Supplement:
From the UCLA-CDU
COVID-19 Task Force

Maternal and Infant Health Inequities, Reproductive Justice and COVID Addressed in RACE Series

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Introduction

This fall 2022 issue of *Ethnicity & Disease* contains the next installment of the Rapid Assessment of COVID Evidence (RACE) Series. The purpose of the RACE Series is to disseminate results from studies conducted by the UCLA-CDU COVID-19 Task Force on Racism & Equity as the findings become available. The research examines the persistence of racism and other social injustices (eg, due to housing discrimination, certain policing practices and unjust sentencing laws) during the pandemic to illuminate key implications for COVID inequities and potential targets for intervention.

The findings presented in this issue of the series focus squarely on emerging threats to reproductive justice. Reproductive justice is a liberatory framework created to capture the complex, intersectional social realities by which structural oppression influences sexual and reproductive health. Thus, this issue provides a near real-time response to the US Supreme Court's consequential decision in *Dobbs, State Health Officer of the Mississippi Department of Health, et al v. Jackson Women's Health Organization et al*,[1] which effectively overturned the rights to abortion established in 1973 in the landmark case, *Roe v. Wade*. The *Dobbs* decision will have immediate as well as long-lasting impacts on health inequities. To help explain its key implications for health inequities and inform strategies to respond to them decisively, I [CLF] invited thought leaders in reproductive justice [JCP], maternal and infant health inequities [VW], and reproductive decision-making and control [JG] to share their expertise on the matter in this commentary. Together, the findings and discussion of *Dobbs* place present reproductive justice concerns within the contexts of the concurrent COVID pandemic and the increasingly restrictive environment surrounding reproductive health and reproductive justice in the United States.

This issue's RACE Series findings are from the COVID Storytelling Project's (CSP's) qualitative arm,[2] which applies Critical Race Theory[3,4] to guide the collection and analysis of data from virtual focus groups conducted with community organizers, front line public health professionals and members of socially marginalized populations. Authors de la Rocha and colleagues illuminate key experiences with and per-

ceptions about birthing injustices during the first year of the COVID pandemic among Black, Indigenous and People of Color (BIPOC) populations and socially marginalized populations. One notable finding is the salience of the concept of the supremacy of a focus on birth only. It suggests that more comprehensive understandings of reproductive, women's and maternal health are too often obscured by a narrow focus on the outcomes of pregnancy rather than more holistic framings that value the well-being of women and other birthing people more fully. Parallels may exist with respect to the *Dobbs* decision, even though the full implications of the decision for abortion-related outcomes and other outcomes cannot yet be known. Those implications are likely to reflect the intersectionality of the COVID pandemic and the increasingly restrictive environment for reproductive and women's health since the Supreme Court decision in *Dobbs*.

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The New Legal Landscape for Reproductive Justice and Inequities

With the Supreme Court's decision in *Dobbs*, the landscape for reproductive rights changed immediately. Nearly six in 10 women of reproductive age, 40 million (58%) women, live in states that are hostile to abortion rights.[5] Within a month of *Dobbs* (7/24/22), 11 states banned abortion completely or at six weeks of pregnancy.[6] Now as ever, where one lives dictates her or their access to basic health care and the consequences of forced birth. While these restrictions will affect all pregnancy-capable people in restricted states, low-income, communities of color, and other marginalized populations will suffer disproportionate impacts.

The number of anti-abortion laws and practices and their degree of severity have both been increasing in recent years. Collectively, they work to force every impregnation to be carried to birth. The threats to reproductive justice reflect the intersectionality of racism, classism, ableism and nativism. There are both immediate and lasting ramifications for maternal and child health, the socioeconomic status of families, and the policing of women and other pregnancy capable people by the prison industrial complex. The vigilante aspects of some of these laws (criminalizing people who 'aid and abet' abortion) are also likely to fall disproportionately on communities/people of color. Therefore, the consequences of forced birth may exacerbate existing income and health inequities. In addition to risks for Black, Indigenous and People of Color being heightened due to inequities in health care access,[7] these populations are also at greater risk of being surveilled regarding their actual or predicted criminal behaviors related to pregnancy (eg, drug use during pregnancy).[7,8]

Reproductive justice organizers have long recognized the limitations of *Roe*; for example, it did not ensure equitable access to abortion care for all US residents.[9] However, the Supreme Court's recent action abandoning the law has already caused an additional layer of unnecessary harm, trauma, and violence that will continue to contribute to inequities in maternal and child health among birthing people unless effective interventions are put in place.

Disproportionate Impact among Black and Latinx Populations

All evidence suggests BIPOC populations will be impacted most severely. They will experience distinct levels of physical and mental harm as they are forced to go without ready access to safe options for quality reproductive and other

care. Several explanations assist in contextualizing this maltreatment.

Forcing a person to carry a pregnancy to term is associated with a 14-fold increase in risk of death due to childbirth complications as compared to receiving an early abortion.[10] Black women are three times more likely to die from pregnancy-related causes than White women due to structural discrimination and interpersonal discrimination and racism that contribute to differences in access to care, quality of care, and prevalence of chronic diseases.[11-13] As estimated by Stevenson et al, a total ban on abortion would result in a projected 21% increase in maternal mortality overall and a projected 33% increase in maternal mortality among non-Hispanic Black individuals.[14]

In addition to its effects on maternal mortality and morbidity, continuing an unwanted pregnancy to birth is associated with longer term impacts, including an increased risk of subsequent poverty, a higher likelihood of remaining in a relationship with an abusive partner, and negative impacts on child development, among other outcomes.[15-17]

Where people live also matters. Compared to states where abortion is protected by law, many states that have banned abortion—such as Texas and Mississippi—have greater percentages of BIPOC residents and higher percentages of residents who are living in poverty.[5,18] States with restrictive abortion policies often restrict access to contraception and comprehensive health care as well. Moreover, many of these states have among the nation's weakest social safety nets for pregnant people and children, which may explain why they also have some of the highest rates of pregnancy complications and maternal mortality.[19,20]

Surveillance Considerations

The control of women's reproductive and sexual activities has always relied on various forms of surveillance to ensure adherence to policies, practices and social norms.[21] The types of surveillance strategies used, how pervasive their use is and what consequences they produce vary in ways that affect racially minoritized and socially marginalized populations most adversely. Historically, the criminalization of pregnancy outcomes like miscarriage and stillbirth has primarily targeted poor, BIPOC, disabled and immigrant populations.[22] The goals of these strategies include both boosting reproduction and curtailing it.

For instance, prior to 1865, the institution of slavery sought to maximize the number of births female slaves could produce while simultaneously maximizing their productivity as manual laborers.[23,24] Since then, however, health care providers and others have more often sought to limit the fertility of Black, Brown and Indigenous women by discouraging pregnancies among these populations, encouraging hysterectomies, forcing or coercing sterilizations, and in some cases performing them without a patient's consent.[21,25] In short, birthing by enslaved women was commoditized to create wealth and political power for those profiting from slavery (ie, slaveholders, banks, etc.). Forced birth in the 21st century is a contemporary way to commoditize reproduction and to limit the wealth and political power of minoritized birthing people and their communities.

Solutions: Learning from the Past to Move toward a More Just Future

We recognize that many tactics used by powerful people and institutions in the United States have constructed this moment in which we, Black women, transgender, and nonbinary people, and our allies, find ourselves.[26] These tactics arise from a legacy of White supremacist, capitalist, patriarchy that seeks to destroy difference, control bodies, and hoard power. To move forward as organizers and people who believe in freedom, we have the opportunity to allow our community's powerful legacies of activism and creation to encourage us

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in dreaming of options for our reproductive health and future that go beyond the limitations of *Roe*.[9,27,28]

One necessary solution is to implement community-based sexuality and reproductive health education extensively across the nation.[2,3] By creating safe spaces where we as individuals and communities can learn about our bodies, consent, and rights, we create pathways to knowledge to be shared by everyone for the purpose of bringing forth more consent, justice, joy, health and pleasure. Knowledgeable and self-determined communities are empowered communities; culturally responsive community-based sexuality education is one vehicle that we can all help drive on the road to freedom.[9,27,28]

To develop effective evidence-based interventions also requires attention to new and existing policies that significantly impact access to care, mortality, and morbidity. In addition to the restrictive abortion laws that were passed swiftly following the *Dobbs* decision, the ruling places other established rights in jeopardy, including the freedom to use contraception and the legality of same-sex marriage. The Supreme Court decision and increasingly restrictive laws in multiple states force birth but provide little to no provisions to support employment or prevent poverty.[29] The lack of childcare resources and policies that are hostile toward reproductive justice disproportionately harm those with the least political influence and power, such as Black, Indigenous, Latina and other minoritized women. They also harm persons with disabilities, immigrants and undocumented persons.[30] Proposals that raid social security and other safety net programs place a greater risk and financial strain on those who historically and currently have the least wealth and wealth-earning potential – again Black, Indigenous, Latina and other minoritized women.

As the evidence base shows, practices that limit access to care among immigrants, those that exclude citizens from the democratic process, and those that systematically undercount US residents in census surveys constitute forms of discrimination that likely exacerbate the cost of health inequities the whole society must bear.[31-33] The United States is supposed to represent a place where vulnerable people from around the world can find refuge. As with the 1996 welfare reform law, however, legal immigrants and, in particular, non-citizens and immigrants without documentation are particularly vulnerable to the loss of human rights with respect to reproductive justice.[33] Similarly, US citizenship is supposed to confer certain rights, including the right to privacy and the right to protect one's property and one's person. To the extent women, females and other birthing people are precluded from fully exercising these rights, however, they are relegated to a second class of citizenry.

The recent efforts of some elected officials—in particular, efforts to suppress the vote in BIPOC communities and to control the decisions and practices of birthing individuals, their families and their health care providers—undermine the democratic process. The systematic disenfranchisement of minoritized and marginalized communities keeps those made most vulnerable by exploitation and disinvestment from attaining and exerting the political power needed to improve our social, economic and health statuses. Access to health care and the quality of available health care depend on policies advanced by people with political power and influence. Therefore, policy change may offer the best solutions to the reproductive justice threats discussed here.

Racism is context-specific; it morphs over time and typically becomes more extreme during epidemics.[34,35] Therefore, the goals of the RACE Series are to illuminate racism and other social injustices as they manifest during the COVID pandemic and to highlight communities' strategies for responding to them.[36] The RACE Series strives to do so by "centering the margins"; that is, by framing each set of health inequities from the perspectives of the people who are experiencing the inequities rather than from the perspective of the researchers who are studying them.

According to public health critical race praxis (PHCRP), health outcomes necessarily reflect the racialized social contexts in which they occur. The reproductive health inequities portended by *Dobbs* may seem unrelated to the COVID pandemic; however, these inequities, COVID inequities and related social injustices (eg, state-sanctioned violence) are inextricably linked to the structural forms of racism and the longstanding, coordinated efforts to restrict the rights of both BIPOC people and birthing people that un-

dergird the inequities and injustices.

The findings reported by de la Rocha et al[37] underscore the need for research on "the impacts of racism and structural violence at the intersection of reproductive health during the pandemic." As the authors explain, this is important not because birthing people have greater risk of COVID infection; they do not. It is important for identifying the intersectional root causes that drive inequities in both birthing and COVID outcomes.

Neither these threats to reproductive justice nor the collective ability to overcome them are new; they are clear echoes of the past.[38] Therefore, the principle of Sankofa can guide us in responding to them. Sankofa, a term originating with the Akan people of Ghana, reminds us to look to the past for direction on our present journey toward a more purposeful and hopeful future. It also reminds us that our ancestors are with us in those efforts. With respect to the threats to reproductive justice posed by *Dobbs*, Sankofa is embodied in the work of the Combahee River Collective, who asserted the importance of naming the various oppressions that we faced then and still face today. It is embodied in Loretta Ross and countless other Black women and people who have worked to give language to what we now understand to be reproductive justice. Sankofa is embodied in us and our determination to bring forth a reality that reflects the truth that Black people have fundamentally always been free. Sankofa will be embodied in those who come after us and take up the mantle for reproductive justice in new ways that respond decisively to the immediate challenges they face. Our communities' legacies of resistance, rigor, and scholarship have given us much on which to draw, including as de la Rocha et al report, the joy and pleasure to be found in the pursuit of health justice.

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Conflict of Interest

No conflicts of interest to report.

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