RN license at time of initial certification		Graduation from a midwifery education program accredited by the Midwifery Education Accreditation Council (MEAC) OR Completion of NARM's Portfolio Evaluation Process (PEP) OR AMCB-Certified CNM/CM with at least ten community-based birth experiences OR Completion of an equivalent state licensure program All applicants must also submit evidence of current adult CPR and neonatal resuscitation certification or course completion
Recertification Requirement	Every 5 years		Every 3 years
LICENSURE			
Legal Status	Licensed in 50 states plus the District of Columbia and U.S. territories as midwives, nurse-midwives, advanced practice registered nurses, or nurse practitioners.	Licensed in Arkansas, Colorado, Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, Virginia, and the District of Columbia.	Licensed in 37 states and the District of Columbia.
Licensure Agency	Boards of Midwifery, Medicine, Nursing or Departments of Health	Boards of Midwifery, Medicine, Nursing, Complementary Health Care Providers or Departments of Health	Boards of Midwifery, Medicine, Nursing, Complementary Health Care Providers; Departments of Health or Departments of Professional Licensure or Regulation
PROFESSIONAL ASSOCIATION			
	American College of Nurse-Midwives (ACNM)		National Association of Certified Professional Midwives (NACPM)

Health Equity and Midwifery Disparities

There are numerous impediments to midwifery care in the United States, including restrictions that curtail midwives from obtaining a license to practice, prescribing medications, admitting patients to hospitals, and placing orders to actualize their care. Midwives are also hindered from providing specific care such as abortion care and receive disparate reimbursement rates for care provision.

Midwifery Education

The United States Government Accountability Office (GAO) cites both high tuition costs and limited clinical training opportunities as key challenges to accessing midwifery education.[80] These challenges disproportionately affect students from underrepresented backgrounds, limiting diversity within the midwifery workforce. The GAO report also highlights lack of funding for preceptors (i.e., practicing midwives who agree to supervise and teach students at clinical sites) as a barrier to educating and training potential midwifery students.[81]

Cost

A survey targeting potential midwives from such groups found that over half considered tuition expenses a significant obstacle to pursuing midwifery.[82] To address this issue, the ACNM has identified direct funding for midwifery education as the top priority for expanding the midwifery workforce.[83] Midwifery education is rapid and cost-effective compared to OB/GYN training, making it a valuable strategy for expanding the perinatal workforce.[84]

Availability of Clinical Training Opportunities

Limited clinical training opportunities hinder the growth of midwifery educational programs and, consequently, the midwifery workforce. Nationally, there are limited clinical placement spots for midwifery students. The lack of compensation for preceptors deters their participation and limits student placements.[85] Unlike medical training, federal funding to

support midwifery preceptors or students at clinical training sites is extremely limited.[86] This incentivizes hospitals to prioritize OB/GYN resident education over midwifery students which reinforces the existing workforce hierarchy.[87]

Lack of Diversity in Midwifery Programs

Students' reports of racism during midwifery training underscore the need for increased racial and ethnic diversity in the workforce.[88] A survey of underrepresented aspiring midwives reported that 38% of respondents considered the lack of midwives with the same racial identity a significant barrier to entering a midwifery education program.[89] Furthermore, the shortage of clinical training exacerbates this issue, leaving students with limited options and the potential to endure racism due to a lack of alternative training sites.

Autonomous Practice

In many states, midwives must meet educational and certification requirements to be licensed and therefore, practice legally. However, in 18 states, licensure additionally requires that midwives enter a practice agreement with a physician.[90] These agreements impose unnecessary burdens on midwives, limit their practice autonomy, and perpetuate a culture that undervalues them. These requirements limit the number of midwives in practices; states allowing autonomous practice had twice as many CNMs per 1,000 births and a greater share of CNM-attended births compared to states with agreement requirements.[91] Legislative restrictions that make licensure conditional upon a practice agreement with a physician create a system where workforce growth depends on physicians wanting to work with midwives rather than consumers' desire to access midwifery care.[92]

Prescriptive Authority

Prescriptive authority allows midwives to prescribe medications. Midwives can independently prescribe within the scope of their practice in 27 states and the District of Columbia. In the remaining states, like states with restrictions on licensure, midwives must

attain a practice agreement with a physician to prescribe. These restrictions vary; they may apply to all medications or be limited to narcotics or abortifacients.[93]

Admitting Privileges

Two states in the U.S. have legislation that ensures midwives can both be part of medical staff and have admitting privileges within hospitals. In 27 states, midwives are explicitly required to have a physician admit patients on their behalf. In the remaining states, this decision is left to the discretion of individual hospitals.[94]

Reimbursement for Care

Although midwives are reimbursed by Medicaid at the same rate as their physician colleagues in 31 states, they receive only a portion of that fee in the remaining states. Adjusted fees for midwifery care range from 75-97% of the physician reimbursement rate.[95] These low rates not only diminish the feasibility of financially sustainable, independent, midwifery practices, but the lower payment rates from Medicaid compared to private insurance can discourage midwives from providing care to Medicaid beneficiaries.[96] This especially problematic for birth centers, where reimbursement rates may not adequately cover costs in several states. Increasing payment levels and expanding insurance reimbursement to cover midwifery services across all birth settings could help improve access to midwifery care.

Policy Recommendations

1. Incentivize Expansion and Diversification of Midwifery Workforce

Why it matters: This effort needs to be undertaken in tandem with increasing opportunities for midwives to practice within states, including reducing barriers to attending births in homes and birth centers. Conditions that contribute to high attrition rates from clinical practice must be identified and addressed, such as poorly integrated maternity practices, a lack of respect from other healthcare professionals, and insurance barriers.

Recommendations: Incentivize state-level funding for midwifery programs housed in state universities to be used for student scholarships. Allocate federal and state funds to support midwifery programs housed in state universities to create faculty practices to facilitate student placements in clinical settings. Improve midwifery clinical training by offering federal and state reimbursement and incentives to clinical sites and preceptors hosting student midwives' clinical rotations parallel to the model in place for physician education. Improve infrastructure for education and training of midwives to increase workforce capacity and flexibility. Prioritize supporting people of color interested in pursuing midwifery careers across all three certifications.

2. Reduce Barriers to Midwifery

Why it matters: Removing restrictive practice regulations, including eliminating collaborative practice and billing agreements with physicians, grants midwives the autonomy to provide independent care, including admitting and prescribing medications.

Recommendations: Create independent State Boards of Midwifery in all states on which most voting members are midwives to oversee regulatory and licensing issues and facilitate a culture of midwives working to the "top of their license." Improve funding and practice of midwifery care regardless of birthing location in hospitals, birth centers, or home. Support changes and programs to improve safety in hospital transfer from planned community births. Strengthen the use of team-based integrated care that meaningfully incorporates the midwifery model. Promote and increase support for midwifery-led models of care. Implement public messaging campaigns to increase awareness of the midwifery-led model of care.

3. Improve Data Collection Supporting Long-Term Development for Midwifery Workforce

Why it matters: Opportunities to improve reporting systems and data collection to ensure that midwives providing care are documented on birth certificates will help enable research on midwives' contributions to birth outcomes.

Recommendations: Expand and improve workforce demographic and practice data collected by state-level divisions that regulate midwifery practice. Items that should be collected include race, ethnicity, spoken languages, practice characteristics, practice location and school attended for terminal degree. Conduct surveys of midwives when updating or renewing their state licenses which parallel data collected during physician licensure renewals. Conduct research on the quality and accuracy of birth certificate data reporting of births attended by midwives. Conduct research on the location of birth to better understand and document the role of midwives in birth centers and home births.

Conclusion

To increase access to midwifery care and its proven benefits, we must work to remove the barriers that make it difficult to grow and sustain the midwifery workforce. These key strategies address specific modifiable barriers known to limit access to midwifery education and increase the number of practicing midwives in the United States. Many recommendations related to increasing access to midwifery-led care overlap, and improvements in one area are likely to have a spillover effect and impact another. For example, improving reimbursement rates and models can support expansion and diversification of the workforce and reduce barriers to practice. Thus, there are multiple pathways and opportunities for improvement, and thereby, multiple chances for us to leverage the power of midwives and change the future of reproductive and maternal healthcare.

Doulas

Led by Aleha Cruz

Introduction

High-quality, affordable, and accessible health care are foundational pillars of a health system. Yet, far too often, individuals, especially women of color, are forced to choose between these essentials, or worse, are denied them altogether. In the birthing space, women of color frequently experience a communication disconnect with providers, resulting in delayed interventions, unmet needs, and avoidable complications. Too often, their voices are disregarded in moments when they are most vulnerable.

One of the most effective tools to combat these inequities is education. When patients are informed about their care, their rights, and their options, they are empowered to advocate for themselves. However, education alone is not enough, especially when systemic barriers persist. That is why community-based support systems like doulas are critical.

Maternal Health Context and Equity Analysis

The United States is currently in a crisis of disproportionate barriers, maternal health inequities, and a lack of affordable healthcare, all of which have devastating outcomes on maternal and reproductive health. Nationally, Black women face a maternal mortality rate of 50.3 deaths per 100,000 live births, compared to 14.5 for White women, making them three to four times more likely to die from pregnancy-related causes regardless of income or education.[97] Systemic racism, historical medical bias—like the misconception that Black women experience less pain than White women—and contemporary structural barriers, contribute to these inequities with long-standing and harmful consequences.

These factors laid the foundation for medical neglect and mistreatment, particularly in gynecological care, and continue to shape the racial and gender-based disparities seen in maternal health outcomes today. In New Jersey, Black non-Hispanic women experience a pregnancy-related mortality ratio of 39.2 deaths per 100,000, compared with 5.9 per 100,000 for non-Hispanic White women: more than six times higher.[98] Over 90% of pregnancy-related deaths in the state are deemed preventable.[99] Since Black and Brown voices are too often minimized or dismissed in medical spaces, warning signs can be overlooked until it is too late.

Doulas serve as trusted advocates, educators, and companions throughout pregnancy, labor, and postpartum. For women of color, doulas often provide culturally competent care and serve as a bridge within medical systems that may overlook or dismiss them. Research consistently demonstrates that doula presence improves birth outcomes, reduces unnecessary interventions and enhances patient satisfaction.

Policy Recommendations

1. Medicaid Expansion for Doula Services

Why it matters: Cost remains a significant barrier to accessing doula care for low-income and marginalized women, despite strong evidence demonstrating its benefits. Medicaid coverage for doula services would increase access to continuous emotional, educational, and advocacy-based support throughout pregnancy, labor, and postpartum. Doula involvement has been shown to reduce unnecessary medical interventions, improve patient-provider communication, and support early identification of complications such as preeclampsia, helping to prevent costly emergency outcomes and improve maternal health equity.

Recommendations: Provide Medicaid expansion for doula services through state plan amendments. Enroll doulas as Medicaid providers with NPI numbers. Set reimbursement rates for prenatal, during-labor, and postpartum care.

2. Improving Doula Workforce Development and Training

Why it matters: Workforce development is essential to ensure an adequate supply of trained, culturally competent doulas serving communities most impacted by maternal mortality. Investing in training and certification programs—particularly those that recruit doulas from Black and Brown communities—helps build trust, improve health literacy, and strengthen patient advocacy. A diverse and well-supported perinatal workforce can alleviate provider shortages, improve continuity of care, and enhance overall birth experiences and outcomes.

Recommendations: Establish sustainable, paid, training pathways for doulas. Provide mentorship opportunities to reduce burnout in doulas. Facilitate peer networks to support doulas.

3. Establishing Clear Hospital and Facility Standards

Why it matters: Establishing clear hospital and facility standards for respectful maternity care is critical to addressing disparities in treatment and outcomes. These measures promote accountability, consistency, and safer clinical environments across healthcare systems.

Recommendations: Implement standards that prioritize informed consent, implicit bias training, and clear escalation pathways for patient concerns. Ensure that warning signs are taken seriously and acted upon promptly.

4. Strengthen Maternal Mortality Review Committees

Why it matters: Strengthening Maternal Mortality Review Committees is essential for identifying patterns, root causes, and preventable factors contributing to pregnancy-related deaths. Incorporating community perspectives and perinatal support professionals helps ensure that findings reflect lived experiences and inform actionable policy and practice changes. Strong review committees support data-driven prevention strategies and system-level improvements.

Recommendations: Diversify Maternal Mortality Review Committees to include a broad range of clinical and community experts to fully understand circumstances surrounding a death. Secure consistent state and federal funding and resources. Implement strong "data to action" frameworks to identify areas of improvement and inform policy change.

5. Equity Requirements for Publicly Funded Perinatal Programs

Why it matters: Equity requirements are necessary to ensure that publicly funded maternal health programs effectively reach populations at highest risk. These requirements reinforce a commitment to maternal health equity and measurable outcomes.

Recommendations: Establish equity benchmarks and accountability measures to help identify service gaps, improve program effectiveness, and ensure that public investments are aligned with reducing racial disparities.

Conclusion

Maternal mortality remains a pressing public health and social justice crisis for women of color. When patients understand their care, rights, and options, they are empowered to advocate for themselves. Yet education alone is insufficient, especially within a system already shaped by barriers and inequities. Black and Brown women in New Jersey face

dramatically higher risks of preventable death, reflecting deep structural inequities in healthcare access, quality, and responsiveness. Evidence-based interventions such as doula support, patient education, and
culturally competent care are vital strategies for improving outcomes and reducing disparities.

Lowering Maternal Mortality Rates

Led by Maxilia Desir

Introduction

Maternal health inequities in New Jersey are rooted in the broader history of reproductive injustice in the United States. For decades, discriminatory practices such as forced sterilization and restrictive access to contraception has undermined trust in health systems, particularly for communities of color.

The United States has the highest maternal mortality rate among high-income nations, with the burden falling disproportionately on Black women. In New Jersey, this disparity is even greater: Black women are approximately seven times more likely to die from such causes, and Black infants are three times more likely to die before their first birthday.[100] These outcomes reflect persistent inequities in access to high quality care, the influence of bias within clinical settings, and long-standing underinvestment in community-based support systems.

Maternal Mortality: Why it Matters

Fragmentation in service delivery across maternal care and delivery magnifies health disparities. Variation in coverage across Medicaid, the Supplemental Prenatal and

Contraceptive Program (SPCP), and commercial insurance lead to unequal access to essential perinatal services, including midwifery care, doula support, lactation counseling, and behavioral health. Structural barriers such as lack of transport, housing instability, and lack of culturally concordant care undermine adherence to prenatal and postpartum care plans, thereby increasing the risk of maternal morbidity and mortality.

Policy Recommendations

1. Leveraging Organizations Dedicated to Maternal Mortality

Why it matters: There are organizations within New Jersey that are dedicated to reducing maternal mortality and morbidity. Leveraging their powerful voices and shared commitment to reproductive justice, significant strides in reducing maternal mortality can be made.

For instance, Nurture NJ is a strategic plan launched by First Lady of New Jersey, Tammy Murphy, with the goal of making the state the safest and most equitable state for childbirth and raising children.[101] The initiative's overall goal is to reduce New Jersey's maternal mortality rate by 50% and ensure equity in care for mothers and children of all races, backgrounds, and ethnicities. Nurture NJ works tirelessly to ensure that health equity is achieved, and for the state of New Jersey to see improved statistics in overall maternal and infant morbidity and mortality rates.[102]

Additionally, aligning with Nurture NJ, the New Jersey Health Care Quality Institute's (NJHCQI) has a maternal health strategy that operationalizes its goals through its initiatives. For example, their Maternity Action Plan is a statewide blueprint structured around four pillars: (1) building the perinatal workforce with an emphasis on diversity and cultural competence, (2) reforming payment systems to encourage equity and quality, (3) strengthening community-based support, and (4) improving data collection and use to enhance accountability.[103]

Maternal mortality rates also have a close relationship with mental health. In partnership with the Mental Health Association in New Jersey, NJHCQI leverages initiatives to equip perinatal community health workers and other providers with tools to identify and respond to mental health or substance use challenges during both pregnancy and postpartum periods.[104] Using existing initiatives, and founding new ones, allow for spaces of shared perspectives and resources to implement powerful, sustainable change.

Recommendations: Use organizations to implement and train healthcare staff and providers on patient safety. Leverage organizational data and state reporting to identify local and actionable trends in preventable maternal deaths. Partner with community-based organizations to provide ongoing, equity-focused training on major drivers of maternal mortality and respectful care.

2. Advancing Equity

Why it matters: Improvements in maternal health outcomes demand a systemic, transparent approach to quality improvement. Research outlines that regulatory and policy reforms are needed to fully integrate midwifery into the maternity care system. Previous recommendations, including the establishment of an independent midwifery board, expanded prescriptive authority, Medicaid reimbursement parity, and the development of additional educational pathways, are several pivotal parts of a functional, equitable healthcare system.

Recommendations: Integrate of racial equity metrics into all maternal health quality measures. Expand culturally concordant care by diversifying the workforce and creating early-career pipeline programs for Black, Indigenous, and other underrepresented clinicians. Center patient autonomy through shared decision-making tools and community-informed models of care. Integrate community-based organizations into perinatal care networks to address the social determinants of health. Sustain statewide

data transparency to monitor disparities and ensure accountability. Benchmark hospital services and outcomes. Establish Perinatal Community Advisory Boards (PCABs) to elevate patient and community voices and expertise.

3. Supporting Perinatal Mental Health First Aid

Why it matters: Mental health conditions are a leading cause of maternal mortality, yet many go unrecognized and untreated, especially in communities that face systemic barriers to care. Several statewide organizations have emphasized the intersection of mental health and maternal mortality in an attempt to eliminate stigma and improve health outcomes. For example, NJHCQI partnered with the Mental Health Association in New Jersey to develop the nation's first perinatal case studies for use in Mental Health First Aid (MHFA) training.[105] Their perinatal mental health initiative equips perinatal community health workers and others with the tools to identify the signs of mental health or substance use challenges and how to assist someone experiencing symptoms. However, in order to truly create change, perinatal mental health first aid efforts must be expanded.

Recommendations: Use scalable and replicable tools that provide blueprints and can be adapted by other initiatives to reduce maternal mortality (i.e. the NJHCQI Maternity Action Plan (MAP) and the Perinatal Mental Health First Aid (MHFA) case studies, or the Nurture NJ Strategic Plan).[106,107] Ensure each initiative is tied to measurable indicators. For example, in NJHCQI's *Raising the Bar,* maternal morbidity and mortality rates, patient satisfaction, and the number of Shared Decision-Making (SDM) conversations documented in patient records are tracked. Hospital adherence to benchmarking standards and community engagement through PCAB activities are also assessed.[108]

Conclusion

New Jersey possesses the policy framework, stakeholder engagement, and pilot-tested interventions necessary to become a national leader in maternal and infant health equity.

Achieving this vision requires a sustained commitment to dismantling systemic racism in health care, ensuring that community voices influence reform, and investing in integrated, patient-centered care models.

Every woman should be able to access the necessary care needed during pregnancy, childbirth, and the critical months following birth. This care is vital for establishing a healthy bond between parent and child, setting the stage for the child's well-being. By ensuring the mother's safety before, during, and after pregnancy, we can give children a healthy start and prevent future health issues that are otherwise avoidable. Adequate maternal health directly correlates with lower rates of premature birth, low birth weight, and other neonatal complications. This proactive approach to care is powerful, preventing future, long-term health issues for the child ranging from chronic illnesses to developmental delays that are otherwise avoidable with timely and comprehensive care. By embedding these strategies into the state's health care infrastructure, New Jersey can both reduce maternal mortality and close the racial equity gap in maternal and infant outcomes.

Reducing Racial and Linguistic Disparities in Maternal Care

Led by Milibeth Castro and Rina Ramirez

Introduction

Maternal health disparities in the United States have deep historical roots, embedded in systemic racism, medical bias, and persistent social inequities. Since the earliest days of American obstetrics, Black and Indigenous women have faced coercion, experimentation, and neglect, leading to entrenched mistrust and consistently poorer health outcomes. Notably, during slavery, Black women were subjected to forced labor and reproductive control, often enduring medical abuses such as those conducted by J. Marion Sims, the

"father of modern gynecology," who performed surgical experiments without anesthesia or consent on enslaved Black women.[109] Historical practices, including the forced sterilization of women of color, unethical medical experimentation, and discriminatory treatment within healthcare institutions, have played a direct role in shaping today's maternal health disparities. These violations have left lasting harm and have fostered deep mistrust and apprehension toward healthcare providers within affected communities.

Throughout the 20th century, eugenics programs institutionalized racial discrimination in healthcare through coerced sterilization, disproportionately targeting women of color.[110] Policies and practices during the Jim Crow era and subsequent systemic segregation further limited access to quality healthcare for minorities, leading to generational health disparities. By the 1930s, more than half of U.S. states had enacted eugenic sterilization laws, targeting individuals deemed "unfit" to reproduce, a designation often based on racist, ableist, and xenophobic criteria. In the South, Black women were especially vulnerable. The term "Mississippi Appendectomy" was coined to describe the routine sterilization of Black women, often without their knowledge or consent, during unrelated medical procedures at public hospitals.[111] These sterilization programs were part of a broader effort to control the reproduction of marginalized groups through state-sanctioned population control.

Latina women were disproportionately affected during the 1920s to 1940s, with studies documenting that they were more likely to be sterilized than white women. The case of *Madrigal v. Quilligan* in the 1970s exposed how Mexican American women were coerced into signing English-language consent forms while in labor, often unaware that they were agreeing to permanent sterilization.[112,113]

These injustices were compounded by segregated healthcare systems, underfunded hospitals serving minority communities, and the exclusion of women of color from clinical research.[114] Language barriers have also been associated with unequal access to health care and poorer health outcomes, resulting in delays in accessing prenatal care, reduced or inadequate patient instruction or education, decreased provider and patient satisfaction,

and increased incidence of adverse events. Evidence shows that language discordance results in lack of informed consent, mistreatment during birthing, and more obstetrical trauma among others.[115] Together, these factors created unequal health outcomes for Black, Indigenous, Hispanic, and immigrant mothers.

Institutional racism within health systems ensured that these were not isolated incidents of mistreatment but part of a broader, enduring pattern that continues to shape maternal health today. Hospitals serving communities of color were routinely underfunded, poorly staffed, and lacked essential equipment—conditions that directly led to lower-quality care. For example, in the segregated South, Black patients were relegated to separate wings or even entire facilities that lacked emergency obstetric services and adequate surgical units.[116] Public hospitals often served Black populations under "separate but unequal" conditions. Even in northern cities, hospitals operated with far fewer resources than their counterparts in predominantly White neighborhoods, resulting in delayed treatment and higher maternal and infant mortality rates.[117]

Segregated healthcare systems not only deny communities of color access to high-quality care but also limited advancement opportunities for healthcare workers of color. Admissions to medical schools remained racially restricted well into the mid-20th century, stifling the development of a diverse healthcare workforce.[118] The resulting lack of Black and Brown physicians continues to hinder culturally responsive care and contributes to deep mistrust of medical institutions among communities of color.

Impacts on Maternal Health

Maternal health disparities have steadily gained national attention due to consistent, alarming statistical evidence combined with compelling personal narratives. In 2018, national attention intensified when tennis star Serena Williams publicly shared her near-death experience following childbirth, underscoring how even wealthy, influential Black women face dismissal and negligence within the healthcare system. Her story brought

widespread visibility to the persistent impact of implicit bias and systemic racism in maternal care, demonstrating that these issues transcend socioeconomic status and affect women across all backgrounds.[119] While Williams' experience drew widespread media coverage, it is far from an isolated incident. Countless Black women with far fewer resources face similar or worse outcomes every day, often without public recognition or accountability. These stories collectively reveal deep-rooted inequities within maternal healthcare and emphasize the urgent need for systemic reform.

The COVID-19 pandemic further intensified these disparities, disproportionately impacting maternal health outcomes among women of color. COVID-19 contributed to approximately 25% of all maternal deaths in 2020 and 2021, further worsening existing disparities. The maternal mortality rate for Black, Hispanic, and Latina women rose sharply[120,121] Those who were pregnant with COVID-19 faced a 2.5 times higher mortality risk than those who were not infected, and racial and ethnic disparities were clearly documented in maternal outcomes during the pandemic.[122] Despite clear recommendations from the American College of Obstetricians and Gynecologists (ACOG) endorsing COVID-19 vaccination during pregnancy, misinformation and mistrust contributed to vaccine hesitancy among many pregnant women.[123] The pandemic exposed longstanding structural inequities in maternal care, prompting increased public awareness, advocacy efforts, and policy discussions focused on achieving racial equity in maternal health.

In addition, more clinical research has focused on this issue in response to the rising rates of maternal morbidity and mortality in the United States. Health care organizations undergoing transformations in care delivery, such as becoming Patient-Centered Medical Homes and adopting trauma-informed practices, are implementing evidence-based approaches to reduce disparities, increase health equity, and improve outcomes. Efforts to improve prenatal, birthing, and postpartum experiences are underway through hospital and prenatal program initiatives, as well as through incentives, interagency partnerships, and

expanded data sharing. Policies are being developed and adopted to address the documented health inequities in maternal care.

A History of Racial and Linguistic Disparities

Despite substantial national investments in medical technology and healthcare services, the United States remains one of the most dangerous high-income countries in which to give birth. This crisis is not the result of inadequate medical knowledge or capacity but of systemic failures rooted in structural racism, economic inequality, and insufficient public health infrastructure.

These disparities are not fully explained by socioeconomic status, educational attainment, or insurance coverage. For example, a college-educated Black woman remains at higher risk of maternal death than a White woman with a high school education. This data reflects systemic bias in how care is delivered, not differences in individual behavior or circumstances.

Hispanic women also face elevated maternal mortality rates, with outcomes 3.5 times worse than those of White women. In New Jersey, these disparities are especially pronounced. Although New Jersey improved its national ranking in maternal mortality from 47th in 2021 to 28th in 2023, these gains have not translated into meaningful reductions in racial disparities.[124]

The underlying causes of maternal health inequities are complex and systemic. Studies consistently show that Black and Brown patients are less likely to be believed when reporting symptoms, more likely to have their pain underestimated or ignored, and more likely to experience delays in diagnosis or intervention. Healthcare institutions that serve communities of color are frequently underfunded, understaffed, and unequipped with modern technology. These conditions are the result of long-standing disinvestment.[125]

Unequal Access

Access to maternal healthcare remains profoundly unequal. Women of color are disproportionately affected by maternity care deserts, areas where there is limited or no access to obstetric services, labor and delivery units, or licensed maternity providers. In New Jersey, for example, counties such as Warren and, until recently, Sussex lacked birthing hospitals, forcing women to travel significant distances to give birth.[126] Even in areas where services are present, barriers persist. These include lack of insurance, immigration-related fears, inadequate transportation, childcare responsibilities, discordant language, and inflexible work schedules.

Language access is another critical and often overlooked issue. Women and families with limited English proficiency frequently report inadequate interpreter services during pregnancy, labor, and postpartum care. This lack of communication support increases the risk of misdiagnosis, poor adherence to care plans, and adverse outcomes. Culturally competent care is similarly lacking. Too often, maternal care providers are not representative of the populations they serve, leading to missed opportunities for trust-building, culturally sensitive education, and individualized care.[127]

Insurance coverage, although expanded in New Jersey, remains inconsistent. Many women still fall through coverage gaps, particularly undocumented or ineligible immigrant women. The process of applying for insurance is often complex and confusing, leading to delays in coverage. Many delays seeking care due to financial concerns or fear of immigration enforcement. Transitions from prenatal to postpartum care are often fragmented, leading to care discontinuation at a time when medical attention is critical.

Institutional racism has led to chronic underfunding of hospitals serving marginalized populations, widespread gaps in provider cultural competence, and a lack of accountability for inequitable outcomes. This includes medical training, clinical practice, and public policy. Alongside language barriers, inadequate interpretation services, and fragmented systems of

care, these structural issues create an environment in which preventable maternal deaths remain unacceptably high. Addressing these failures requires a coordinated and comprehensive response grounded in equity, justice, and community-informed solutions.

Every pregnant woman deserves safe, respectful, and high-quality care. Each maternal death that could have been prevented represents a profound loss to a family, a community, and the state.

How It Affects Us

Maternal health disparities are not abstract figures but daily realities with profound consequences for families, communities, and health systems across the United States. Severe maternal morbidity, defined as life-threatening complications during pregnancy or postpartum, affects more than 60,000 women annually, with Black and Latina women disproportionately represented.[128]

More than one-third of counties in the United States have no or very limited maternity care, affecting an estimated 5.5 million women of reproductive age, especially within rural communities.[129] Workforce shortages further compound this crisis. The American College of Obstetricians and Gynecologists projects a national shortfall of between twelve thousand and fifteen thousand obstetrician-gynecologists by 2050.[130] Limited access to maternal-fetal medicine specialists creates additional risks for high-risk pregnancies, as many hospitals do not have subspecialists available and reimbursement challenges limit access to care.[131]

Emerging research highlights how social and environmental conditions intensify risks. Studies show that neighborhood-level deprivation, such as disinvestment, poor housing, and lack of food resources (i.e. food deserts), interacts with medical conditions like hypertension to increase the risk of severe maternal complications.[132] The Nulliparous Pregnancy Outcomes Heart Health Study demonstrated that pregnant individuals living in disadvantaged neighborhoods scored lower on cardiovascular health assessments and

faced higher long-term cardiovascular risks in the years after pregnancy.[133] These findings confirm that pregnancy serves as a "stress test" for long-term cardiovascular vulnerability, especially among women of color.

Federal Impact

Relative to peer nations, the United States remains an outlier. Comparative analyses consistently show that the United States has the highest maternal mortality among high-income countries despite spending more per capita on health care.[134] To place the United States in clearer international context, the World Health Organization reports that the average maternal mortality ratio among high-income countries is roughly one third to one half of the current United States level, even after recent declines.[135] Studies find that continuity models reduce interventions, improve patient experience, and are at least comparable on infant outcomes, with some evidence of reduced preterm birth.[136]

Federal laws and regulations provide partial but incomplete protection. Civil rights requirements under Title VI of the *Civil Rights Act* and Section 1557 of the *Affordable Care Act* mandate nondiscrimination and language access, but enforcement remains uneven and many hospitals fail to provide trained interpreters or translated materials consistently.[137] Workplace protections such as the *Pregnant Workers Fairness Act* and the *Providing Urgent Maternal Protections for Nursing Mothers Act* extend important safeguards, but both laws rely heavily on complaint-driven enforcement, leaving many workers without timely remedies.[138] Emergency care under the *Emergency Medical Treatment and Labor Act* guarantees stabilization in labor regardless of insurance status, yet does not address barriers to ongoing prenatal or postpartum care, leaving critical gaps in continuity.[139] Federal Hospital Conditions of Participation require discharge planning, but they lack specificity for postpartum patients, allowing variable practices that fail to ensure timely follow-up.[140]

The plateauing of maternal mortality in 2024–2025 at levels nearly triple those of peer nations underscores the depth of the United States gap.[141,142] Preventable death proportions

consistently exceed 80% across states, with review committees repeatedly identifying failures in recognition, communication, and follow-up.[143,144] National benchmarks reveal persistent gaps in postpartum visit adherence, especially among Medicaid beneficiaries and women of color.[145] State and federal oversight has acknowledged these failings, but interventions have not yet reached the scale necessary to shift outcomes.

Federal oversight and funding offer opportunities but remain fragmented. HRSA's Title V Block Grant and Healthy Start program support community and Black- and Brown-led organizations, but these programs remain modest relative to the scale of need.[146,147] CDC-funded Perinatal Quality Collaboratives and NIH's IMPROVE initiative provide critical research and translation, but their reach is limited without mandatory adoption by hospitals and health plans.[148,149] The CMS Transforming Maternal Health Model aims to advance equity-centered care, but depends on state uptake and variation in implementation.[150] Collectively, these efforts show progress but also expose persistent weaknesses: voluntary participation, short-term grants, uneven enforcement of civil rights, and insufficient integration of equity into federal payment structures.

This crisis matters because it is accelerating inequities even as the overall maternal mortality rate has declined from its pandemic peak. Every preventable maternal death reverberates through families, workplaces, and communities. The loss destabilizes households, damages community trust in healthcare, and imposes long-term economic burdens on health systems. For New Jersey, where Medicaid covers approximately half of all births, gaps in continuity of care, language access, and specialty reach perpetuate these inequities. Addressing them is both a moral imperative and a public health necessity.

The evidence is clear: maternal health disparities in the United States are preventable, yet they persist because of structural inequities in healthcare systems, discriminatory policies, and gaps in accountability. To reverse these trends, systemic reforms must prioritize equity, continuity, and accountability.

Policy Recommendations

1. *Investing in Black and Brown-led Models of Care*

Why it matters: Culturally congruent care provided by Black and Latina doulas, midwives, and community health workers have been shown to reduce unnecessary interventions, improve patient experience, and increase early help-seeking. When these providers are funded and integrated into the healthcare system, rather than treated as optional pilot projects, families of color experience greater autonomy and earlier recognition of complications. Medicaid reimbursement for doulas, midwives, and home visiting remains inconsistent, creating inequitable access.[151,152,153]

Recommendations: Support and invest in Black and Brown-led models of care through hospital policy and implementation practices. Advocate for Medicaid reimbursement for doulas, midwives, and home caregivers.

2. Funding Community-Based Organizations

Why it matters: Funding community-based organizations is critical to sustain trust, yet current federal investments are modest and often rely on temporary grants rather than durable financing streams.

Recommendations: Actively compensate community members for their time and expertise and ensure that their feedback shapes policy recommendations and quality improvement strategies.

3. Ensuring Comprehensive Language Access

Why it matters: Ensuring comprehensive language access is vital for safety and equity. All patients must have real-time access to trained interpreters and written materials in their preferred language at appropriate reading levels. Although federal law requires this, enforcement is inconsistent, leaving patients vulnerable to dangerous miscommunications.[154,155]

Recommendations: Require hospitals and payers to demonstrate compliance, and federal oversight must link language access to accreditation and payment.

4. Improving Anti-Racism and Implicit Bias Training

Why it matters: Anti-racism and implicit bias training must be mandated, continuous, and tied to measurable outcomes. Current laws and accreditation standards encourage training but stop short of making it enforceable. Without federal requirements, hospitals treat equity training as optional, leaving systemic discrimination unaddressed.

Recommendations: Design training in collaboration with communities, integrated into medical education, and evaluated through accountability metrics.

5. Guaranteeing Paid Family and Medical Leave

Why it matters: Paid family and medical leave must be guaranteed for all individuals who are pregnant or have recently given birth, as well as their partners. While federal law provides job protection under the *Family and Medical Leave Act*, it does not guarantee income, leaving millions without the ability to take needed leave.[156,157] Evidence from peer nations shows that paid leave improves postpartum recovery, breastfeeding, mental health, and infant survival.[158] The absence of federal paid leave is one of the most significant gaps in United States maternal health policy.

Recommendations: Guarantee paid family and medical leave for mothers and fathers.

6. Strengthening Surveillance and Accountability in Maternal Health

Why it matters: Every state must have a fully resourced Maternal Mortality Review Committee with standardized, timely reporting, stratified data by race, ethnicity, and language, and clear dissemination of recommendations.[159] Unlike the United Kingdom's mandatory system of confidential enquiries, the United States leaves adoption voluntary, limiting impact.[160]

Recommendations: Require hospitals to implement fully resourced committees and standardize reporting, with equity tied to funding.

7. Improving Continuity of Care

Why it matters: Continuity of care must extend beyond the traditional six-week postpartum visit. Many maternal deaths occur months after birth, yet federal measures and payment policies still emphasize a single postpartum check.

Recommendations: Policies must support individualized discharge planning, early postpartum follow-up, remote monitoring, and integration of behavioral health and cardiology into postpartum care. Federal Conditions of Participation require discharge planning, but the lack of postpartum-specific mandates creates dangerous gaps.[161]

8. Embedding Systemic Reforms in Medical Education and Workforce Policy

Why it matters: Current accreditation standards call for equity training, but requirements remain weak and unevenly enforced.[162]

Recommendations: Implement comprehensive reform of medical education that incorporates patient-centered didactics, a trauma-informed approach, and qualified attendings and mentors is needed to address systemic racism, implicit bias, and culturally and linguistically appropriate care across the training continuum.

Conclusion

Maternal deaths and severe complications in the United States are largely preventable. Yet they persist because of unstable coverage, fragmented systems, structural racism, workforce shortages, and linguistic barriers that erode trust and safety. Expanding continuous insurance coverage, investing in Black and Brown-led care models, guaranteeing paid leave, ensuring comprehensive language access, rebuilding maternity capacity, mandating anti-racism education, and embedding accountability into health systems are proven solutions. International evidence indicates that these measures are effective. Each preventable maternal death is not just a statistic but a profound loss that destabilizes families and communities. Solving this crisis is both a public health necessity and a moral imperative to dismantle structural inequities in healthcare.

Postpartum Care and Support

Led by Robyn D'Oria & Adele Cappucci

Introduction

Throughout history, postpartum care in the United States has evolved dramatically. Prior to the 19th century, the standard for childbirth was home-based care with support of one's social circle. By the early 20th century, maternal mortality rates were high due to poor obstetric care and a lack of formal medical education.[163] In response, maternal health boards formed in hospitals across the United States throughout the 1930s and 1940s.[164] Over time, hospital births became more frequent than home births and healthcare practices evolved, leading to a decrease in maternal mortality.[165]

In the 1970s, the legalization of abortion led to a drop in maternal mortality, as people were able to receive safe care rather than seeking illegal and unsafe alternatives.[166] Additionally, the six-week postpartum visit became the standard of postpartum care.[167] However, the focus of the visit was to assess the physical standpoint of the parent, not the emotional effect. This presented a limited approach that ignored the ongoing needs of postpartum women. Despite medical advancements, the history of postpartum care demonstrates the need for a more comprehensive and supportive system for birthing people in the United States.

Not all communities benefited equally from medical advancements. Rural areas, low-income communities, and people of color were often left behind when others were flourishing. Laws such as those during the Jim Crow period limited Black women from delivering in hospitals or receiving care, forcing them to find other, potentially unsafe alternatives.[168] As the postpartum check-up became standard, those who were uninsured or reliant on Medicaid were excluded due to lack of transportation, insurance coverage, and

child support.[169] Historically, with care being withheld to marginalized communities, significant persistent gaps in health outcomes became common. These historical disparities continue to shape maternal health outcomes today. Without further improvements, marginalized communities will continue to be harmed by a system that was not designed to care for them.[170]

Current Landscape

Today in the United States, disproportionate health outcomes remain an issue in postpartum care. Despite being one of the wealthiest nations, the United States has one of the lowest proportions of OB/GYNs and midwives per 100,000 births, limiting access to timely in consistent care in the critical period after delivery.[171] Additionally, data on the pregnancy-related mortality ratio in the United States reveals that rates have been increasing over time, demonstrating that instead of improving, we are seeing higher rates of pregnancy-related death.[172] While the gaps in postpartum care in the United States impact all mothers, this burden is not shared equally. In 2022, it was reported that there were 22 maternal deaths for every 100,000 live births in the United States, yet for Black women, the rate was 49.5, the highest out of any group.[173]

Structural barriers within the healthcare system leave many women without the ongoing support needed during the postpartum period.[174] Stigmas and misconceptions also prevent vulnerable populations from receiving the care they need, which can cause a lingering negative impact on mothers and babies.[175] Ultimately, women of color, those on Medicaid, young mothers, and non-English speakers were less likely to be screened for postpartum depression, creating gaps in health outcomes.[176,177]

Based on poor outcomes in maternal mortality rates and postpartum depression in the United States, it is no secret that improvement in our healthcare system is long overdue. If left unaddressed, these gaps will continue to perpetuate cycles of poor health for infants, mothers, and families, with vulnerable communities being hit the hardest. These health

disparities reflect deeper social and economic disparities rooted in racism and discrimination, and demand urgent policy attention to ensure all mothers in the United States receive the postpartum support they need.

Data from the Maternal Mortality Review Committee (MMRC) highlights disturbing trends about maternal health in our country.[178] In 2021, 19.5% of pregnancy-related deaths occurred during pregnancy, 23.2% the day of delivery or within a week after delivery, and 57.3% between 7 days to 1 year after pregnancy.[179] During that year, the leading cause of pregnancy-related deaths was substance abuse, followed by mental health conditions.[180,181] 87% of pregnancy-related deaths were determined by the MMRC to be completely preventable.[182] Among these deaths, 40.5% of prevention recommendations made by MMRCs were made at the system level, defined as interacting entities that support services before, during, or after pregnancy, ranging from healthcare systems and payors to public services and programs.[183]

Policy Recommendations

1. Leveraging Social Determinants of Health Care

Why it matters: To bridge the gaps that exist in the United States, it is valuable to consider what programs have been proven to work. Research has demonstrated how social determinants play a role in health at every level of care, often outweighing genetic or medical care and driving a major portion of health inequalities. Data from the National Library of Medicine shows that a comprehensive healthcare approach, from preconception to postpartum, is critical to improving maternal morbidity and mortality disparities.[184] Similarly, the Journal of Women's Health examined maternal mortality-related federal legislation from 2017 to 2021 to identify where work was needed, finding significant gaps in legislation regarding the impact of social and structural determinants of health on maternal health disparities.[185]

Recommendations: Consider support at the individual, community, provider, and systemic levels. In the future, it would make an impact on health outcomes by considering structural reforms and supporting legislation in policy training to prevent implicit bias in clinical settings.

2. Addressing Racial Disparities

Why it matters: Addressing racial disparities is vital to improved outcomes in postpartum health. Marginalized communities, especially Black and Indigenous populations, observe disproportionately poor maternal health outcomes compared to their White counterparts, with pregnancy-related deaths over 3 times higher in Black and American Indian/Alaska Native populations than for White populations.[186]

Similar disparities were also visible when addressing postpartum mental health care. Poor access to treatment was found in low-income women, with racial and ethnic disparities further worsening statistics.[187] Mothers with household incomes of less than $25,000 were much less likely to seek out mental health consultations than women making between $50,000-$74,999; of these low-income women, Latina women were 61% less likely than White women to seek these same services.[188] 9% of White women initiated postpartum mental health care, compared to only 4% of Black women and 5% of Latina women; even among those who initiated, they were less likely to receive follow up treatment or continued care.[189] Women of color, Medicaid recipients, young mothers (24 years of age or younger), and non-English speakers were also less likely to be screened for postpartum depression (PPD).[190]

Recommendations: Invest in cultural competency and implicit bias training for clinicians, as well as investing in community health worker and home visiting programs that provide critical postpartum education, mental health support, and care coordination.[191]

3. Invest in Cost-Effective Postpartum Care Programs

Why it matters: In New Jersey, the Family Connects NJ program provides parents with a free, at home nurse visit within the first two weeks after their child's birth.[192] As outlined by the Bridgespan Group in their case study on Nurture NJ, expanding family leave, increasing supply and quality of prenatal provider and maternal health workforce, implementing Medicaid expansion and establishing a dedicated state body to focus on maternal health from preconception through postpartum and the intrapartum period have improved maternal mortality rates and decreased racial disparities.[193]

Recommendations: Implement models like Family Connects NJ at a broader national level. Invest in programs that provide care and target issues faced by vulnerable populations to improve the racial and socioeconomic disparities in maternal health.

4. Expand Medicaid Coverage

Why it matters: The *Affordable Care Act* created progress in the expansion of healthcare coverage to parents, cultivating a more supportive environment for postpartum individuals. The National Institutes of Health found that the ACA was associated with increases in retention of postpartum insurance and reductions in postpartum depressive symptoms.[194] This research demonstrates that insurance reforms and Medicaid expansion lead to more screenings for postpartum mental health and more treatment access for low-income populations. While the provisions in the ACA strengthened coverage for maternity care, the actual access to benefits depends on geographic location and the type of insurance, and out-of-pocket costs can significantly vary as well.[195] It is clear from observing this impact that insurance reforms and Medicaid expansion contribute to greater access for postpartum individuals, and building upon these programs could further improve maternal health outcomes.

Recommendations: Expand Medicaid to cover services such as doulas and postpartum visits. Reform existing insurance systems to provide more services and further support to all postpartum individuals.

5. Improve the Ratios of Healthcare Providers to Patients

Why it matters: Compared to other high-income countries, the United States has double the maternal mortality rate.[196]

Yet when comparing the maternal care workforce in these countries to the United States, data demonstrates that the United States has a shortage of maternity providers compared to its number of births. The American College of Nurse-Midwives, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the American College of Obstetricians and Gynecologists (ACOG) all recommend improving the ratios of healthcare providers to provide further support for pregnant individuals.

The Commonwealth Fund reports that the United States is the only developed country that does not provide at least one visit within a week postpartum.[197] Finally, the United States is the only high-income country that does not guarantee paid maternity leave, while the other high-income countries mandate at least 14 weeks.[198] These key differences are contributing to poorer health outcomes in the United States compared to other countries, demonstrating the need for policy reform.

Recommendations: Expand funding for midwifery training, retention, and support. Invest in healthcare provider education, postpartum home visits. Implement mandatory paid leave for postpartum individuals to mend the gaps in maternal health.

Conclusion

Overall, policy reform is desperately needed in maternal health care. By requiring cultural competency and implicit bias training, we can work to reduce racial disparities and inequities apparent in clinical care for postpartum women. Continuing to invest in midwives, doulas, and programs supporting postpartum parents, including community health initiatives, educational home visiting programs, care coordination, and mental health support programs is critical for improving overall health and wellbeing. By taking these steps, the United States can bridge the gaps in maternal health and support American families.

Mental and Behavioral Health Access Improvement

Led by Kemi Alli

Introduction

Maternal mental health represents one of the most pressing public health challenges in the United States. Perinatal mental health conditions, including depression, anxiety, bipolar disorder, and postpartum psychosis, constitute some of the most common obstetric complications during pregnancy and the postpartum period. Approximately one in five mothers in the United States has experienced a mental health or substance use disorder before, during, or after pregnancy.[199] These conditions extend far beyond the immediate postpartum period, affecting maternal well-being through the first year postpartum and significantly impacting family functioning and child development.

Pregnant women encounter substantially lower treatment acceptance rates to substance abuse treatment compared to the general population, creating a critical disparity in access to evidence-based care. Women in rural areas face limited access to resources and difficulty navigating a complex health system that lacks integrated maternal substance use treatment

services.[200] These systemic gaps occur against the backdrop of counterproductive state policies. The number of Neonatal Abstinence Syndrome (NAS) or Maternal Narcotic Exposure that happens at birth haven't decreased, as they deter pregnant women from seeking treatment during pregnancy.[201] This evidence-practice gap prompted federal policy evolution; the *Child Abuse Prevention and Treatment Act (CAPTA)* reauthorization represents a critical shift from child safety–focused punishment toward public health-focused approaches that integrate treatment access with family recovery outcomes.[202]

Structural barriers impacting access include insufficient childcare support at treatment facilities, fear of custody loss or child protective services involvement, and inadequate integration of obstetric care with substance use treatment.[203] Integrated medication-assisted treatment programs specifically designed for pregnant and parenting women demonstrate clear effectiveness in reducing substance use severity.[204] However, these comprehensive services remain severely underfunded and geographically limited relative to population need, particularly in regions disproportionately affected by the opioid crisis.[205] The American Academy of Pediatrics emphasizes that expanding access to high-quality integrated programs requires both financing reforms and enhanced provider training, yet current reimbursement structures actively disincentivize providers from treating pregnant women, creating a fundamental misalignment between clinical evidence and financial incentives.

In New Jersey, maternal mental and behavioral health exists within a complex system characterized by significant disparities, systemic barriers, and uneven access to evidence-based care. While the state has made some progress in recognizing the importance of perinatal mental health, substantial gaps persist between the need for services and their availability, particularly for marginalized and economically disadvantaged populations.

Pregnancy- and Parenting-Related Barriers to Behavioral Health Treatment

Pregnancy-specific clinical barriers directly impede treatment initiation and continuation, leading to physician hesitancy in prescribing medication-assisted treatment (MAT) for pregnant patients, limited availability of integrated prenatal and postpartum care, and pervasive provider knowledge gaps regarding safe opioid treatment protocols.[206] These clinical barriers reflect underlying regulatory uncertainty and inadequate training in evidence-based maternal Opioid Use Disorder (OUD) management. Beyond clinical factors, pregnant women describe deep anxieties about fetal health outcomes, fears of government authorities' involvement through child protective services, and exposure to stigmatizing treatment environments that invalidate their experiences and autonomy.[207]

Parenting-related barriers create competing priorities that substantially deter treatment engagement, with insufficient childcare access at treatment facilities preventing women from navigating appointments and treatment meetings.[208] The anticipation of losing custody or access to children serves as a powerful motivator for some women to seek treatment, yet this same fear simultaneously prevents others from disclosing their substance use disorder to healthcare providers, effectively concealing treatment need.[209] In suburban populations, relationships with partners, family members, and healthcare providers function as both barriers and facilitators depending on social context, with stigma and creating substantial treatment resistance.[210] Women prioritizing their children's immediate needs over their own recovery further delay treatment, reducing the likelihood of sustained behavioral health intervention.

Prevalence and Burden of Disease

The prevalence of maternal mental health conditions varies across studies and populations. Perinatal mood and anxiety disorders (PMADs) affected approximately 13.2% of mothers nationally as of 2018, with some populations experiencing substantially higher rates.[211] Among pregnant and postpartum women during the COVID-19 pandemic, rates increased

significantly, with reports indicating that up to one in three postpartum women experienced postpartum depression in some areas.[212] The prevalence of specific conditions presents a concerning picture. Postpartum depression (PPD) ranges from 10-25% among postpartum women, while comorbid anxiety and depression affect approximately 1 in 10 women during the perinatal period.[213,214]

While New Jersey-specific prevalence data is limited in recent comprehensive surveys, the state's broader maternal health challenges suggest that maternal mental health conditions are a substantial public health concern.[215]

Disparities in Maternal Mental and Behavioral Health

Significant racial and ethnic disparities persist in the diagnosis and treatment of maternal mental health conditions in the United States. Black women experience disproportionately high rates of perinatal mood disorders compared to the national average, and these disparities are driven by complex intersectional factors including structural racism, socioeconomic inequities, and systemic barriers to care.[216] Black mothers often face social and structural barriers that limit their opportunity to seek and engage with mental health interventions and treatment.[217]

One of the most significant challenges in maternal mental health access in New Jersey is the stark racial and ethnic disparities in both availability and utilization of services. Racial and ethnic minorities experience disproportionately high burdens of perinatal mental health conditions and face greater structural barriers to accessing care. Black mothers experience significantly higher rates of perinatal mood disorders, including postpartum depression and anxiety, compared to U.S. national estimates.[218] In New Jersey specifically, community-based perinatal mental health programs show substantial racial and ethnic disparities in accessibility and utilization, with Black, Hispanic, and Asian individuals comprising less than 10% of total annual participants in the majority of programs.[219] Beyond program utilization, structural and social determinants of health create fundamental vulnerability;

poverty, residential segregation, interpersonal racism, domestic violence, and limited access to safe food and housing make women from underrepresented populations particularly susceptible to adverse reproductive health outcomes.[220] These social determinants carry a physiologic cost, manifesting as increased rates of pregnancy complications and maternal mortality.

Nationally among low-income women, the self-reported prevalence of postpartum depression was 24%, well above the national average.[221] Financial insecurity and alcohol use were positively associated with postpartum depression, whereas higher education and reported physical health were protective factors.[222] Black mothers had an 8.3% higher probability of postpartum depression compared to White mothers in low-income samples.[223]

For Black women specifically, structural racism creates significant inequities in the diagnosis of perinatal and maternal mental health disorders and access to perinatal and maternal mental health treatment.[224] Black mothers in New Jersey often face social and structural barriers that limit their opportunity to seek and engage with interventions and treatment that address the root causes of their perinatal mood disorders.[225] The disjointed healthcare system, combined with limited access to resources and lack of universal screening and mental health education, creates compounding disadvantages for Black mothers in autonomous decision-making regarding their mental health care.[226]

Risk Factors and Predictors

Beyond individual-level factors, unmet social determinants of health (SDOH) significantly impact maternal mental health risk during pregnancy and the postpartum period. Over 43% of pregnant and postpartum people screened through digital interventions reported at least one unmet SDOH need, with financial strain (55.1%), disabilities (34.6%), and food insecurity (33.3%) being the most frequently identified challenges.[227] Individuals with neglected SDOH needs were significantly more likely to screen positive for mental health

concerns underscoring the role of structural stressors in shaping mental health vulnerability. When provided with accessible, text-based screening programs, this same population was also more likely to attend mental health treatment, suggesting that early identification may be particularly impactful for individuals facing elevated social risk.[228]

Food insecurity represents a particularly notable predictor of maternal health disorders. Among women experiencing moderate or severe food insecurity, 26.8% received treatment for postpartum mental disorders within the six-month postpartum period, compared to 13.9% of food-secure women.[229] These findings highlight food insecurity not only as a marker of socioeconomic disadvantage, but as a distinct and measurable risk factor for adverse maternal mental health outcomes.

Access and Engagement Barriers

Access to behavioral health services remains inequitably distributed across the United States, with critical gaps in New Jersey. Behavioral and mental health conditions present significant challenges in settings where access to care is limited, yet family medicine physicians and other frontline clinicians feel inadequately prepared to manage complex conditions.[230,231] Barriers to appropriate care include lack of timely access, distance to facilities, cost, insurance status, stigma, and fragmented resources.[232] The behavioral health workforce faces substantial shortages and burnout, particularly in rural regions and underserved urban communities, limiting expansion of services to vulnerable populations.[233] Community-based perinatal mental health programs across the state further identify mental health stigma, lack of support from family, fear of disclosure, social determinants, language-concordant gaps, and limited community awareness as significant barriers to participation of racial and ethnic minorities.[234]

Stigma and Cultural Factors

Program administrators across New Jersey identified mental health stigma as a significant barrier to participation, particularly for racial and ethnic minorities.[235] Fear of disclosing

mental health challenges and concerns about how mental health conditions might be perceived within families and communities prevent many women from seeking help. These barriers intersect with cultural beliefs and values that may not align with conventional medical approaches to mental health treatment, further limiting engagement.[236]

Language and Culturally Concordant Services

Limited availability of language-concordant services represents a critical access barrier within New Jersey's perinatal mental health landscape.[237] Many women, particularly those from Hispanic, Asian, and immigrant communities, struggle to access services delivered in their primary language. This linguistic barrier not only limits access but also reduces the effectiveness of mental health interventions that rely on clear communication about complex emotional and psychological issues.

Social Determinants of Health

Economically marginalized mothers in New Jersey face unsatisfied social and healthcare needs that significantly contribute to maternal mental health conditions.[238] Financial strain, housing instability, food insecurity, and lack of reliable transportation are among the most frequently reported social determinants that impede access to mental health services. National data indicate that among low-income mothers, 22.6% report antepartum depression, with those experiencing intimate partner violence having 3.71 times higher odds of depression.[239] Access to basic information about maternal health, such as breastfeeding support and prenatal care, has been associated with decreased likelihood of depression, underscoring the role of comprehensive support systems in facilitating both access and engagement.[240] In urban New Jersey communities like Paterson, structural barriers including poverty, housing instability, limited healthcare access, and chronic stress exacerbate maternal mental health challenges, creating a cascade of disadvantage across generations.[241]

Healthcare System Fragmentation

The disjointed nature of maternal healthcare delivery in New Jersey contributes to inadequate mental health screening and treatment. Whether obstetric providers ask women about perinatal depression is inconsistent across sites.[242] Comprehensive perinatal care requires screening, assessment, triage, referral, treatment access, initiation, symptom monitoring, and adaptation of care based on measurement-based outcomes.[243] However, many obstetric practices in New Jersey fall short of implementing all these components systematically.

Provider Capacity and Competency

A significant challenge in New Jersey is the limited mental health provider workforce and the inadequate training of obstetric providers in maternal mental health assessment and management. Many obstetric providers do not have formal training in perinatal mental health and may lack confidence in screening, diagnosing, and treating maternal mental health conditions.[244] This gap in provider competency contributes to missed opportunities for early identification and intervention, allowing treatable conditions to progress with serious consequences for mothers and their families.

Financial Barriers and Healthcare Delivery Models

Financial barriers significantly limit access to maternal mental health services in New Jersey. Medicaid reimbursement rates for mental health services are often inadequate, affecting both the sustainability of community-based programs and the willingness of providers to offer comprehensive services. The state's freestanding birth centers, which operate using the midwifery model of care and could serve as alternative points of access for maternal mental health support, face considerable financial challenges due to low Medicaid reimbursement rates, high startup and operating costs, and an insufficient supply of trained midwives.[245] These challenges limit access to these settings, particularly for traditionally marginalized populations.[246]

Current Service Gaps and Unmet Needs

The current landscape of maternal mental health access in New Jersey is marked by significant service gaps:

Screening and identification

While universal screening for perinatal depression and anxiety is recommended as best practice, implementation across New Jersey remains inconsistent. Screening rates vary considerably across different healthcare settings and geographic regions.[247]

Treatment access

Among women who screen positive for perinatal mental health conditions, the percentage who actually receive evidence-based treatment remains far below optimal levels.[248]

Specialized services

There is a notable lack of specialized maternal mental health services that address the specific needs of pregnant and postpartum women. Services addressing comorbid substance use disorders, trauma-informed perinatal care, and culturally specific mental health interventions remain limited across the state.

Continuity of care

The postpartum period is often when maternal mental health conditions emerge or worsen, yet healthcare continuity beyond the standard 6-week postpartum visit is inadequate. Extended mental health support during the postpartum year is not systematically provided.[249]

Clinical and Public Health Significance of Maternal Behavioral Health

Maternal behavioral health conditions carry substantial consequences that extend far beyond individual mental health status, affecting maternal physical health, child

developmental trajectories, and long-term population health outcomes. Alarmingly, maternal mental health conditions create direct physiologic risks for offspring—women with perinatal mental health conditions are 60% more likely to deliver babies with low birth weight and more than twice as likely to deliver prematurely, with documented associations extending to delayed cognitive and motor development in children.[250] These adverse birth outcomes represent only the acute consequences; untreated maternal behavioral health conditions create detrimental risks throughout the developmental lifespan.

The developmental impact of maternal behavioral health extends across infancy and childhood, fundamentally shaping neurobiological and emotional trajectories. Perinatal mental health conditions directly impair critical mother-child bonding and attachment processes that are foundational to infant emotional and neurological development.[251] Beyond infancy, maternal depression and anxiety during the perinatal period create vulnerability to behavioral problems, emotional dysregulation, and long-term mental health challenges in offspring.[252] The developmental pathways linking maternal mental health to child outcomes demonstrate remarkable persistence; early childhood adversity related to untreated maternal behavioral health conditions predicts worse educational achievement, reduced employment prospects, and poorer adult health outcomes. This intergenerational transmission of risk underscores why perinatal mental health represents not merely an individual clinical concern but a critical determinant of population health trajectories.

Maternal behavioral health constitutes an urgent maternal mortality and morbidity prevention priority, particularly given the intersection with suicide—a leading cause of pregnancy-related death. Serious perinatal mental disorders are directly associated with increased maternal mortality by suicide.[253] The clinical significance of maternal behavioral health merges with profound public health imperative: attending to maternal mental and behavioral health during the perinatal period represents one of the highest-leverage interventions available for simultaneously improving maternal health, preventing adverse child outcomes, and reducing health disparities across generations.

Nationally, women with past-year substance use disorders particularly non-Hispanic Black and Latina women demonstrated significantly lower odds of receiving any substance use disorder treatment compared to non-Hispanic White women[254,255] Mandatory reporting policies for prenatal substance exposure including exposure to evidence-based medications for opioid use disorder create additional deterrents: pregnant women identified mandated CPS reporting as unjust, stigmatizing, and harmful to family well-being, generating psychological stress that actively discourages prenatal care engagement and treatment initiation.[256] These multilayered structural and policy barriers create a system in which the populations with greatest clinical need pregnant women from marginalized racial, ethnic, and economic backgrounds with untreated substance use disorders face the most formidable obstacles to accessing evidence-based treatment.

Impact on Maternal and Child Outcomes

Maternal substance use during pregnancy carries profound and far-reaching consequences for mothers, infants, and families, representing one of the most complex and urgent challenges within the perinatal health landscape. The clinical and social impacts extend well beyond delivery, contributing to significant neonatal complications, heightened maternal morbidity and mortality, increased involvement of child protective services, and deep disruptions to family stability and child development. These outcomes are not isolated events, but interconnected manifestations of untreated or inadequately supported substance use disorders, often rooted in structural inequities, behavioral health gaps, and multigenerational cycles of trauma and addiction. Understanding these pathways is essential to designing policy, clinical, and community-based responses that protect the health and resilience of mothers and their children.

Maternal morbidity and mortality

Severe maternal morbidity conditions, including placental insufficiency, cardiac complications, preeclampsia, and postpartum overdose deaths (the leading cause of

pregnancy-associated mortality in the immediate postpartum year) have a significant impact on maternal mental health.

Intergenerational substance use transmission

Prior substance use in pregnancy is the strongest predictor of future substance use in subsequent pregnancies; untreated maternal addiction creates cycles of repeated perinatal exposure across multiple generations.

Impaired child development and family resilience

Untreated maternal substance use co-occurs with economic instability, housing insecurity, intimate partner violence, and mental health conditions that constrain child attachment, disrupt early brain development, and reduce family capacity for resilience and protective factors.

Screening and Diagnosis

The Edinburgh Postnatal Depression Scale (EPDS) is widely used as a validated screening tool for identifying perinatal depression.[257] However, despite recommendations from professional organizations for universal screening, rates of screening remain low, occurring in fewer than 20% of patients during both pregnancy and postpartum periods.[258]

Screening efforts have expanded through innovative approaches. Text- and telephone-based screening programs have demonstrated substantial improvements in detection and treatment engagement. Participants assigned to text- and telephone-based screening and referral programs were three times more likely to be screened compared with those assigned to usual care.[259]

Barriers to Care

Multiple barriers impede access to mental health screening and treatment for pregnant and postpartum women. Healthcare providers frequently report discomfort with screening and

limited mental health resources in their settings.[260] Individuals who experienced delayed care exhibited higher rates of mental health symptoms compared to those without delays, especially during postpartum, with 69.4% vs. 30.7% reporting major depressive disorder and 46.6% vs. 24.8% reporting generalized anxiety disorder.[261]

Reasons for delayed care include financial and time issues, lack of transportation, nervousness about seeing a doctor, and rural residency, all of which were associated with increased mental health symptoms.[262] Rural women require further support to improve their physical and psychological health in the postpartum period, as they often experience limited pelvic health knowledge and increased rates of depression.[263]

Emerging Initiatives and Promising Approaches

Despite these challenges, New Jersey has initiated some positive developments:

Workforce development

New Jersey has implemented a student loan redemption program for healthcare, behavioral health, and social services professionals serving individuals in homes and communities.[264] Nearly 450 individuals are enrolled in this program, representing an investment in building the behavioral health workforce capacity.

Community-based programs

While disparities persist, community-based perinatal mental health programs exist throughout New Jersey. Program administrators have identified strategies to address barriers, including adding language options, improving outreach to communities of color, and increasing the diversity of program facilitators and staff.[265]

Birth center development

New Jersey is well-positioned to expand access to birth centers as alternative care settings that integrate maternal mental health support, though policy and financial reforms are needed to make this viable, particularly for marginalized populations.[266,267]

Treatment options and interventions

Multiple evidence-based treatment modalities are available for maternal mental health disorders. First-line treatments include psychotherapy approaches such as cognitive behavioral therapy, interpersonal therapy, and psychodynamic therapy.[268] When appropriately indicated, pharmacologic interventions including selective serotonin reuptake inhibitors (SSRIs) have demonstrated efficacy and safety during pregnancy and lactation.[269]

The Psychiatric Collaborative Care Model has shown promise in obstetric settings, with studies demonstrating improved clinical outcomes and enhanced cost-effectiveness for patients with behavioral health conditions.[270] This model integrates a behavioral health care manager and psychiatric consultant into the primary care setting, expanding the primary care team's capacity to address mental health needs. Paid maternity leave policies have also been shown to improve maternal mental health outcomes, with evidence suggesting that paid leave is associated with beneficial effects including decreased postpartum maternal depression, decreased intimate partner violence, improved infant attachment and child development, and increased breastfeeding initiation and duration.[271]

Telehealth has emerged as a critical modality for expanding access to substance use treatment. Early use of telehealth with video in the initial 14 days of substance use disorder diagnosis was associated with a substantially lower hazard of dropout compared to solely in-person services, while both video and telephone modalities were associated with greater odds of early treatment engagement compared to in-person care alone.[272] For pregnant women with substance use disorders—who face transportation barriers, childcare constraints, and stigma-related avoidance of clinical settings—telehealth offers promise for

reducing engagement friction. However, standardized telehealth protocols for behavioral health services remain fragmented across regions, with many obstetric settings lacking integrated video or telephone-based substance use treatment.[273] The absence of standardized training, infrastructure, and reimbursement models for telehealth behavioral health in pregnancy represents a critical gap that prevents broader implementation despite demonstrated efficacy.

Despite evidence-based medication treatment options for opioid use disorder (methadone, buprenorphine, and naltrexone being the gold standard interventions), access remains profoundly limited across healthcare systems and populations. Nationally, only 10.6% of individuals with past-year substance use disorder received treatment, with women including pregnant women, particularly underserved and facing significantly lower odds of treatment receipt than men, especially among Black and Latinx populations.[274] Expanding access for pregnant populations specifically requires not only increasing medication treatment prescribing capacity but also developing specialist training, integrated delivery models, and addressing provider knowledge gaps regarding optimal medication selection and dosing in pregnancy to ensure that evidence-based treatment becomes the standard rather than the exception.

Recommendations for Improvement

Addressing the current gaps in maternal mental health access in New Jersey requires a multilevel approach:

Healthcare system level

Implementing integrated collaborative care models within obstetric settings including systematic screening, clear referral pathways, and measurement-based follow-up can significantly improve outcomes.[275] Training programs for obstetric providers must include

competencies in mental health screening, culturally responsive care, and implicit bias awareness.[276]

Community level

Investments in Black women–led community-based organizations, support for traditional and community healing practices, and efforts to increase mental health literacy within communities can enhance access and engagement.[277] Text- and phone-based screening and referral programs have shown promise in improving identification and treatment engagement, particularly among those facing social determinants barriers.[278]

Provider capacity

Continued investment in the behavioral health workforce, including targeted recruitment and training in perinatal mental health, is essential. Programs such as New Jersey's loan redemption initiative should be expanded and linked to service provision requirements in underserved areas.[279]

Recent policy developments have begun to address the maternal mental health crisis. HEDIS (Healthcare Effectiveness Data and Information Set) tracking reveals that screening for depression during pregnancy and postpartum remains inadequate, although some states have improved screening rates through targeted policy initiatives.[280] The expansion of postpartum Medicaid coverage from 60 days to one year holds promise for improving continuity of care and engagement in mental health treatment.[281]

Addressing maternal mental health requires multifaceted approaches. Pathways to equitable and antiracist maternal mental health care include educating and training practitioners, investing in the Black women mental health workforce, investing in Black women-led community-based organizations, valuing and honoring community and traditional healing practices, and promoting integrated care and shared decision-making.[282]

Federal policy must operate through three coordinated mechanisms regulatory requirements, financing restructuring, and accountability infrastructure to systematically eliminate barriers to maternal substance abuse treatment access. These mechanisms address the fundamental misalignment between clinical evidence supporting integrated maternal treatment and financial structures that actively penalize providers treating pregnant populations. Existing federal policy instruments, including Medicare and Medicaid authority, Section 1115 waiver flexibility, and CAPTA reauthorization frameworks, provide the statutory basis for comprehensive reform; however, effective implementation requires deliberate policy design that moves beyond discrete training initiatives toward sustained systemic change.

Policy Recommendations

1. Mandate pregnant patient acceptance and capacity requirements for all publicly funded treatment providers

Why it matters: Current data demonstrate that buprenorphine providers accepting insurance are nine times less likely to treat pregnant women, revealing that regulatory standards rather than clinical expertise create exclusionary barriers.[283]

Recommendations: Establish federal regulations requiring all opioid treatment programs, buprenorphine providers, and substance use disorder treatment facilities receiving any form of public funding (Medicare, Medicaid, SAMHSA grants) to accept pregnant patients and maintain minimum capacity thresholds dedicated to this population. Have federal standards specify that insurance acceptance cannot function as justification for pregnancy-based exclusion.

2. Implement mandatory integrated care delivery infrastructure standards

Why it matters: Comprehensive, integrated care co-locating prenatal care, obstetric care, pediatric services, and substance use disorder treatment reduces navigation burden for pregnant women while improving outcomes for mother-infant bonding.[284]

Recommendations: Have federal regulations require all treatment programs receiving public funding to establish formalized partnerships with obstetric care, pediatric services, and prenatal/postpartum providers, with documented care coordination protocols. Make guidance specify minimum components including on-site or immediate-referral prenatal care, postpartum follow-up protocols, pediatric assessment services, and formalized pathways for treatment continuation during pregnancy and postpartum periods. Programs unable to develop partnerships must redirect pregnant patients to comprehensive centers with documented integration rather than refusing care.

3. Establish accessibility and communication standards aligned with Section 1557 compliance

Why it matters: 59% of substance use disorder treatment facilities receiving public funds fail to provide sign language services, representing systematic exclusion of Deaf and hard-of-hearing populations from essential behavioral health services and noncompliance with federal accessibility mandates.[285]

Recommendations: Codify requirements that all substance use disorder treatment facilities receiving federal funds provide services in American Sign Language, multiple languages relevant to their service populations, and alternative communication formats for individuals with disabilities.

4. Standardize evidence-based screening and treatment protocols across state systems

Why it matters: Federal guidance should specify mandatory implementation of standardized screening instruments in all obstetric settings, coupled with automatic referral mechanisms to substance use disorder treatment upon identification.

Recommendations: Eliminate punitive policies criminalizing pregnancy-related substance use, and replacing these with evidence-based brief intervention protocols paired with automatic treatment referral and care coordination.[286] Eradicate discretionary judgment that currently permits pregnant women to exit the healthcare system undetected or diverted toward child welfare systems rather than treatment.

5. Transform Medicaid reimbursement to incentivize rather than penalize maternal treatment

Why it matters: Providers accepting insurance demonstrate reduced willingness to treat pregnant women, indicating that reimbursement structures actively disincentivize maternal care; federal policy must reverse these financial signals through enhanced rates and simplified authorization pathways.[287]

Recommendations: Have federal guidance to states mandate elimination of step therapy barriers, prior authorization requirements, or coverage restrictions specifically applied to pregnant populations receiving medication-assisted treatment. Establish enhanced reimbursement rates reflecting the complexity of comprehensive maternal care (50-75% above standard rates) through CMS policy, with risk adjustment mechanisms recognizing pregnancy-related clinical complexity.

6. Mandate disaggregated outcome reporting for pregnant women with public accountability requirements

Why it matters: Data should be publicly reported with financial incentives or penalties based on performance, creating accountability for currently invisible disparities in maternal treatment outcomes.

Recommendations: Establish federal regulations requiring all treatment programs receiving public funding to report facility-level data on acceptance rates, engagement duration, medication-assisted treatment completion rates, and maternal-infant health outcomes disaggregated by pregnancy status (i.e. gestational age, obstetric history) and demographic characteristics. Publicly report data with financial incentives or penalties based on performance, creating accountability for currently invisible disparities in maternal treatment outcomes.

7. Establish federal equity audits incorporating maternal substance use treatment access into health equity assessments

Why it matters: Federal funding allocations to states should be contingent on demonstrated progress in reducing documented equity gaps in maternal treatment access.

Recommendations: Require states receiving Medicaid funding to conduct annual equity audits documenting access disparities by race, ethnicity, geography, disability status, and other demographic characteristics. Make federal funding allocations to states contingent on demonstrated progress in reducing documented equity gaps in maternal treatment access.

8. Create continuous learning infrastructure supporting iterative policy adaptation

Why it matters: Evidence from state-level policy implementation reveals that training without sustained engagement fails to produce fidelity to evidence-based standards; federal

infrastructure must support the often-overlooked sustainment phase where programs risk collapse without continued support and problem-solving mechanisms.[288]

Recommendations: Establish technical assistance centers providing states with implementation science guidance, real-time data feedback mechanisms, and stakeholder engagement support.

Conclusion

The current state of maternal mental health access in New Jersey is characterized by significant disparities, systemic barriers, and unmet needs, particularly for Black, Hispanic, and economically disadvantaged birthing populations. While the state has made some progress in recognizing the importance of perinatal mental health, transformative changes are needed to ensure equitable, accessible, and comprehensive mental health care throughout the perinatal period. This requires coordinated efforts across policy, healthcare systems, community organizations, and workforce development to address the structural inequities that currently limit access and perpetuate disparities in maternal mental health outcomes.

Future efforts should prioritize equitable access to comprehensive maternal mental health screening and treatment across the perinatal period, improved training for healthcare providers across all disciplines, integration of mental health services into primary obstetric and pediatric care, addressing underlying social determinants of health, and developing culturally responsive and trauma-informed approaches to care. The involvement of community members, women with lived experience, and healthcare providers in designing solutions is essential to advancing maternal mental health equity in the United States.

Lactation Support

Led by Lorraine Mejias

Introduction

Breastfeeding is one of the most effective investments in lifelong health and well-being, serving as an early intervention point for reducing chronic disease and advancing health equity for both infants and birthing parents. Its benefits are well-documented, ranging from improved immune function in infants to reduced maternal risk of certain cancers. Despite these well-established benefits, breastfeeding rates remain inequitable across racial, socioeconomic, and geographic lines in New Jersey and across the United States. These disparities are not the result of individual choice but reflect systemic barriers, most notably limited access to paid parental leave, lack of board-certified lactation support coverage for low-income residents, and inadequate workplace accommodations. Addressing these policy gaps is critical for advancing health equity.

Historical Context of Breastfeeding in the United States

Breastfeeding has always been a healthy and natural way for a mother to feed her baby, yet, in the U.S., its practice has been shaped by colonization, medicalization, and economic policy. During slavery, African women were often forced to serve as wet nurses for their masters, disrupting their ability to feed their babies.[289] With the rise of industrialization, the feminist movements, and baby formula in the early 20th century, the United States saw a decline in breastfeeding rates. Formula was marketed as modern and superior, especially to middle- and upper-class White families.[290] Today, however, there's been a trend of women wanting to reclaim breastfeeding. Even as options for feeding a new baby have become ever more abundant, more women are acknowledging the health and emotional benefits of nursing their baby and are wanting to feed them breastmilk. While national breastfeeding

initiation rates are high, exclusivity and duration rates drop sharply postpartum, especially among communities of color, low-income families, and those without workplace protections.[291,292]

The Health Case for Breastfeeding

The benefits of breastfeeding for infants are infinite.[293] Babies who are given human milk have a reduced risk of infections, SIDS, obesity, asthma, and Type 1 diabetes, among other ailments. Breastfeeding also allows for enhanced cognitive development and emotional bonding between the baby and their mother.[294]

Mothers who breastfeed have a lower risk of breast and ovarian cancer, Type 2 diabetes, and postpartum depression.[295] It also allows the mother to get back to their pre-pregnancy health more quickly and aids in postpartum recovery.[296] Despite these benefits, systemic barriers often prevent families from initiating or continuing breastfeeding.

Health Equity and Breastfeeding Disparities

Communities impacted by poverty, racism, and limited healthcare access face compounded breastfeeding barriers. Black infants are less likely to be breastfed than White infants at hospital discharge.[297] Latino and Indigenous families often experience linguistic barriers and under-resourced community support. Low-wage workers are disproportionately denied paid parental leave and workplace lactation accommodations, and Medicaid recipients frequently lack access to clinical support from International Board-Certified Lactation Consultants (IBCLCs), widely recognized as the gold standard in lactation support. These disparities are not due to lack of desire or cultural interest in breastfeeding; they are the result of unequal access to resources, support, and policy protections.

Policy Recommendations

1. Implement Universal Paid Parental Leave

Why it matters: Paid leave is one of the strongest predictors of breastfeeding success. Studies show parents with at least 12 weeks of paid leave are significantly more likely to meet breastfeeding goals.[298] New Jersey is one of only 13 states that has a paid family leave program and has demonstrated that comprehensive, job-protected leave is both feasible and effective. The state offers up to 12 weeks of paid leave for bonding with a new child at 85% of the parent's weekly average income, which has led to measurable increases in breastfeeding duration, maternal mental health stability, and workforce retention.[299.300]

Importantly, the program includes job protection and broader eligibility than many states, making it a model for equity-centered policy. These outcomes show that when families are given time and financial support, they can prioritize infant feeding and recovery without sacrificing economic security.[301] A national paid parental leave policy modeled on New Jersey's success would ensure all families, regardless of zip code or employer, can access the time they need to support optimal infant and maternal health outcomes.

Recommendations: Implement a federal paid family and medical leave program guaranteeing at least 12 weeks of job-protected, income-replaced leave for all parents.

2. Expand Workplace Protections for Lactation

Why it matters: Returning to work is one of the most frequently cited reasons for breastfeeding cessation. Low-income workers are particularly disadvantaged, as they are less likely to have access to private lactation spaces or flexible break time. Since 2018, the *New Jersey Law Against Discrimination (NJLAD)* has required employers to provide reasonable accommodations and protections for employees to express breast milk in the workplace, including reasonable break time and a private space other than a toilet stall. Notably, the law does not impose an age limit on the child for whom the milk is expressed.

Under *NJLAD (N.J.S.A. 10:5-12),* breastfeeding is now considered a protected class, making it illegal to discriminate against, harass, or retaliate against employees based on their breastfeeding status.

At the federal level, the PUMP Act of 2022 also protects employees' right to express milk in the workplace.[302,303] However, it is less comprehensive than New Jersey's protections, as it limits coverage to the child's first year of life and allows employers with fewer than 50 employees to claim exemption. In contrast, New Jersey requires that all employees receive these protections, regardless of company size. Despite these laws, many employers remain unaware of their obligations or choose not to comply, particularly in low-wage industries such as factories and restaurants, where employees often work long hours without adequate breaks.

Recommendations: Strengthen enforcement of the PUMP Act and expand its protections to all workers. Educate employers on the PUMP Act, as well as NJ's laws that protect lactation within the workplace.

3. Invest in Culturally Congruent Lactation Support

Why it matters: Black, Indigenous, and Latino lactation professionals are underrepresented both statewide and nationally.[304] This shortage limits the ability of Black, Indigenous, and Latino families to access lactation support from qualified professionals who are more likely to understand their language, social and cultural norms, and family structures. Culturally competent support can help bridge the trust between families and healthcare providers, particularly given the implicit bias that people of color often encounter in healthcare settings. While ethnically diverse breastfeeding peer counselors exist in WIC offices and other community programs, the pool of IBCLCs both nationwide and in New Jersey remain far less diverse. When families face barriers in receiving culturally competent support, the support they receive will less likely be effective, which can affect if and how long they breastfeed.

Recommendations: Addressing this workforce gap requires targeted policies and investments, including funding scholarships and training programs for ethnically and culturally diverse lactation professionals, integrating culturally competent lactation education into healthcare curricula, and creating mentorship pipelines to support underrepresented providers.

4. Medicaid Coverage for IBCLCs

Why it matters: Low-income parents often rely on community-based programs such as WIC, Chocolate Milk Café, La Leche League, and other peer support networks for breastfeeding support. While these resources provide invaluable education, encouragement, and culturally relevant support, they cannot replace clinical lactation care provided by an IBCLC. IBCLCs are trained clinicians who can assess high level infant latching difficulties, evaluate milk supply, manage maternal complications such as mastitis, and provide evidence-based strategies tailored to each family's medical and social context.

Currently, Medicaid does not cover IBCLC services, meaning that parents enrolled in Medicaid often lack access to this "gold standard" of lactation support.[305] This creates a significant equity gap: families with higher incomes or private insurance can access individualized, clinical guidance, while low-income families must rely solely on peer support. The result is a structural barrier that disproportionately affects marginalized communities, contributing to disparities in breastfeeding initiation, exclusivity, and duration.

Recommendations: Expanding Medicaid coverage to include IBCLC consultations would directly address these inequities, ensuring that all families, regardless of income, can access clinically trained lactation professionals. Coverage should include in-person and telehealth consultations. This policy change would support longer breastfeeding duration, improve maternal and infant health outcomes, and advance broader health equity goals.

Conclusion

Breastfeeding is more than a personal choice; it is a critical public health intervention and a cornerstone of health equity. The disparities in breastfeeding rates across racial, socioeconomic, and geographic lines reflect systemic barriers rather than individual behavior. Policies that provide paid parental leave, robust workplace lactation protections, access to culturally competent lactation support, and Medicaid coverage for IBCLCs are essential to ensuring that all families can initiate and sustain breastfeeding. By addressing these structural inequities, we can improve infant and maternal health outcomes, reduce chronic disease, and promote economic and social well-being. Supporting breastfeeding equitably is not only an investment in individual families but a commitment to a healthier, more just society.

Conclusion

The necessity of fair and equitable healthcare has never been accessible for women or many Black, Indigenous, and People of Color (BIPOC) communities—especially being shown as a systemic failure that is painfully apparent in the crisis of Black maternal health. Without access to proper education and safe birthing options, many women cannot feel secure, empowered or supported during or after the labor process. The inability to offer diverse and equitable healthcare for all is related to high mortality rates, restricted access to early and consistent parental care and lack of culturally aware clinicians. These inconsistencies are not unintentional but are well established in systemic barriers that prohibit women from accessing the resources, information and support necessary for their birthing experience. The denial of this fundamental right creates a never-ending cycle of distrust and inequity.

The well-being of the families and the entire community depends on ensuring that every birthing person has access to safe and affirming care. Addressing and dismantling these ingrained health inequities is not merely a moral responsiveness—it represents a key public health obligation that impacts every member of society. The health, stability and well-being of families and the entire community ecosystem depends on ensuring that every person who gives birth has access to safe, respectful and affirming care throughout the reproductive cycle.

Nevertheless, data continually demonstrates that these meaningful solutions can promote change. When BIPOC communities have inexpensive access to quality prenatal, perinatal, postpartum and mental health care, maternal death rates fall, and delivery experiences become safer and healthier. Addressing inequality through a multitude of services is critical to ensure that all families receive the quality of care they need and deserve. Expanding Medicaid coverage, strengthening midwifery and doula care, reintegrating historically rooted birthing practices, and investing in culturally responsive, community-led healthcare models

all have the potential to drastically improve the outcome of safety and livelihood for mother and child alike.

This report directly addresses the structural injustices that have historically put women in danger during their pregnancy and childbirth. These solutions directly confront the structural injustices that have historically endangered woman and birthing persons during pregnancy and childbirth. Too many families' healthcare remains inaccessible because of the established structural hurdles that limit access to lifesaving treatment and support. We can reverse the terrible pattern of maternal mortality and insufficient care. The importance of adopting these solutions cannot be overlooked. It saves lives, eliminates preventable suffering and honor the inherent dignity of all birthing people.

The Advisory Coalition on Health Equity (ACHE) reflects this dedication to progress. By concentrating on the lived experiences, statistics and policy knowledge ACHE challenges the structural problems buried in the present system and offers bold, equity centered alternatives. This unified movement and its advocacy underscores that reproductive healthcare must be recognized as a right, not a privilege. Minor reform is no longer sufficient. By implementing these meaningful, thought-out solutions, the conversation around high maternal mortality rates and overall reproductive health can change towards a more hopeful outlook for woman to not only survive childbirth but experience it with safety, respect and pride.

Acknowledgements

Meet the Coalition

Kemi Alli

Dr. Kemi Alli is a nationally recognized leader in community healthcare, bringing over 25 years of expertise in Federally Qualified Health Center (FQHC) operations, clinical integration, and organizational transformation. As the co-founder of allied executive solutions, she partners with health centers and non-profits across the country to navigate leadership transitions, optimize programs, and enhance regulatory compliance. Her strategic guidance has helped organizations seamlessly integrate primary and behavioral healthcare, elevate patient outcomes, and establish vital services. Known for blending innovation with compassion, Dr. Alli has become a trusted advisor to mission-driven organizations striving to better serve their communities.

Dr. Alli's impact is rooted in her legacy as a trailblazing FQHC CEO, where she led a dramatic transformation of a health center into a comprehensive, multi-service provider. Her visionary leadership introduced telemedicine, advanced scheduling, and Mercer County's first Clinical Pharmacy and Advanced Nurse Practitioner Residency programs. A sought-after speaker and respected authority on healthcare operations and policy, she has presented at national forums hosted by Health Resources Services Administration, the Centers for Disease Control, and other key institutions. Whether guiding teams through compliance with federal standards or revitalizing organizational culture, Dr. Alli delivers measurable results that drive sustainable impact in underserved communities.

Julie Blumenfeld

Julie Blumenfeld, DNP, CNM is a Midwife and Fellow of the American College of Nurse Midwives and American Academy of Nursing. She is a Clinical Associate Professor & Program Director of the Midwifery Program at Rutgers School of Nursing. For over two decades she has provided midwifery care in Trenton, NJ. Dr. Blumenfeld is a passionate advocate for creating lasting change through health policy. She is the Chair of the NJ Maternal Mortality Review Committee, the past Chair of the NJ Maternal Care Quality Collaborative, and serves on the NJ Board of Medical Examiners Midwifery Liaison Committee. As the Principal Investigator on the New Jersey Midwifery Education Project she has made significant contributions to the body of research related to midwifery clinical education and to innovative training of midwifery preceptors in the state.

Dr. Blumenfeld is active in the American College of Nurse-Midwives and serves as Chair of its Government Affairs Committee and President of its New Jersey Affiliate. She is the recipient of the A.C.N.M Foundation's 2025 Dorthea M. Lang Pioneer Award presented to midwives who have demonstrated exceptional vision, leadership, and innovation and the American College of Nurse-Midwives 2023 Policy Award in recognition of her work to expand access to midwifery in New Jersey.

Adele Cappucci

Adele Cappucci is a senior at Virginia Tech studying Public Health with a minor in Biological Sciences. She hopes to pursue a Master of Public Health degree with a concentration in Epidemiology and Biostatistics, with a long-term goal of working in chronic disease and maternal health research. She is passionate about improving maternal health disparities in the United States. This summer, she gained firsthand experience supporting maternal and infant health programs through her internship with the Central Jersey Family Health

Consortium. During her time there, she observed the importance of comprehensive prenatal and postpartum care in promoting health.

Milibeth Castro

Milibeth Castro currently serves as the VP of Quality Assurance and Clinical Risk Management at Zufall Health Center. She is dedicated to achieving high-quality health care, focusing on a multidisciplinary, data-based, outcomes-driven process for continuously improving the quality and safety of the care provided at Zufall. She joined Zufall in 2020 as the Integrated Services and Telehealth Coordinator, where she successfully implemented a telehealth program across all sites. With over a decade of experience in public health, Milibeth's expertise is grounded in her dedication to enhancing organizational strategy and performance. This is particularly evident in her efforts to meet and exceed community healthcare needs.

In addition to her quality and risk management leadership, Milibeth is deeply committed to advancing maternal health and improving outcomes for pregnant and postpartum patients. Her work is driven by a strong focus on equity, patient safety, and strengthening systems that support mothers and families across the continuum of care.

Before her tenure at Zufall, she significantly contributed to the maternal and child health field as the Quality Improvement and Planning Program Manager at the Partnership for Maternal and Child Health. In this capacity, she played a pivotal role in identifying best practices and emerging trends in perinatal and pediatric care, leading initiatives that markedly improved patient safety and health outcomes in regional birthing hospitals. Milibeth holds a Master of Public Health from Rutgers, the State University of New Jersey.

Aleha Cruz

Aleha Cruz is a dedicated Full-Spectrum Doula, Maternal Health Advocate, and Community Health Educator committed to transforming birth experiences and reducing maternal mortality rates, particularly among Black and Brown birthing people. Since beginning her doula journey in 2021, Aleha has supported 13 births, walking alongside families through pregnancy, labor, postpartum healing, and reproductive decision-making. Her hands-on experience has given her a front-row view of the systemic gaps that disproportionately impact marginalized birthing communities in both New Jersey and Pennsylvania especially as 11 of those births resulted in emergency cesarean sections due to preventable complications.

Drawing from her lived experience and professional training, Aleha centers compassion, informed consent, and culturally rooted care in all her work. She provides emotional, physical, and educational support while advocating fiercely for patient autonomy and respectful treatment in clinical settings. Beyond the birthing room, she is deeply involved in community-based initiatives focused on health literacy, improved access to care, and empowering families with the tools to navigate their healthcare journeys.

As a leader and emerging voice in maternal health, Aleha brings a grounded, human centered perspective to her work. She believes that improving maternal outcomes requires collaboration between communities, healthcare systems, and policy leaders and she is committed to bridging those worlds through advocacy, storytelling, and evidence-informed solutions. Her mission is clear: to ensure that every birthing person is seen, heard, and supported from the earliest stages of pregnancy through the postpartum period.

Robyn D'Oria

Robyn D'Oria (MA, RNC, APN) is the Chief Executive Officer of the Central Jersey Family Health Consortium, a 501(c)3, not-for-profit agency. The Consortium is a regionalized network of agencies and providers involved in the delivery of perinatal and pediatric services in central New Jersey whose mission is to promote an equitable and healthy future for families through services, advocacy, education and collaboration.

Robyn has over 40 years of experience in maternal child health in a variety of roles. She is the NJ Section Chair for the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and was a member of AWHONN's Expert Panel on Maternal Mortality, lead facilitator/member of four of the initial Alliance for Innovation in Maternal Health (AIM) bundles, and most recently a member of the Severe Hypertension in Pregnancy bundle revision workgroup. Additionally, she was a consultant for AWHONN and their Merck for Mothers Postbirth Warning Signs Initiative.

Robyn currently serves as Board Chair for the Preeclampsia Foundation, member of the Executive Advisory Board for the Institute for Perinatal Quality Improvement, Treasurer of the NJ OBGYN Society, co-chair of the NJ Perinatal Quality Collaborative, and member of the NJ Maternal Mortality Review Committee as well as the Governor appointed Maternal Care Quality Collaborative. Robyn has been integrally involved in developing and promoting quality improvement work not only locally but nationally having published and spoken on efforts to reduce maternal mortality and morbidity at the state and national level. She is a graduate of Columbia University with a certificate in Nonprofit Management, New York University with an MA in nursing education, and Seton Hall University with a BS in nursing.

Maxilia Desir

Maxilia Desir is a Program Officer at the New Jersey Health Care Quality Institute, where she works on Maternity Action Plan (MAP) and Oral Health by turning strategic goals into on-the-ground initiatives that improve care and reduce disparities. A big part of her role is supporting quality improvement in the field, helping teams use data and practical tools to test changes, strengthen care delivery, and expand equitable access, especially for underserved communities. Her mission at NJHCQI works on improving the safety, quality, and affordability of health care for everyone. She is currently studying to get my Master's in Public Administration (MPA) at Cornell University, and her Bachelor's is from Rutgers University in Political Science. Maxilia is grateful for the opportunity to try to combat systemic barriers that pregnant women face in this country.

Erin-Ellen Dillon-Fink

Erin Fink, CNM, WHNP-BC, PMHNP-BC, is a Certified Nurse-Midwife and carries additional certifications as a Women's Health Nurse Practitioner and Psychiatric–Mental Health Nurse Practitioner whose work focuses on improving care for vulnerable populations and advancing the integration of mental health within whole-person reproductive care. Her clinical practice is grounded in trauma-informed principles, evidence-based care, and a commitment to equitable access for individuals across the reproductive and hormonal lifespan.

Erin has completed advanced training in menopause and hormone therapy, as well as in reproductive psychiatry, allowing her to provide comprehensive support for patients navigating perimenopause, menopause, mood disorders, and other hormone-related mental health concerns. Her approach emphasizes the deep interconnection between emotional well-being, physiologic transitions, and overall health.

She serves as Adjunct Faculty in the Midwifery Program at the Rutgers School of Nursing, where she contributes to the education and mentorship of emerging midwives and promotes curricular approaches that integrate mental health into reproductive and primary care.

Erin is also the founder and owner of a thriving private practice dedicated to hormone replacement therapy and comprehensive mental health care for women, offering a space where clients receive individualized, evidence-based, and compassionate support.

Through her clinical work, teaching, and ongoing professional engagement, Erin continues to advance models of care that recognize and honor the full complexity of individuals' reproductive, hormonal, and mental health needs.

Lorraine Mejias

Lorraine Mejias is a devoted mother, doula, lactation counselor, and founder of Repose Postpartum, a care company that exclusively focuses on postpartum recovery, newborn care, and lactation. As a passionate advocate for health equity, she served as the President of the New Jersey Breastfeeding Coalition from 2022-2025, leading statewide efforts to advance breastfeeding education, policy, and equity. She is also the co-founder of the Care Forest, a dynamic mutual aid and support network for doulas.

With a deep commitment to empowering birth workers, Lorraine serves as a business mentor, guiding doulas, lactation professionals, and other professionals in the care industry with building sustainable, thriving practices through strategic guidance and real-world experience. She intentionally weaves sustainability into the fabric of Repose Postpartum, creating a model that values both high-quality client care and the well-being, longevity, and success of the doulas she works with.

Lorraine holds a Bachelor of Science in Psychology & Criminal Justice, with a minor in Cognitive Neuroscience, and a Master's in Public Administration, all from Rutgers University.

Brianna Paden-Williams

Brianna Paden-Williams serves as Program Manager, Policy and Advocacy at Trenton Health Team (THT) spearheading the organization's policy and advocacy and THT's Regional Health Hub to reduce health disparities and improve access to care for Medicaid members. Brianna previously served at LiveOn NY, a membership advocacy organization, representing a diverse network of organizations that provide critical services for older adults.

In her role, she spearheaded the organization's communications and marketing efforts including supporting the communication for the Reframing Aging Initiative as well as advocating for policy and systems change for older adults and the human sector at large including funding for aging services and legislation to better support us all as we age. She holds a BA in Journalism from Rutgers University and Master of Social Work at Rutgers University New Brunswick.

Rina Ramirez

Rina Ramirez-Alexander, M.D, internal medicine physician, has held the position of Chief Medical Officer at Zufall Health since 2007. Under her leadership, the health center has received numerous quality awards from HRSA, achieved NCQA Patient Center Home recognition and The Joint Commission accreditation. Zufall Health was one of the first health centers to be recognized as a Million Hearts Hypertension Control Champion by CDC and continues to receive annual recognition by the AHA/AMA on hypertension, diabetes and cholesterol control.

Dr. Ramirez has been recognized as an Outstanding Executive Leader by HRSA, by the New Jersey PCA and by Morristown Medical Center. She is the recipient of NACHC's Samuel U. Rodgers, MD, Achievement Award in recognition as a distinguished primary care clinician who exemplifies excellence in clinical practice and leadership at the local, state, or national level. Dr. Ramirez is a champion in national learning collaboratives and innovation projects, fostering a patient-centered, trauma-informed primary care model that focuses on quality clinical services, integrated care, staff wellness, and patient satisfaction.

As an active member of NACHC, Dr. Ramirez is a representative at the Board of Directors, is a member of the Clinical Practice Committee, past Vice-Chair of the Behavioral Health-HIV Integration Committee and current Chair of the Healthcare for Patients Experiencing Homelessness Committee. She continues to serve on expert panels and has presented at national, regional, and local medical convenings on clinical best-practices and quality improvement activities.

In addition to leading the integrated clinical team (medical, dental and behavioral health services) at Zufall, Dr. Ramirez, along with her talented team and state and community partners, has spearheaded innovative programs including promoting SUD and HIV services within a primary care practice, enhanced behavioral health services to treat PTSD, street medicine to help those experiencing homelessness, mobile unit clinics at food pantries, faith-based organizations and shelters, vaccinations to reduce respiratory illness and delivery of food and fresh produce to patients in need. Her focus is to champion wellness in her staff and patients, with the ultimate goal of achieving good health for all.

Nyeilla Veale

Nyeilla Veale serves as the Director of the Perinatal Health and Wellness Program at KinderSmile Foundation, New Jersey's leading nonprofit organization promoting public health dentistry. In this role, she spearheads efforts to break the dangerous cycle of

untreated dental diseases by empowering underserved mothers from pregnancy through three years postpartum, with culturally sensitive care, and personalized education on the importance of maternal oral health and its impact on fetal and early childhood development. A proud Boston native, Nyeilla earned her Bachelor's degree in Biology from Worcester State University, before completing a Master's in Biomedical Science from Rutgers University with a concentration in stem cell biology. During her graduate studies, she participated in research at Rutgers School of Dental Medicine, exploring the connection between periodontal disease and carotid artery calcification. This experience deepened her interest in the intersection of oral and systemic health, particularly in maternal care.

Nyeilla is a passionate advocate for health equity, with a special focus on expanding access to oral healthcare in marginalized communities. Through education, prevention, intervention, and integrated care models, she works tirelessly to reduce adverse birth outcomes and early childhood care. Her work reflects a vision of community-centered care where oral health is treated as an essential component of perinatal and overall health.

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