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

A Qualitative Analysis on Sexual and Reproductive Health Needs and Issues During COVID-19 Using a Reproductive Justice Framework

Patanjali de la Rocha, MSW, MPH[1]; May Sudhinaraset, PhD[2]; Nicole V. Jones, MPH[2]; Catherine Kim, BS[2]; Alejandra Cabral, MPH[2]; Bita Amani, PhD, MHS[3]

The COVID-19 pandemic exacerbated existing health inequities, further exposing the challenges in meeting the sexual and reproductive health (SRH) needs, particularly for Black, Indigenous and People of Color (BIPOC). We interviewed 11 key informants through three focus groups to explore barriers and pathways to SRH care for BIPOC during COVID-19 in the United States. Reimagining reproductive health practices requires holistic practices and multisector pathways, a comprehensive reproductive justice approach. This includes interventions across the sexual and reproductive health continuum. Using a deductive-dominant approach grounded in reproductive justice values, we explore themes around SRH during COVID-19. Five themes for advancing reproductive justice were identified: "supremacy of birth"; police violence as a determinant of SR mental health; addressing quality of care outside of hospital settings; digital redlining; and centering joy, liberation, and humanity.
Ethn Dis. 2022;32(4):357-372; 10.18865/ed.32.4.357

Keywords: Reproductive Justice; Health Equity; Sexual and Reproductive Health; Structural Racism

1 Department of Global Health, University of Washington, Seattle, WA
2 Fielding School of Public Health, University of California, Los Angeles, CA
3 Charles R. Drew University of Medicine and Science, Los Angeles, CA

Address correspondence to : Patanjali de la Rocha MSW, MPH; Charles Drew University & UCLA COVID-19 Task Force on Racism and Equity; patanjali.delarocha@gmail.com

Introduction

Exacerbated by the pandemic, structural racism has produced and maintained reproductive health inequities through the maintenance of White supremacist systems.[1] In the late 1990s, co-founder of SisterSong Women of Color Reproductive Justice Collective, Lorretta J. Ross, PhD was clear about the connections between racism, reproductive health, and necropolitics[2] when she stated, "the system of White supremacy constructs different destinies for each ethnic population of the United States through targeted, yet diffuse policies of population control."[3] This design has created "medical apartheid"[4] (the persisting inequity in medical care and research since colonization and slavery) conditions perceptible today in the unrelenting differential access to care.[5] Racism is a persisting cause of both adverse maternal and infant health outcomes and of stark disparities in maternal and infant mortality.[6–8] Its impacts occur across the reproductive lifespan and structural determinants of health equity.[9,10]

Prior to the pandemic, population and community sexual and reproductive health (SRH) were inadequately promoted due to: 1) reduced access to respectful care[11]; 2) barriers to care (eg, insurance coverage, professionalization, and scope of practice)[12]; 3) racial discrimination in the delivery of care[13]; and 4) biopolitical contestations regarding which types of care are socially and politically permissible.[14] This all occurs within a system, "where it would seem equity is not the priority, but retaining power and control is."[14] In Table 1, we offer established definitions of racism, SRH, reproductive justice, socio-ecological and transdisciplinary models.

Inequities and structurally racist policies shape the distribution of risks and resources for health; therefore, overlapping epidemics (eg COVID-19 and racism) can produce synergistic effects due to interactions between biological processes and social, economic, and power inequities.[23] A systematic review of peer-reviewed studies of the impact of COVID-19 on SRH through May 2021 found gaps in the evidence on: service provision, access, and utilization among marginalized groups of women and girls and those with intersectional identities, including adolescent and young girls, those with disabilities, sexual or ethnic/racial minorities, refugees and immigrants.[24] Historically, these findings are consistent with the

impact of disasters on reproductive health access and needs across varied racial and economic contexts.[25–29]

This article describes the methodology, theoretical frameworks, and results of our qualitative study and present recommendations for how to move forward using a social justice framework. Reproductive Justice and Transdisciplinary Conceptual Resilience Framework of Contextualized Resilience for Reducing Adverse Birth Outcomes (TCRF) were integrated to guide this study because they demand connections be made between historical racial injustices, current inequities, and community-based resiliency. We used both frameworks to guide all aspects of study design and analysis.

Inequities and structurally racist policies shape the distribution of risks and resources for health, overlapping epidemics (eg COVID-19 and racism) can produce synergistic effects due to interactions between biological processes and the social, economic, and power inequities.[23]

There are multiple complex pathways from racism to reproductive health disparities, but all levels fundamentally function by devaluing certain historically oppressed populations and restricting their access to fundamental resources and needs. Policy interventions to address needs across the reproductive lifespan should be informed by sustained collaboration and input from the communities most impacted by racism have potential in undoing the structural harms that contribute to health inequities.[30,31] From grassroots movements to institutional protocols to federal legislation,[32] policies can be shaped and they create change across disciplines and ecological layers.[33] This study sought to highlight the importance of policy change in undoing structural racism. For these reasons, we have chosen to illuminate themes that expose gaps in the existing literature or hold potential for policy impact.

The purpose of this article is to identify strategies and opportunities to improve access to the full spectrum of SRH care needs across the lifespan as identified by community and academic leaders working in the SRH field during the COVID-19 pandemic. This article's focus is not on the bio-medical impacts of COVID-19 on SRH, but rather the impact of the pandemic on the racial and sociopolitical contexts for SRH care needs and the ways this impact exacerbated existing and historical racial inequities in health care. Through focus groups, we explored barriers and pathways to SRH access for populations of Black, Indigenous, People of Color (BIPOC) during COVID-19 in the United States. In doing so, we center the experiences and recommendations from those most impacted by structural oppression and White supremacy. Centering those most impacted is necessary to achieve true equity,[34] especially when operating within applied sciences of academia, which has been widely understood as an 'ivory tower,' disconnected from actual community practice and lived experience.

Methods

Study Design

This qualitative study gathered focus group data and analyzed it using thematic analysis with a qualitative description approach.[35–37] These findings are from focus groups that were conducted as part of the larger, multi-armed study called the COVID Storytelling Project ("Project") of the UCLA/CDU COVID-19 Task Force on Racism and Equity. The larger project seeks to explore existing community health systems, to determine how the pandemic has compromised them and how historically SRH has been affected, and to understand how it does so in the current moment. Participants and their stories are centered in this project to: 1) reconceptualize our beliefs of the world; 2) be intentional on what world we prioritize knowing; and 3) challenge conventional approaches to research that do not stand in solidarity with the oppressed and instead reproduce heteropatriarchal colonial research enterprises.[38] The Project

Table 1. Definitions

Racism	According to past American Public Health Association (APHA) President Camara Jones, MD, MPH, PhD, racism is a system of structuring opportunity and assigning value based on how one looks, which unfairly advantages some, disadvantages others, and saps the strength of the whole society.[15] The mechanisms of racism are in our structures, policies, practices, norms, and values, which are different elements of decision-making.[16]
Sexual and Reproductive Health	From the World Health Organization (WHO), sexual health is an integral part of overall health, well-being, and quality of life. It is a state of physical, emotional, mental, and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected, and fulfilled. Much remains to be done to ensure that public health policy and practices recognize and reflect this.[17]
Reproductive Justice	Reproductive justice is defined as all people having the social, political, and economic power and resources to make healthy decisions about their gender, bodies, sexuality, and families for themselves and their communities.[18] We utilize the three primary reproductive justice principles developed at the foundation of the formation of the 1994 reproductive justice movement. These principles identify emerging health issues across the reproductive lifespan and are: 1) the right not to have a child; 2) the right to have a child; and 3) the right to parent children in safe and healthy environments. A reproductive justice framework supports an analysis of reproductive health, diminished reproductive rights, and the denial of reproductive justice as they are connected to racism. Reproductive justice encompasses health, safety, dignity but it moves beyond these components to ask for an interrogation of socially constructed barriers to reproductive rights along racialized lines.[19]
Transdisciplinary and Socio-ecological Models	Transdisciplinary models of practice aim to provide more family-centered, coordinated, and integrated services to meet complex needs.[20] By transcending disciplinary boundaries, there is a sharing of knowledge, skills and decision-making, a focus on real-world problems and the inclusion of multiple stakeholders including patients, their families and their communities.[21] The socio-ecological model is a framework of prevention that considers the complex interplay between individual, relationship, community, and societal factors. This model recognizes the necessity to act across multiple levels of the model at the same time, is more likely to sustain prevention efforts over time, and to achieve population-level impact.[22]

applies Public Health Critical Race Praxis (PHCRP) and other critical methodologies (ie, anti-colonial and feminist methodologies) to frame racism as impacting all facets of how society operates under a system of White supremacy, capitalism, and patriarchy that intersect and mutually enforce each other.[15,39–45] Details on the application of PHCRP and the understanding of the researchers to this theory is published elsewhere.[38]

Sample and Sampling Strategy

Participants were recruited using a purposive referral sampling process.[46] This technique was chosen because it is widely used in qualitative research to identify and select information-rich cases for the most efficient use of limited resources.[47] We identified and selected individuals who are especially knowledgeable about, experienced in, and identified with the communities most impacted by reproductive justice issues and systemic racism.[48]

Participants were asked to identify the community(ies) they work with and their relationship to that community. All participants identified as members of the community they work with, and many reported holding multiple roles and identities in their communities (Table 2).

Conceptual Framework

This study integrates two conceptual frameworks: the TCRF of Contextualized Resilience for Reducing Adverse Birth Outcomes and the Reproductive Justice Framework.[49] The TCRF represents six layers of resilience in response to structural violence and oppression: 1) capacity (individual); 2) entitlement (familial, intimate, and friends); 3) resistance (community and collective culture); 4) structural vulnerability (structural and institutional); 5) historical oppression and manifesting (policy); 6) embodiment and transformation (hegemonic discourse). Within these dynamic and interactive layers, the framework identifies, "resilience as a strength-based process, praxis, and symbolic action or belief that women use as a means of claiming sovereignty over themselves."[49] This framework was selected to develop themes because it is a strengths-based approach. Also, the transdisciplinary aspect mirrors the transdisciplinary

Table 2. Participant profiles including unique de-identified number, professional identifications, and their communities

Participant ID	Professional Role	Area of SRH	Communities
FG1S3	Research scientist, advocate	Full spectrum sexual and reproductive health (SRH) needs	Black Indigenous People of Color (BIPOC), Queer community
FG1S4	Public health official, midwife	Pregnancy and birth, lactation and breastfeeding, perinatal peer support	Black, African American, American Indian Alaska Native (AIAN) and Native Hawaiian Pacific Islander (NHPI)
FG1S5	Director of Maternal & Infant Health, non-profit	Neonatal care	Black community
FG2S3	Non-profit director, advocate	Sex education, abortion access	Youth
FG2S4	Non-profit director, International Board Certified Lactation Consultant (IBCLC), midwife, public health practitioner	Full spectrum sexual and reproductive health needs, breastfeeding and lactation, perinatal peer support	Black community
FG2S5	Professor of Health Sciences	Lactation and breastfeeding, pregnancy and birth, perinatal peer support	Hispanic, Latinx, and Black community, students becoming lactation consultants (IBCLC)
FG2S6	Sexual health educator, abortion access community organizer, activist, community doula	Sex education, abortion access, pregnancy and birth, youth, perinatal peer support	Youth activists of color ages 14-24
FG3S3	Community health worker, birth professional, researcher, academic	Sexually transmitted infections (STIs) & HIV/AIDS, Lesbian Gay Bisexual Trans Queer Intersex and Asexual (LGBTQIA)	People living with HIV, Black, Latinx, Queer community, and Cisgender women
FG3S4	National health law attorney	abortion access, gender-based violence	Immigrants, refugees, Asian American community
FG3S5	Non-profit executive director, community doula training, health equity consultant, activist	Pregnancy and birth, full spectrum SRH needs, gender-based violence, breastfeeding and lactation, perinatal peer support	Black, Brown and Indigenous peoples, low-income, undocumented
FG3S6	Community midwife, maternal health activist	Pregnancy and birth, perinatal peer support, gender-based violence	Black and Latino, Latina women and families

goal of collaborative care across health sectors and stakeholder levels, and lastly it is a methodical and peer-reviewed framework that contextualizes the historical inequities in the field of reproductive health.

Reproductive Justice (RJ) frameworks have been recommended for application in other health science disciplines, such as psychology, particularly for addressing health needs of Black and other medically underserved communities.[1,50–53] RJ has historically addressed the need to bring reproductive care and reproductive rights together through a justice lens that takes into account structural determinants. This framework offers a set of values that recognizes that everyone has the right to: 1) have a child; 2) not have a child; and 3) parent that child in a safe and healthy environment.[18] SRH care and needs are conceptualized within these frameworks as being comprehensive and across the lifespan as well as contextualized as historical inequities driven and impacted by racism. TCRF, which itself is a RJ-based framework, played a significant role in the development of our interview guide, generation of our codebook, and our analysis of find-

Table 3: Interview guide questions and Transdisciplinary Conceptual Resilience Framework (TCRF)

Interview guide main questions	TCRF domain
We recognize that there are folks working with different groups of people. Can you describe the community you work with? What is your role within the community?	Resistance
Where is the community you work with getting their information on COVID? Such as how to avoid catching or spreading it?	Resistance, Historical Oppression (Manifesting)
In terms of COVID-19 testing and vaccination, can you give us a sense of what the community's experiences have been around testing and vaccinations?	Structural Vulnerability, Historical Oppression (Manifesting)
What are the challenges in receiving reproductive health care that you've seen, heard about, or experienced? How has the pandemic impacted reproductive health care (eg. prenatal care, postnatal care, birth, doula, education, fertility treatment, abortion, etc.)?	Structural Vulnerability, Entitlement, Historical Oppression (Manifesting)
How easy has it been for those you work with to shelter in place safely?	Structural Vulnerability, Capacity, Entitlement, Embodiment
How can we integrate practices that: center pleasure, liberation, bodily autonomy, cultural respect?	Capacity, Embodiment, Resistance
How are people finding strength or drawing on strength right around their own reproductive health needs (individual)?	Capacity, Embodiment, Entitlement, Resistance
In what ways is racism operating?	Structural Vulnerability, Capacity, Entitlement, Historical Oppression (Manifesting)

ings. The RJ framework was utilized in the development, reviewing, and defining of themes. RJ also guided the interpretation of the themes primarily by orienting them towards the larger goal of racial equity.

Data Collection

From May - August 2021, three focus groups were conducted over Zoom to interview 11 key informants from the medical field, public health, health care, community-based grassroots movement, health equity, and social justice organizations in the United States. The methodology is described in detail elsewhere.[38] Twelve key informants were recruited; however, one participant had Internet and connectivity issues during the focus group, was unable to join after the first half-hour, and declined their incentive. As a result, we excluded all data from this participant in the analysis.

Interview Guide

Three main research questions guided the creation of the semi-structured focus group interview guide (Table 3) based on the TCRF framework. The guiding questions, showing TCRF ecological layers in parentheses, were: 1) What are policies for interrupting racism within reproductive health practice during COVID-19? (Structural Vulnerability); 2) What are person-centered practices and challenges related to racism in reproductive health practice during COVID-19? (Capacity); 3) How can we integrate practices that: center pleasure, liberation, bodily autonomy, cultural respect? (Embodiment). A qualitative description approach was used to guide the development of these questions. This approach has been identified in the literature as important and appropriate for research questions focused on discovering the who, what, and where of events or experiences and gaining insights from informants regarding phenomena that are underrepresented in the literature.[54,55]

Analyses

This study utilized a thematic analysis.[56] Transcripts generated from focus group recordings were independently read multiple times by each member of the research team who had been involved with collecting the data to both familiarize themselves with the data and to do the initial preparation of codes. To generate the initial codes, the team used the TCRF to identify the racial and socio-political context within which BIPOC access reproductive health care during COVID-19. Codes were also inductively generated to allow for the identification of novel concepts that represented deeper mean-

ings related to the research question of exploring barriers and pathways to SRH access. After codes were generated and the codebook was finalized, the transcripts were systematically coded by two members of the research team and all data were coded and finalized through consensus.

Themes were initially developed through multiple discussions involving reviews of code maps (to visualize the relationships between codes) and examination of collated data associated with specific codes, more frequent codes, and co-occurring codes to search for unifying concepts within the data to both represent and give deeper meaning to RJ principles. The team looked for trends and defining concepts across the data to continuously and iteratively reflect on: opportunities and challenges to becoming a parent; avoiding pregnancy and birth; and parenting during the pandemic. The codes prioritized in theme development were reproductive health, access, advocacy and policy, racism, structural determinants of equity (SDOE), historical references, mobilization, and mental health.

After initial themes were generated, themes were reviewed, selected, and refined. Final themes represent a set of ideas that draw connections between issues of RJ (eg, racism and equity) to COVID-19-related factors (eg, testing), reproductive health and health care (eg, fertility and doctor's appointments), reproductive rights (eg, leave policies), and social determinants of health (eg, policing, isolation, and insecurities). To aid in thematic analysis, two software programs, Dedoose(dedoose.com) and LucidChart(lucidchart.com), were used to code all data, organize data extracts and to visualize relationships within and across codes so that reoccurring patterns and deeper meanings within the data could be grouped together and categorized into themes.

Results

Through thematic analysis we identified health issues occuring across the reproductive lifespan. Qualitative analysis of the 11 expert participants revealed the following main themes: 1) "supremacy of birth"; 2) police violence and sexual and reproductive mental health; 3) digital redlining; 4) quality of care; and 5) joy, liberation, and humanity. By using a RJ framework, each theme connects back to an existing RJ principle(s) on: 1) challenges related to the pandemic around achieving and maintaining healthy pregnancy and birth (Theme 1-5); 2) getting SRH needs met to not get pregnant or address other types of needed reproductive care during the pandemic (Theme 1-5); and 3) safety and dignity in parenting during this time (Theme 2, 3, 4 and 5). How these themes connect directly to these principles are discussed in more detail below. For the presentation of the quotes below, participants were given unique identifiers to indicate the focus group they participated in (FGx) and a number assigned on the order they spoke (Sx). For example, the first person to speak in Focus Group 2 was given an identifier of FG2S1.

"Supremacy of Birth"

This theme brings together many challenging considerations related to SRH needs and equity as it has to do with the type of care that is prioritized, the historical trajectory that has resulted in birth being mostly done in hospitals, and the racial history that has produced these conditions. Perinatal health policy and advocacy in the United States was described in the focus groups as mostly occurring in certain spaces (ie, hospitals) and dismissing other types of needed SRH services (eg, abortion services, infertility). "Supremacy of birth" is a theme named by a participant who said "…birthing is not the only outcome that is possible from pregnancy," she continued:

> "This supremacy of birth - we need to deal with the jacked-up situation that most of the births in the United States happen in hospitals. But let's not forget that there were people who needed abortion care. Let's not forget that there were people who have fibroids who needed a Morena ring. Let's not forget that people have sexually transmitted infections that needed to get treated." (FG1S3)

This theme is directly connected to RJ principles through its highlighting of challenges of choosing to not be a parent (and having birth overshadow other important SRH needs) and the challenges of deciding to be a parent in an environment that focuses primarily on hospital-based birth (as opposed to a community-based mid-

Table 4. Representative quotes to further illustrate the theme "supremacy of birth" and how it aligns with Transdisciplinary Conceptual Resilience Framework (TCRF) and Reproductive Justice (RJ) Principles

TCRF Domain & RJ Principle	Participant quote further illustrating the theme "supremacy of birth"
Capacity; The right to not have a child	"We've seen a lot of abortion funds pop up, which is great. But there's still so many people who, at least in the communities that I'm supporting and working with, and specifically young people in low-income communities trying to access services in a space where there is no possibility for insurance to help cover the cost can mean a lot, and can also mean delaying a procedure, and then the cost increasing as a result." (FG2S3)
Entitlement; The right to not have a child	"There is this sentiment that is growing around we don't need a medical provider to support a medication abortion. And it is safer than many, many, many other medications. I've been seeing and supporting a lot of information dissemination around self-managed abortion and around safe abortion with medication. I think there's some parallels there with the home delivery piece, to be able to manage your own care in the ways that feel okay." (FG2S3)
Resistance; The right to raise children in safe and healthy environments	"I had a child who was suicidal, and we had to get her to voluntarily commit to some treatment because we weren't going to call the police because what caused her mental health to spiral was being beat at a protest by police. I had to take a week off of work, and I will tell you, I still get knots when I think about this. I didn't know if I was going to be okay at the end of it because all I could do was go into mama bear mode. I had to fight the system every step of the fucking way to get just basic respectful treatment, basic. Treat her like a damn human. She's in crisis. This is my child who went to [an Ivy League], extremely brilliant, smart…And from the moment we entered that hospital it was racist treatment." (FG1S4)
Structural Vulnerability; The right to have a child	"I've had experience with a lot more postpartum psychosis, more than I've seen in the 40 years [I've been working] as a nurse practitioner...It is pretty rampant. The isolation, the hormones, the regular hormonal things that you go through as a postpartum mother, it's been pretty rough, particularly for Black women, because they've already been mistreated and neglected in birth and beyond and the isolation and the treatment during this period of COVID has been pretty horrendous." (FG2S4)
Structural Vulnerability; The right to raise children in safe and healthy environments	"Folks are definitely having a lot more problems with domestic violence. There are several agencies, that we have been working with that counsel and help women or people to understand some things that they can do. But it is, from what we're hearing, very, very difficult if you don't have any place to go. In fact, today, I got a text from a young lady asking about how she could secure some funds because her significant other was turning off the utilities at her place. He's been gone for two months, but he's going to turn on utilities at the place where he's going to. So he's taking them out of his name where she is, but she's there with the four children…It's always been a problem but more of a problem. Just like when women get pregnant, they tend to get abused more at that time. So this has been a really peak time for domestic violence, too." (FG2S3)
Historical Oppression; The right to raise children in safe and healthy environments	"If [the pandemic] has not changed you in ways to move towards really understanding how this could have all been different and you're not trying to operationalize that, then you're wasting my time. I cannot continue to perpetuate people who talk a good game about equity and justice but there's no action to it. So that means leveraging every tool that we have in our toolbox, whether it's the federal government, private philanthropy…I want to see some results. I'm not trying to be hyperbolic, but I'm nervous…That's what history teaches us, right? And for anybody who wants to stand in some frustration around, "Oh, it's so polarized," I'm like -- you act like it wasn't polarized during reconstruction? I don't have time for ahistorical, fearful folks who don't understand the moment we in right now. I don't because I want to see some action." (FG1S3)
Embodiment; The right to have a child	"[I was at] a home birth [that turned to a hospital transfer]. At the hospital, they immediately separated mother from baby and father from the both of them, until they could all get COVID tested. She was Indigenous and he is Black, the couple. And I said to the father, 'You got to advocate. I don't think they can separate you from your baby legally,' and he's said, 'But I don't want to be an angry black man in that space. They have my wife. They have my baby.' And so it was just this really heartbreaking moment of the ways that the COVID safety measures become weaponized against people of color and used as a way to further control and subjugate." (FG2S2)

wifery model). Others corroborated "supremacy of birth" as a theme by describing how the pandemic itself limited their access to the full spectrum of SRH services, including routine pelvic exams, domestic and gender-based violence counseling, abortion services, and fertility awareness.

A participant in a lineage of granny midwives in the South described the removal of community knowledge around birth and midwifery in the Black community. She described the impact it has had on birthing experiences and outcomes – to the extent that not having a horrible birth experience felt like a privilege:

> "So my grandmother, my father's mother was a lay midwife in Arkansas. Her infant

> mortality, maternal mortality rate was fantastic. She delivered over three hundred babies and she actually lost two babies and one mother. And that was really great. But it is just-- and that's what my frame of reference was. And I heard someone talking about how they felt guilty about sort of feeling like we may be a little more privileged because of the resources and knowledge that we have…[a]nd so I always felt guilty too that so many of the friends and family and folks that I knew were having horrible birth stories and trauma." (FG2S4)

Another participant who practiced as an urban midwife in the Pacific Northwest connected birth supremacy and White supremacy as the policing of who, when, and how Black people can and should have children:

> "White supremacy shows up everywhere every second of the day. And White supremacy is the structure …So, this idea around when a young African American person gets pregnant…[T]hey're already living in a world of racism, and then it just gets exacerbated, and questions around their ability to parent, calling CPS when it's not necessary, not seeing them as fully human or able to understand certain things. …Because it is racism, period that's what this country was built on. If anybody was confused, the last four years should have shown people something. And then if they were still confused, if January 6th [White supremacist attack on the White House] didn't once and for all reveal what we have been saying for over 400 years, I don't know what it's going to take." (FG1S4)

Table 4 provides additional quotes around this concept of "supremacy of birth" in hospitals, and how it also intersects with the TCRF.

Police Violence and Sexual and Reproductive Mental Health

While many discussions were about the relationship between the environment and resources, policing and SRH continued to be salient. While many reported an increase in negative mental health impacts for BIPOC, one community member reported sheltering at home created less anxiety, because she knew her Black son was safe at home:

> "I'm traumatized for a lot of things around this pandemic. But the one thing that has kept me sane is I have a teenage Black boy that's been under my watch for a year…[T]he fact that…I can keep him safe – safer – that stress in my life has gone down." (FG1S5)

In response, another participant shared:

> "[My colleague] just described to you what a blessing the pandemic was so that she didn't have to worry about her 15-year-old Black son being the next George Floyd. Because the only reason my Black boys haven't been shot by the police is because they weren't there…There is no other reason. George Floyd is my two boys. Tamir Rice was my two boys." (FG1S4)

The same participant described it as impossible to separate perinatal mental health from reproductive justice, given the inter-related structures tying inequities together:

> "It is really important that we're having this dialogue on record because we cannot-- as a Black mom, I can't separate out reproductive and perinatal mental health from this larger system of a broken mental health system that is-- that's broken for everyone, but it's particularly broken for Black and Brown folks." (FG1S4)

The right to raise children in safe and healthy environments is impeded by not only inequitable policing, but other structures of surveillance and criminalization of minoritized identities – whether that is by care providers, or in schools. Participants connected policing to impacting youth mental health, anti-Blackness, disparate treatment, and having community/family impacts.

Digital Redlining

The negative impacts experienced during the pandemic due to

restricted access to basic determinants of health, such as housing, education, health care, and Internet service, was a persistent theme across focus groups. When considering community solutions to addressing mental health care during the pandemic, participants also spoke of telehealth as a potential barrier due to inequitable access to Internet, cell phone technology, and government and institutional mistrust:

> "What does it mean to kind of create a mental health program in the midst of an epidemic? There is a lot of innovation there…[however] a lot of communities and organizations that we work with, they don't have strong Internet access in the house or on the cell phone…They're relying on flip phones or government phones, though they may or may not jibe with it because another conspiracy theory is some truth about what our government phone is really for. We want to build up this needed service, but we're doing it without even recognizing the Internet access issue, which is big. Everybody doesn't have a strong Internet." (FG3S3)

Related to other health care services, several participants spoke about the benefits and drawbacks of telehealth. While the virtual space provided opportunities for community connection and healing, particularly around isolation and perinatal mood disorders, one participant described telehealth as, "poorly organized… which was a little bit scary, is that they would just go straight to pharmacy…They would just write scripts. And then people were like, 'You don't even know what I have. What are you doing just sending me to pharmacies?'" (FG3S3). Participants used the term "digital redlining," or the inequitable access to computers, Internet, and technology, to describe inequitable access to vital telehealth, educational and mental health services, in similar ways that redlining has historically created inequities in access to housing and utilities.

> "[D]igital redlining…is a term that we've definitely been pushing [in response to telehealth] because a lot of folks just, they don't have the computers. They don't have the tablets. They don't have the data on their phones that they can keep up with all this telehealth that everybody was pushing out there." (FG3S5)

Telehealth can be both a benefit and a barrier to a community, aiding those who have access to technology and further isolating those who do not have that access. This participant also spoke to Internet and technology access as a barrier due to lack of coordinated care systems:

> "Many community organizations were [unable to provide services and were], left out in the dark for a good number of months until the federally qualified health centers started to think in a more mutual aid, a more grassroots way. And a lot of them ended up starting to restructure themselves to provide [mobile] services outside their physical location." (FG3S3)

Another community health worker reported an exacerbation of existing maternal mortality disparities for Black women birthing in New York, which already has some of the highest MMR disparity ratios in the country:

> "We have had maternal deaths in our community and our birth worker community because of telehealth. The quality that was already subpar, that was available to our communities, just decreased even more. Things that may have been caught, such as preeclampsia or things of that nature, of cardiac conditions, have just gone even further off the radar. If you can imagine. That's something that was already terrible, got even worse." (FG3S6)

Despite the drawbacks of telehealth, it also affected access in other ways, especially for communities with historical legacies of mistreatment and mistrust in care settings. When it came to abortion access, one participant shared the benefits to telehealth in making self-managed abortion more accessible because people could, "have ritual around it or be able to surround themselves with whatever makes them feel safe and supported at the time and not have to interface with a provider or

a clinician." (FG2S3) This idea that high quality care can exist without the presence of a provider, or that a provider can even be the reason for poor quality of care was reflected in other areas of SRH care.

Quality of Care

When discussing SRH, quality of care continues to be a relevant issue. When asked about the accessibility of high-quality care in a medical setting, one participant who works in the medical field responded definitively, "High quality? Hell no. I will tell you that people got the minimum that was required to not have a lawsuit." (FG1S3) Another participant reflected on a maternal death, the impact of immigration status as a barrier to safety during maternity care:

> "Hospitals should be sued. You'd look at the case, and you're like, 'This is an undocumented family. They're not going to go up against this hospital that killed their loved ones basically.' And that breaks my heart too, seeing these cases. I mean there are some cases that I'm like, 'Who can we talk to?' People are just straight up killing folks." (FG1S5)

Another participant reflected on the important role that doulas play in mitigating harm by "filling in the gap" of "social support and care around mental and emotional health." However, this same individual also describes how the reliance on doulas, who play a critical supportive role, is

> "…letting systems off the hook to provide respectful, responsive, quality care." (FG1S4)

The lack of cultural responsiveness, the racial discordance of patient provider dyads, and the quality of care received were connected to "structurally racist policies" by another participant:

> "There is a fundamental reason why midwifery is 90% White. When you have racist policies that continue to perpetuate the notion that some humans are more deserving than others, then you have a situation where there will always be racism embedded in a society and structures because that's part of the policies." (FG1S3)

Many participants spoke of alternatives for accessing care, including mutual aid, and increasing community-based "knowledge around body literacy is actually really important where you can't access these medications that we would normally do," in response to loss of access to birth control.

Joy, Liberation, and Humanity

Joy, liberation, and humanity is a theme that was developed to reflect the underlying connections between SRH needs and larger issues of quality of life. This theme unifies many connections made directly by the participants in ways that link all three RJ principles (ie, the right to have a child, to not have a child, or parent in safe and healthy environments).

Joy was described as a necessity for survival for Black women giving birth in the United States:

> "You have Black birthing people, women, being afraid or not wanting to have children because they think they're going to die in pregnancy or that their babies are going to die. And then it becomes this-- in raising awareness around this issue in the media causes trauma and causes harm. It's probably by design about how we uplift. What does joyous Black birth look like and how do we help folks activate their village so that they can have joyous, healthy, and safe birth experiences?" (FG1S5)

Many participants shared that to cope with the compounding structural barriers rooted in racism, they chose to focus on practices and spaces that centered joy and rest such as spending time with family, using social media to stay connected to supportive groups, applying ancestral technologies, and implementing restorative practices:

> "What does it mean to center hope and to center joy and to center love? Let me tell you about what people are doing to bring themselves joy and happiness through starting mutual aid and doing those things and just seeing the joy that families have…We had this whole Centering Black Futures series: What does it mean for us to look towards

> liberatory practices?…We have to use ancestral technologies to really uplift our communities." (FG3S5)

Another participant named the reality that for many communities of color, "we learned very quickly how interconnected we really are." They described living in structural racism as preparation for living in apocalyptic conditions, and how that helped them honor and recognize each other's humanity:

> "The apocalypse is here… we rehearsed for this…I'm taking care of a small part of humanity…around donations of diapers, wipes, and formula. [In doing this], we also were then finding out that some of these folks needed food. Some of these folks needed an apartment. Some of these folks needed food stamps. Some of these folks needed still help with their immigration status. So then, we very organically, not just on social media, but connected with other folks that were taking care of those specific needs…We learned very quickly how interconnected we really are." (FG3S6)

Others described similar experiences in creating mobile STI/HIV testing sites, finding creative solutions, and creating community care systems and mutual aid when government funded outreach was not reaching communities in response to questions on finding joy and liberation.

Discussion

This study examined SRH needs and issues within the RJ and TCRF frameworks that connect these issues/needs to the larger systems of racism and the associated reproductive harm. As seen through the eyes of our participants, the harms are perpetuated through disproportionate decreases in access to much-needed services (eg, through digital redlining) and increases in exposure to harms (eg, policing). This article identifies barriers in access to SRH care being provided to BIPOC communities during the COVID-19 pandemic and the reproductive justice-related concerns and desires of BIPOC communities.

Our five themes map across the principles of reproductive justice as complex SRH needs and issues whose gaps in care impact a person's right to have a child, not have a child, and parent that child in safe and healthy environments. The themes capture a wide range of SRH needs and issues that are not frequently in conversation with one another. For example, "supremacy of birth" highlights the ways that national dialogue and policy surrounding reproductive health equity on birth ends up competing with the full spectrum of RJ access needs across a lifespan and across health systems and government bodies. Full spectrum of SRH needs, as defined by the Guttmacher-Lancet Commission on SRH,[57] may not currently be met due to disproportionate public and policy focus in perinatal health practice on birth. In addition, our final theme highlights the importance of thinking about pleasure, joy, bodily autonomy, and its relationship to SRH needs and issues. The complexity of pleasure joy and bodily autonomy as an intersectional SRH need is not only because it is integral to human health and wellbeing, but that it is also a response to histories of forced labor and productivity. Rest is a form of resistance; and centering pleasure is activism.[58,59]

Our qualitative study contextualizes other surveys and recommendations related to SRH needs and care. For example, Internet-based surveys conducted early in the pandemic found changes in women's intentions to have children and ability to access contraception.[60] Synthesizing the evidence across our study and previous surveys and recommendations by experts in SRH disparities and community-based research[61–64] reveals an imperative for reproductive health access for BIPOC communities to be

This article identifies barriers in access to sexual and reproductive health care being provided to BIPOC communities during the COVID-19 pandemic and the reproductive justice-related concerns and desires of BIPOC communities.

addressed by: 1) taking a full-spectrum approach that inherently recognizes the humanity of women and birthing peoples inclusive of birth but also across the reproductive lifespan; 2) validating the effectiveness and legitimacy of community-based responses to public health needs; and 3) providing unrestricted funding[65–68] and resources for communities with inequitable access to address health disparities especially during disaster contexts. Additionally, these recommendations align with existing literature for addressing racism as a public health crisis more broadly.[30]

While the qualitative findings of this study are limited in generalizability and do not represent all gaps in SRH needs and care, a significant strength of this analysis is its conceptual framework and the ways it is connecting reproductive justice issues across the lifespan and across determinants of health. At the time of this writing, 17 children and 2 adults were gunned down with an automatic weapon at an elementary school in Uvalde, Texas. The Supreme Court overturned *Roe v. Wade*, eliminating a federal standard for abortion access. These are both critical RJ issues and should be in dialogue with one another within a framework of full spectrum SRH needs. "Supremacy of birth," police violence, digital redlining, and honoring humanity are thematic groups that are unified through an intersectional reproductive justice approach. To amplify the conversation on issues and realities simultaneously tied to the pandemic and racism, this approach asks, 'what is reproduction to racial justice?'

The majority of literature on reproductive justice during COVID-19 has centered on a singular issue (eg, abortion or midwifery access).[24,60,69,70] Reproductive justice is a framework of expansion and liberation meant to capture the complex reality of structural oppression vis-à-vis SRH access. This article's findings not only align with existing literature but also addresses a gap in capturing experiences of marginalized communities in accessing care. While pregnant people and parents are not at a higher risk of contracting or transmitting COVID-19, birthing people seem to face disproportionate socio-economic impacts, with little study being put toward the impact of health care access and systems for individuals during the pandemic.[71] Further, there is even less research on the impacts of racism and structural violence at the intersection of reproductive health during the pandemic, and what is known is that the pandemic highlighted and made more severe existing issues in racial and health equity.

Participants connected "supremacy of birth" with barriers to SRH care, structural violence, criminalization of identity, devaluing life, stigma and mental health, and historical experiences or traumas. While birth supremacy was not explicitly discussed as a form of White supremacy by the participant, it draws our attention to the dominance of racism within the history of obstetrics itself. Specifically, the midwifery bans that date back to the formal institutionalization of slavery and Jim Crow. In this context, there is a continued need for racial equity to be addressed in reproductive health policy to undo White supremacy within systems.

This connection to birth supremacy and White supremacist policing of Black peoples during pregnancy highlights the RJ issue of being able to parent children safely and with dignity and how the "supremacy of birth" compromises this. Policing and maternal mental health directly connects to the RJ principle demanding that the environment be addressed as a determinant to parenting.[72]

The specific attention drawn to policing and digital redlining[73–75] have not, to our knowledge, been explored as an RJ issue previously in the health science literature. Digital redlining is an RJ issue as access to these determinants influences all aspects of parenting from access to quality health care, accessing care to not be pregnant, and to parenting in an environment where basic material and health needs are met. Structural racism and structural violence are threats to health equity and anti-racist public health work[34] across many health issues and SRH is no exception. The public health community must take lead from those most impacted. Community healing could center pleasure, bodily autonomy, and cultural respect as a standard. This could include taking strengths-based approaches and increasing pathways to professionalization for providers of color, resourcing community midwifery and reproductive health centers[24] in particular during disaster contexts, and expanding Medicaid coverage[69] to everyone.

To achieve RJ requires significant change across many systems level factors. When it comes to policies, they must be financially responsible[33, 76-78] and consider intangible individual, community, and societal

costs and how funding is allocated. These things are not typically valued in White supremacist, patriarchal, and capitalist societies. Examples can include but are not limited to use of reparations,[79,80] debt forgiveness for medical bills, extending paid maternity and paternity leave, and universal Internet access.

Those most affected by police violence have been advocating for decades for the inclusion of police violence as an RJ issue because it, among other reasons, violates Black parents' right to raise their children to adulthood safely.[29] Structural racism and structural violence are threats to health equity and anti-racist public health work.[30] Divesting from policing[72,81,82] as a community harm response and re-investing in alternative strategies rooted in mutual aid, collective care, harm reduction, de-escalation, and mental health have also been identified as emerging approaches.[83]

Study Limitations and Strengths

While our stakeholders represent expertise and lived experience, the scope of this article was largely exploratory. As a result, themes generated here should not be considered to be exhaustive and representative of all SRH needs and issues. Participants also did not meaningfully represent the experiences of non-binary and transgender community in experiences of accessing reproductive care. Similarly, while the lead author on this article identifies as Indigenous, and Indigenous methods were incorporated in our analysis, there was no Indigenous representation in our participants. We have therefore contributed unintentionally to ongoing erasure. Lastly, many things have shifted and changed during the pandemic and so this is period-specific but also very salient and important as the themes are enduring.

Our participants, as experts in their field, were chosen for their unique expertise and contributions to the field, collectively representing over a century of professional experience across the full spectrum of sexual and reproductive health and public health. Additionally, they held the complexity of navigating between worlds as both health professionals and members of the community in which they work. Despite the small numbers within this cohort of focus groups, we feel it is important to weigh the unique perspectives and expertise that our participants shared as invaluable to advancing the field of reproductive justice.

During the manuscript writing process we remain with the participants to: 1) confirm sensitive quotes to ensure they are accurately conveyed to the participants agreement; and 2) create opportunities for the participants to publicly engage with the findings after publication; this is important as the ideas represented in this article are a synthesis and analysis of their intellectual and experiential contributions; and 3) we hope to create future dissemination opportunities that engage this community of experts through storytelling and call to action.

Conclusion

Academia and public health are situated as institutions of historical oppression.[84] It is important to consider pharmakon, or the potential to act both as medicine and poison, as a limitation of academic research in general.[2,85] Meaningful change requires careful and thoughtful measures across planning, design, and implementation to not perpetuate legacies of harm.[86,87] Therefore, we have been intentional on engagement, study design, and dissemination to follow a public health critical race praxis to support a shift in best practices for meaningful equity and justice. To reckon with this potential for harm too, we must consider the resilience and the existing work that communities are doing to address lack of care, particularly behind the idea that high quality care can exist without the presence of a provider, and that providers can be the reason for poor quality of care, when considering and planning for health intervention.

Disrupting the cycles of harm in sexual and reproductive health within health care systems in the United States starts by acknowledging the collusion of health care in perpetuating structural inequities along racialized lines. But it is only the first step. Unless systemic change centers accountability, partnership, humanization, and therefore the autonomy, liberation, joy, and pleasure BIPOC communities, any efforts to improve health outcomes will only serve to further entrench racist paradigms. Multi-system approaches across ecological layers have the potential to undo systematic racialized policy harm. Doing so will increase accessible pathways that have the potential to improve SRH outcomes across generations.

Acknowledgments

We would like to thank the staff at the Center for the Study of Racism, Social Justice & Health and UCLA FSPH Department of Community Health Sciences for administrative and technical support; and members of the COVID-19 Task Force on Racism & Equity for feedback on earlier versions of this work.

Amani was supported by the Charles Drew University (CDU) Black Maternal Health Center of Excellence (BMHCE) and has received support from the University of California, Los Angeles (UCLA), Resource Centers for Minority Aging Research Center for Health Improvement of Minority Elderly (RCMAR/CHIME) under NIH/NIA Grant P30-AG021684.

We honor and acknowledge that America rests on the occupied ancestral lands of the Indigenous peoples of this continent. We honor that the original peoples are still here, despite not having treaty rights honored or having yet to be justly compensated for their land, resources, and livelihood. We acknowledge that America has been made possible by the labor of enslaved Africans and their ascendants. We raise our hands to the resiliency, dedication, perseverance, and radical wisdom of the descendants of these communities.

Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: de la Rocha, Sudhinaraset, Jones, Kim, Amani; Acquisition of data: de la Rocha, Sudhinaraset, Jones, Cabral, Amani; Data analysis and interpretation: de la Rocha, Sudhinaraset, Jones, Kim, Cabral, Amani; Manuscript draft: de la Rocha, Sudhinaraset, Jones, Kim, Cabral, Amani; Acquisition of funding: Amani; Administrative: Sudhinaraset, Kim, Cabral, Amani; Supervision: de la Rocha, Amani

References

1. Niles PM, Asiodu IV, Crear-Perry J, et al. Reflecting on equity in perinatal care during a pandemic. *Health Equity*. 2020;4(1):330-333. https://doi.org/10.1089/heq.2020.0022 PMID:32775943
2. Mbembe A. *Necropolitics*. North Carolina: Duke University Press; 2019.
3. Ross LJ. The color of choice: White supremacy and reproductive justice. In: INCITE! Women of Color Against Violence, ed. *Color of Violence*. North Carolina: Duke University Press; 2016:53-65. https://doi.org/10.1215/9780822373445-006
4. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Doubleday Books, 2007.
5. Khazanchi R, Evans CT, Marcelin JR. Racism, not race, drives inequity across the COVID-19 continuum. *JAMA Netw Open*. 2020;3(9):e2019933. https://doi.org/10.1001/jamanetworkopen.2020.19933 PMID:32975568
6. Noursi S, Saluja B, Richey L. Using the ecological systems theory to understand Black/White disparities in maternal morbidity and mortality in the United States. *J Racial Ethn Health Disparities*. 2021;8(3):661-669. https://doi.org/10.1007/s40615-020-00825-4 PMID:32720294
7. Bray SRM, McLemore MR. Demolishing the myth of the default human that is killing Black mothers. *Front Public Health*. 2021;9:675788. https://doi.org/10.3389/fpubh.2021.675788 PMID:34109150
8. Heck JL, Jones EJ, Bohn D, et al. Maternal mortality among American Indian/Alaska Native women: A scoping review. *J Womens Health (Larchmt)*. 2021;30(2):220-229. https://doi.org/10.1089/jwh.2020.8890 PMID:33211616
9. Chambers BD, Arega HA, Arabia SE, et al. Black women's perspectives on structural racism across the reproductive lifespan: A conceptual framework for measurement development. *Matern Child Health J*. 2021;25(3):402-413. https://doi.org/10.1007/s10995-020-03074-3 PMID:33398713
10. Chambers BD, Arega H, Spellen S, et al. 961: Pregnant Black women's experiences of racial discrimination. *Am J Obstet Gynecol*. 2018;218(1):S569. https://doi.org/10.1016/j.ajog.2017.11.448
11. Vedam S, Stoll K, Taiwo TK, et al; GVtM-US Steering Council. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health*. 2019;16(1):77. https://doi.org/10.1186/s12978-019-0729-2 PMID:31182118
12. Benoit C, Zadoroznyj M, Hallgrimsdottir H, Treloar A, Taylor K. Medical dominance and neoliberalisation in maternal care provision: the evidence from Canada and Australia. *Soc Sci Med*. 2010;71(3):475-481. https://doi.org/10.1016/j.socscimed.2010.04.005 PMID:20570030
13. Edwards BN, McLemore MR, Baltzell K, Hodgkin A, Nunez O, Franck LS. What about the men? Perinatal experiences of men of color whose partners were at risk for preterm birth, a qualitative study. *BMC Pregnancy Childbirth*. 2020;20(1):91. https://doi.org/10.1186/s12884-020-2785-6 PMID:32041561
14. Larocque C, Foth T. Which lives are worth saving? Biolegitimacy and harm reduction during COVID-19. *Nurs Inq*. 2021;28(4):e12417. https://doi.org/10.1111/nin.12417 PMID:33886134
15. Jones CP. Toward the science and practice of anti-racism: launching a national campaign against racism. *Ethn Dis*. 2018;28(Supp 1):231. doi:10.18865/ed.28.S1.231
16. Jones CP. Confronting institutionalized racism. *Phylon (1960-)*. 2002;50(1/2):7. doi:10.2307/4149999
17. Sexual and Reproductive Health. World Health Organization. Accessed June 1, 2022. https://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/news/news/2011/06/sexual-health-throughout-life/definition
18. Ross L, Solinger R. *Reproductive Justice: An Introduction*. Oakland, California: University of California Press; 2017.
19. Ross LJ. Reproductive Justice as Intersectional Feminist Activism. *Souls*. 2017;19(3):286-314. doi:10.1080/10999949.2017.1389634
20. King G, Strachan D, Tucker M, Duwyn B, Desserud S, Shillington M. The Application of a Transdisciplinary Model for Early Intervention Services. *Infants & Young Children*. 2009;22(3):211-223. doi:10.1097/IYC.0b013e3181abe1c3
21. Van Bewer V. Transdisciplinarity in Health Care: A Concept Analysis. *Nurs Forum*. 2017;52(4):339-347. doi:10.1111/nuf.12200
22. Dahlberg L, Krug E, Mercy J, Zwi A, Lozano R. Violence: a global public health problem. In: *World Report on Violence and Health.* World Health Organization; 2002:1-21.
23. Gravlee CC. Systemic racism, chronic health inequities, and COVID-19: A syndemic in the making? *Am J Hum Biol*. 2020;32(5):e23482. https://doi.org/10.1002/ajhb.23482 PMID:32754945
24. Mukherjee TI, Khan AG, Dasgupta A, Samari G. Reproductive justice in the time of COVID-19: a systematic review of the indirect impacts of COVID-19 on sexual and reproductive health. *Reprod Health*. 2021;18(1):252. https://doi.org/10.1186/s12978-021-01286-6 PMID:34930318
25. Loewen S, Pinchoff J, Ngo TD, Hindin MJ. The impact of natural disasters and epidemics on sexual and reproductive health in low- and middle-income countries: A narrative synthesis. *Int J Gynaecol Obstet*. 2022;157(1):11-18. https://doi.org/10.1002/ijgo.13768 PMID:34043817
26. Endler M, Al-Haidari T, Benedetto C, et al. How the coronavirus disease 2019 pandemic is impacting sexual and reproductive health and rights and response: results from a global survey of providers, researchers, and policy-makers. *Acta Obstet Gynecol Scand*. 2021;100(4):571-578. https://doi.org/10.1111/aogs.14043 PMID:33179265

27. Beek K, Drysdale R, Kusen M, Dawson A. Preparing for and responding to sexual and reproductive health in disaster settings: evidence from Fiji and Tonga. *Reprod Health*. 2021;18(1):185. https://doi.org/10.1186/s12978-021-01236-2 PMID:34544448
28. Feizolahzadeh S, Vaezi A, Mirzaei M, et al. Barriers and facilitators to provide continuity of care to dischargeable patients in disasters: A qualitative study. *Injury*. 2019;50(4):869-876. https://doi.org/10.1016/j.injury.2019.03.024 PMID:30929805
29. Kim JH, Sutley EJ. Implementation of social equity metrics in an engineering-based framework for distributing disaster resources. *Int J Disaster Risk Reduct*. 2021;64:102485. https://doi.org/10.1016/j.ijdrr.2021.102485
30. Paine L, de la Rocha P, Eyssallenne AP, et al. Declaring racism a public health crisis in the United States: Cure, poison, or both? *Front Public Health*. 2021;9:676784. https://doi.org/10.3389/fpubh.2021.676784 PMID:34249843
31. Soled DR, Chatterjee A, Olveczky D, Lindo EG. The case for health reparations. *Front Public Health*. 2021;9:664783. https://doi.org/10.3389/fpubh.2021.664783 PMID:34336763
32. 116th Congress H.R. 2508. Better Respiration through Expanding Access to Tele-Health Act; BREATE Act, Bill Text.; 2019. Last accessed August 7, 2022 from https://www.govinfo.gov/content/pkg/BILLS-116hr2508ih/pdf/BILLS-116hr2508ih.pdf
33. Shute T. Confronting oppression, restoring justice: From policy analysis to social action. 2nd edn *Katherine van Wormer, Laura Kaplan and Cindy Juby. Journal of Social Work*. 2014;14(6):661-662. https://doi.org/10.1177/1468017314535537
34. Sharif MZ, García JJ, Mitchell U, Dellor ED, Bradford NJ, Truong M. Racism and structural violence: Interconnected threats to health equity. *Front Public Health*. 2022;9:676783. https://doi.org/10.3389/fpubh.2021.676783 PMID:35186857
35. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health*. 2000;23(4):334-340. https://doi.org/10.1002/1098-240X(200008)23:43.0.CO;2-G PMID:10940958
36. Bradshaw C, Atkinson S, Doody O. Employing a Qualitative Description Approach in Health Care Research. *Glob Qual Nurs Res*. 2017 (e-Collection). https://doi.org/10.1177/2333393617742282 PMID:29204457
37. Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Serv Res*. 2007;42(4):1758-1772. https://doi.org/10.1111/j.1475-6773.2006.00684.x PMID:17286625
38. Amani B. Integrated methods for applying critical race theory to qualitative COVID equity research. *Ethn Dis*. 32(3):243-256. https://doi.org/10.18865/ed.32.3.243
39. Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. *Soc Sci Med*. 2010;71(8):1390-1398. https://doi.org/10.1016/j.socscimed.2010.07.030 PMID:20822840
40. Gee GC, Ford CL. Structural racism and health inequities: Old issues, new directions. *Du Bois Rev*. 2011;8(1):115-132. https://doi.org/10.1017/S1742058X11000130 PMID:25632292
41. Bonilla-Silva E. Rethinking Racism: Toward a Structural Interpretation. *Am Sociol Rev*. 1997;62(3):465-480. https://doi.org/10.2307/2657316
42. Hill Collins P. *Intersectionality as Critical Social Theory*. North Carolina: Duke University Press; 2019.
43. Combahee River Collective. Black feminist statement. In: Moraga C, Anzaldua GE, eds. *This Bridge Called My Back: Writings by Radical Women of Color*. Watertown, Mass. Kitchen Table: Women of Color Press; 1986:286.
44. Robinson CJ. *Black Marxism: The Making of the Black Radical Tradition*. North Carolina: University of North Carolina Press; 2000.
45. COVID-19 Taskforce on Racism and Equity. Statement on Policing and the Pandemic [webpage]. 2020. Last accessed June 21, 2022. https://www.racialhealthequity.org/blog/policingandpandemic
46. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm Policy Ment Health*. 2015;42(5):533-544. https://doi.org/10.1007/s10488-013-0528-y PMID:24193818
47. Azungah T. Qualitative research: deductive and inductive approaches to data analysis. *Qual Res J*. 2018;18(4):383-400. https://doi.org/10.1108/QRJ-D-18-00035
48. Vanover C, Mihas P, Saldaña J, eds. *Analyzing and Interpreting Qualitative Research: After the Interview*. Thousand Oaks, California. SAGE; 2022.
49. Sumbul T, Spellen S, McLemore MR. A transdisciplinary conceptual framework of contextualized resilience for reducing adverse birth outcomes. *Qual Health Res*. 2020;30(1):105-118. https://doi.org/10.1177/1049732319885369 PMID:31752598
50. Morison T. Reproductive justice: A radical framework for researching sexual and reproductive issues in psychology. *Soc Personal Psychol Compass*. 2021;15(6). https://doi.org/10.1111/spc3.12605
51. Bakhru TS, ed. *Reproductive Justice and Sexual Rights: Transnational Perspectives*. New York: Routledge; 2019. https://doi.org/10.4324/9781315099408
52. Samarasekera U. Joia Crear-Perry. Collaborating for racial and reproductive justice. *Lancet*. 2021;397(10281):1255. https://doi.org/10.1016/S0140-6736(21)00723-6 PMID:33812483
53. Burger K, Evans-Agnew R, Johnson S. Reproductive justice and Black lives: A concept analysis for public health nursing. *Public Health Nurs*. 2022;39(1):238-250. https://doi.org/10.1111/phn.12919 PMID:33970521
54. Kim H, Sefcik JS, Bradway C. Characteristics of qualitative descriptive studies: a systematic review. *Res Nurs Health*. 2017;40(1):23-42. https://doi.org/10.1002/nur.21768 PMID:27686751
55. Neergaard MA, Olesen F, Andersen RS, Sondergaard J. Qualitative description - the poor cousin of health research? *BMC Med Res Methodol*. 2009;9(1):52. https://doi.org/10.1186/1471-2288-9-52 PMID:19607668
56. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101. https://doi.org/10.1191/1478088706qp063oa
57. Starrs AM, Ezeh AC, Barker G, et al. Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet*. 2018;391(10140):2642-2692. https://doi.org/10.1016/S0140-6736(18)30293-9 PMID:29753597
58. Brown AM. *Pleasure Activism: The Politics of Feeling Good*. Chico, California: AK Press; 2019.
59. Hersey T. *Rest Is Resistance: A Manifesto*. First edition. New York: Little, Brown Spark; 2022.
60. Lindberg LD, VandeVusse A, Mueller J, Kirstein M. *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences*. Washington, DC: Guttmacher Institute; 2020. https://doi.org/10.1363/2020.31482
61. Aina A, Asiodu IV, Castillo P, Denson J, Drayton, C. Black Maternal Health Research Re-Envisioned: Best Practices for the Conduct of Research With, For, and By Black Mamas. Black Mamas Matter Alliance Research Working Group. Harvard Law and Policy Review. 2020(14):393-415. Last accessed August 9, 2022 from https://harvardlpr.com/wp-content/uploads/sites/20/2020/11/BMMA-Research-Working-Group.pdf
62. Eichelberger KY, Doll K, Ekpo GE, Zerden ML. Black lives matter: claiming a space for evidence-based outrage in obstetrics and gynecology. *Am J Public Health*. 2016;106(10):1771-1772. https://doi.org/10.2105/AJPH.2016.303313 PMID:27626348

63. Echohawk A. *Data Genocide of American Indians and Alaska Natives in COVID-19 Data*. [webpage] Urban Indian Health Institute; 2021. Last accessed August 8, 2022 from https://www.uihi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/
64. Echohawk A. *Missing and Murdered Indigenous Women and Girls Report*. Published online 2018. Last accessed June 18, 2022 from https://www.uihi.org/wp-content/uploads/2018/11/Missing-and-Murdered-Indigenous-Women-and-Girls-Report.pdf
65. Aizer A, Eli S, Ferrie J, Lleras-Muney A. The long-term impact of cash transfers to poor families. *National Bureau of Economic Research Working Paper Series*; 2014:w20103. https://doi.org/10.3386/w20103
66. van Daalen KR, Dada S, James R, et al. Impact of conditional and unconditional cash transfers on health outcomes and use of health services in humanitarian settings: a mixed-methods systematic review. *BMJ Glob Health*. 2022;7(1):e007902. https://doi.org/10.1136/bmjgh-2021-007902 PMID:35078813
67. Troller-Renfree SV, Costanzo MA, Duncan GJ, et al. The impact of a poverty reduction intervention on infant brain activity. *Proc Natl Acad Sci USA*. 2022;119(5):e2115649119. https://doi.org/10.1073/pnas.2115649119 PMID:35074878
68. Villanueva E, Barber WJ. *Decolonizing Wealth: Indigenous Wisdom to Heal Divides and Restore Balance*. 2nd ed. Oakland, California: Berrett-Koehler Publishers; 2021.
69. Britt AJ, Carlson NS, Joseph NT, Amore AD. The convergence of COVID-19 and systemic racism: an evaluation of current evidence, health system changes, and solutions grounded in reproductive justice. *J Midwifery Womens Health*. 2021;66(3):298-303. https://doi.org/10.1111/jmwh.13250 PMID:34114324
70. Jones RK, Lindberg L, Witwer E. COVID-19 abortion bans and their implications for public health. *Perspect Sex Reprod Health*. 2020;52(2):65-68. https://doi.org/10.1363/psrh.12139 PMID:32408393
71. Kotlar B, Gerson E, Petrillo S, Langer A, Tiemeier H. The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review. *Reprod Health*. 2021;18(1):10. https://doi.org/10.1186/s12978-021-01070-6 PMID:33461593
72. Friedline T, Naraharisetti S, Weaver A. Digital redlining: poor rural communities' access to Fintech and implications for financial inclusion. *J Poverty*. 2020;24(5-6):517-541. https://doi.org/10.1080/10875549.2019.1695162
73. Gilman S. Proliferating predation: reverse redlining, the digital proliferation of inferior social welfare products, and how to stop it. *Harvard Civil Rights – Civil Liberties Law Review*. 2019 eCollection. https://doi.org/10.2139/ssrn.3511892
74. Nadaf AH. "Lockdown Within a Lockdown": the "digital redlining" and paralyzed online teaching during COVID-19 in Kashmir, a conflict territory. *Commun Cult Crit*. 2021;14(2):343-346. https://doi.org/10.1093/ccc/tcab019
75. Vedam S, Stoll K, Martin K, et al. The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care. *PLoS ONE*. 2017;12(2):e0171804. https://doi.org/10.1371/journal.pone.0171804
76. Brown KS, Kijakazi K, Runes C, Turner MA. Confronting structural racism in research and policy analysis: charting a course for policy research institutions. *Urban Institute*. February 29, 2019. Last accessed August 9, 2022 from https://www.urban.org/research/publication/confronting-structural-racism-research-and-policy-analysis
77. Bardach E, Patashnik EM. *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving*. 5th ed. Thousand Oaks, California: CQ Press/SAGE; 2016.
78. Bassett MT, Galea S. Reparations as a public health priority - a strategy for ending Black-White health disparities. *N Engl J Med*. 2020;383(22):2101-2103. https://doi.org/10.1056/NEJMp2026170 PMID:33031653
79. Richardson ET, Malik MM, Darity WA Jr, et al. Reparations for Black American descendants of persons enslaved in the U.S. and their potential impact on SARS-CoV-2 transmission. *Soc Sci Med*. 2021;276:113741. https://doi.org/10.1016/j.socscimed.2021.113741 PMID:33640157
80. Noguchi Y. How police violence could impact the health of Black infants [transcript]. *NPR: Morning Edition*. November 13, 2020. Last accessed August 8, 2022 from https://www.npr.org/2020/11/13/933084699/how-police-violence-could-impact-the-health-of-black-infants
81. Rogers A. How police brutality harms mothers: linking police violence to the reproductive justice movement. *Hastings Race and Poverty LJ*. 2015;12(2): 205-233. Last accessed August 9, 2022 from https://repository.uchastings.edu/cgi/viewcontent.cgi?article=1125&context=hastings_race_poverty_law_journal
82. Premkumar A, Nseyo O, Jackson AV. Connecting police violence with reproductive health. *Obstet Gynecol*. 2017;129(1):153-156. https://doi.org/10.1097/AOG.0000000000001731 PMID:27926648
83. Almeida M, Shrestha AD, Stojanac D, Miller LJ. The impact of the COVID-19 pandemic on women's mental health. *Arch Women Ment Health*. 2020;23(6):741-748. https://doi.org/10.1007/s00737-020-01092-2 PMID:33263142
84. Ferguson RA. *The Reorder of Things: The University and Its Pedagogies of Minority Difference*. Minneapolis, MN: University of Minnesota Press; 2012. https://doi.org/10.5749/minnesota/9780816672783.001.0001
85. Patel L. *Decolonizing Educational Research: From Ownership to Answerability*. Milton Park, Abingdon, Oxon; New York, NY: Routledge; 2016.
86. Derrida J. *Dissemination*. Chicago, IL: University of Chicago Press; 1981. https://doi.org/10.7208/chicago/9780226816340.001.0001
87. Gwayi-Chore MC, Del Villar EL, Fraire LC, et al. "Being a person of color in this institution is exhausting": defining and optimizing the learning climate to support diversity, equity, and inclusion at the University of Washington School of Public Health. *Front Public Health*. 2021;9:642477. https://doi.org/10.3389/fpubh.2021.642477 PMID:33937172