Abortion Criminalization: A Public Health Crisis Rooted in White Supremacy

Taylor Riley, MPH, Yasaman Zia, MPH, Goleen Samari, PhD, MPH, MA, and Mienah Z. Sharif, PhD, MPH

See also Hing et al., p. 1529.

The Supreme Court decision to overturn *Roe v. Wade* and the growing onslaught of state laws that criminalize abortion are part of a long history of maintaining White supremacy through reproductive control of Black and socially marginalized lives.

As public health continues to recognize structural racism as a public health crisis and advances its measurement, it is imperative to explicate the connection between abortion criminalization and White supremacy.

In this essay, we highlight how antiabortion policies uphold White supremacy and offer concrete strategies for addressing abortion criminalization in structural racism measures and public health research and practice. (*Am J Public Health*. 2022;112(11):1662–1667. https://doi.org/10.2105/AJPH.2022.307014)

AJPH November 2022, Vol 112, No. 11

> "One of the key problems addressed by Reproductive Justice is the isolation of abortion from other social justice issues that concern communities of color: issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation, and a host of other community-centered concerns."
>
> —*Loretta Ross, "What is Reproductive Justice"*[1]

Across the country, public health agencies and academic institutions are following the lead of health equity scholars and the charge from the Centers for Disease Control and Prevention to recognize and confront racism as a core driver of health inequities. As the public health field continues to work toward addressing structural racism as a public health crisis and as we enter a post-*Roe* era, conceptualizing and connecting antiabortion policies as structurally racist and rooted in White supremacy is fundamental to advancing health equity.

Abortion criminalization aligns with the undercurrents of structural racism through both whom it disproportionately impacts and how power is wielded to erase, suppress, and threaten the livelihoods of racially minoritized communities. There were a record-breaking 108 state laws enacted in 2021 that criminalized abortion, including gestational age bans, restrictions on medication abortion, trigger bans that automatically banned abortion when *Roe* was overturned, and "Texas-style" bans that rely on bounty-hunter enforcement mechanisms.[2] This follows decades of laws such as the Hyde Amendment that prohibit federal funds from covering abortion services and undermine abortion rights and access for pregnant people in federally funded programs, including 7.8 million people on Medicaid, half of whom are people of color.[3]

This has made the legal precedent of *Roe* a minimal baseline that has failed to protect abortion access for all. For all public health professionals and all people concerned with the ties between social injustices and health, it is crucial to consider how these policies of reproductive control uphold White supremacy both historically and contemporarily.

Abortion criminalization is an overlooked dimension of state control in existing measures of structural racism. Structural racism refers to the "state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death"[4(p28)] that works through "mutually reinforcing inequitable systems."[5(p1454)] Structural racism is sustained through White supremacy, which is the system of

conditions and ideologies that underscore the hegemony of whiteness and White political, social, cultural, and economic power.[6]

In this essay, we provide a historical overview of how the origins of antiabortion policies are rooted in White supremacy and outline the current disastrous public health effects of abortion criminalization. A guiding framework for understanding abortion criminalization as rooted in White supremacy is reproductive justice, which was coined by Black women in 1994 as the right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities.[7] Following the lead of Black feminists and reproductive justice scholars,[7,8] we propose an intersectional[9–11] approach to measures of structural racism in the public health literature that makes the critical connections between abortion criminalization and the other interrelated dimensions of structural racism that maintain White supremacy.

HISTORY OF WHITE SUPREMACY AND REPRODUCTIVE CONTROL

The policing of bodies of pregnant-capable people racialized as Black is central to the historical perpetuation of White supremacy, starting with the forced reproduction of women who were enslaved. After 1808, when slaveholders could no longer rely on the international slave trade, the expansion and sustaining of slavery depended on the reproduction of those already enslaved.[12] This gave enslavers an economic incentive to control and govern Black women's reproduction because the law made the enslaved women's children the property of the enslaver.[13] As Dorothy Roberts explains, "it marked Black women from the beginning as objects whose decisions about reproduction should be subject to social regulation rather than to their own will."[13(p23)]

Indeed, some of the first laws in the United States involved control over enslaved women's reproduction, and the country's legal system was built off this racial and gender subjugation.[13] Critically, women who were enslaved were not passive victims of this reproductive control and practiced resistance using methods of birth control and abortion to resist the oppressive conditions of slavery that, if discovered, were punished by slaveholders.[14]

Whereas this controlled reproduction laid the foundation of the US legal system, medical experimentation on and violence against women who were enslaved were the foundation of the medical field, particularly obstetrics and gynecology. The career of J. Marion Sims, recognized as the "father of American gynecology," was entirely built on the grotesque obstetric and gynecological experimentation on enslaved women, specifically Anarcha, Betsey, and Lucy.[15] Years later, the medical and public health fields contributed to the state-sanctioned strategy of eugenics and forced sterilization to maintain White supremacy through reproductive control.

The 20th-century eugenics movement supported forced birth for "socially desirable" women through racist, classist, and ableist standards while simultaneously implementing a widespread campaign of involuntary sterilization among Black, poor, immigrant, and incarcerated women.[13] This abuse continued with the involuntary sterilization of between 25% and 50% of Indigenous women in the 1970s by the federal government via the Indian Health Service.[16] The impact of the scale of this government-sponsored reproductive coercion cannot be understated. It is estimated that in 1972 alone the federal government funded 100 000 to 200 000 sterilizations, which is an annual number equivalent to the estimated total number of all sterilizations carried out during Hitler's reign in Nazi Germany under the Nazi Hereditary Health Law.[17]

To this day, as evident with recent laws and policies, White supremacy continues to operate through reproductive control of certain lives. One example is family cap policies that deny additional assistance to families who have another child while receiving Temporary Assistance for Needy Families benefits. These policies are rooted in racist narratives that mothers have more children to qualify for more public assistance.[13] Since their introduction in the 1970s, these family cap policies that discourage childbearing have received bipartisan support, disproportionately affect Black families, and wield societal "ideals" of family size unto Black communities.[13]

A second example is the increasing number of state laws that aim to prosecute people for drug use during pregnancy, which serves as another mechanism of reproductive control.[18] Black women are more likely to be screened for drug use during pregnancy, reported to child welfare authorities, lose custody of children, and face criminal prosecutions than women in other racialized groups.[18]

A final example of how White supremacy is wielded through policies of reproductive control is seen in our immigration system, with the high rates of hysterectomies performed on individuals detained by Immigrations and Customs Enforcement, abortion bans for unaccompanied minors in

detention, mistreatment of pregnant immigrants in detention, and forced separation of families at the border.[19,20] These anti-immigrant policies utilize reproductive coercion to control the reproductive agency of immigrants and punish migrants with the goals to deter future immigration and maintain White demographic and political power.[19,20]

ANTIABORTION LEGISLATION

The original laws that criminalized abortion intended to ensure that the United States remained a White nation.[12] The first antiabortion laws enacted in the 19th century made abortion illegal and criminalized midwives, who were primarily Black and Indigenous and provided the majority of reproductive health care including abortion.[21] The campaign was led by physicians to consolidate power and medical legitimacy among White, male doctors and to ensure demographic stability and dominance of White Anglo-Saxons.[21–23]

Whereas these laws are historically grounded in maintaining White political power through childbearing of White offspring,[23] the current onslaught of antiabortion legislation is also part of a long history of criminalizing bodily autonomy, especially for Black, Indigenous, migrant, disabled, working-class, and trans people who experience the harshest effects of antiabortion laws.[24] Recent laws such as SB8 in Texas, which deputizes civilians to police each other's reproductive decisions, harken back to the Fugitive Slave Act, which deputized citizens to aid in the capture of enslaved people who were seeking freedom.[25] Laws such as SB8 increase the surveillance and carceral power of the state, adding to the existing harms of surveillance and policing that already disproportionately criminalize, punish, and disrupt access to multiple social determinants that affect the health of undocumented, Black, Indigenous, and low-income communities.[24,26,27]

PUBLIC HEALTH EFFECTS

There have already been upwards of 1200 people arrested, disproportionately Black, Latinx, Indigenous, and working-class individuals, because of their pregnancy outcomes (e.g., stillbirth, miscarriage, abortion) since 1973, the year *Roe* was decided.[28,29] A recent harrowing example of this increasing criminalization was the arrest of a Latina woman in Texas who was charged with murder after seeking care at a hospital whose staff reported her to the police for allegedly self-managing an abortion.[30]

This expansion of the carceral state further into our health care systems is detrimental to public health. The adverse population health effects of policing and incarceration, both within and outside the health care system, are well documented.[31,32] Beyond the impact on individuals and families who are criminalized for seeking pregnancy care, these laws have collateral effects that can contribute to larger patterns of racism-related daily stressors among Black and other minoritized women that have serious health consequences.[33,34] Medical and public health professionals cannot be complicit in this expansion of the carceral state but, rather, should mobilize around abortion criminalization as a public health crisis that is grounded in White supremacy and has deleterious effects on population health inequities.

As argued by birth equity scholars in an amicus brief for the *Dobbs v. Jackson Women's Health Organization* case that overturned *Roe*, abortion criminalization directly contributes to the profound disparities in maternal health in the United States.[35] Evidence suggests that abortion restrictions contribute to rising US maternal mortality.[36–38] Overturning *Roe* is estimated to lead to a 21% increase in the number of pregnancy-related deaths overall and a 33% increase among Black pregnant people because there are higher risks in pregnancy relative to abortion.[39]

Abortion bans not only restrict access to essential health care but can also have destructive implications across the life course and wide-reaching effects on families and communities as a result of the negative economic and health consequences of being denied an abortion.[40,41] People denied a wanted abortion have experienced increases in household poverty, debt, and evictions and elevated levels of anxiety and stress, and their existing children have shown worse child development than children of people receiving a wanted abortion.[41–43]

Alongside increasing economic inequality and the rising costs of housing, food, and health care, abortion restrictions continue to suppress the socioeconomic power of families and communities to make decisions that are aligned with their wishes and abilities to reproduce in safe, supportive environments. It is critical to consider laws restricting or criminalizing abortion as part of the larger web of structural racism that leads to population health inequities, particularly when considering reproductive, maternal, infant, and child health outcomes.

ABORTION CRIMINALIZATION AND STRUCTURAL RACISM

Recent studies have advanced our epidemiological approaches toward examining multiple interconnecting political, economic, and social forces that maintain White supremacy and perpetuate population health inequities.[44–52] These distinct analytic approaches (e.g., indices, latent constructs) generally include similar dimensions indicative of social determinants of health (e.g., racialized inequities in education, employment, homeownership, and political participation) that reflect the structural limitations of bodily autonomy dictating where minoritized people can live, work, vote, learn, and raise families in safe and healthy environments.

Most of the common structural racism measures capture area-based inequities, but it is also important to consider the laws and policies that either explicitly or implicitly contribute to population health inequities.[49,52,53] Although separate measures of racial and gender oppression have been introduced,[49] it is critical to include antiabortion laws as a dimension of the underlying forces of structural racism given the disproportionate individual and population-level health effects of abortion restrictions as well as the racist justifications and implications of these restrictions. Recognizing abortion criminalization as a key component of the system that perpetuates structural racism allows for a more complete interrogation of the institutional connections that maintain White supremacy.[44]

States have been conceptualized as racializing institutional actors that play critical roles as legal and administrative entities to shape population health.[49,50,54] According to the Guttmacher Institute, 26 states either had laws in place to ban abortion or were likely to ban abortion once *Roe v. Wade* was overturned on June 24, 2022.[55] Using the most recently available data from all sources (Table A, available as a supplement to the online version of this article at http://www.ajph.org), we mapped common measures of structural racism (e.g., index of concentration at the extremes, education and employment inequity) and racist policies to show the glaring overlap between structural racism measures and abortion hostility at the state level. States that are hostile to abortion also pass policies that gut welfare and the social safety net, restrict voting access, and involve high levels of racialized inequities (Figure A, available as a supplement to the online version of this article at http://www.ajph.org).

Most measures of structural racism focus on political and socioeconomic patterns of exclusion and suppression embedded in American institutions; however, missing from these measures are the reinforcing ways in which bodily and reproductive autonomy is structurally limited. Abortion criminalization is central to the intersecting oppressive systems that undergird the US racial hierarchy.

PUBLIC HEALTH MOBILIZATION

Abortion criminalization has and will continue to have devastating public health implications. The public health field must heed the calls of reproductive justice advocates and scholars to examine and address structural determinants of reproductive health in our research, advocacy, and clinical care.[56] The public health critical race praxis offers multiple approaches for doing so.[57] Namely, we must first acknowledge our field's historic and contemporary complicity and perpetuation of racist policies of reproductive control, coercion, and harm. Beyond this acknowledgment and repair, there are several actions public health professionals can take to, at a baseline level, interrogate and disrupt the White supremacy embedded in abortion criminalization and, most necessarily, mobilize with communities to advance reproductive health equity and justice.

Measurement

Conceptualizing abortion criminalization laws as a measure of structural racism meets recent calls to capture the intersectionality, historical, and geographic contexts to improve the measurement of structural racism.[50] In addition to a stand-alone measure, abortion criminalization laws could be included in multidimensional measures of structural racism to more fully capture the multifaceted, intersecting webs of structural racism and its impact on population health. Particularly when studying reproductive health inequities, it is important to understand the potential compounding effects of racial, gender, and class oppression to develop multifaceted interventions for structural change.[58] In accord with the public health critical race praxis, the individuals and communities directly affected by this structural violence must be centered and lead the knowledge production of how White supremacy is enacted through abortion criminalization.[57]

Data

The lack of funding (e.g., from the National Institutes of Health and the Centers for Disease Control and Prevention) for abortion-related research

and large gaps in abortion surveillance data in the United States further uphold the process of science that reinforces White supremacy and limits advances in structural approaches to achieving equitable access to abortion. Following previous calls, we need timely public health indicators for abortion access and a public health abortion surveillance system that respects the confidentiality of abortion clients and providers.[59] Together, data and measurement will allow the public health field to develop antiracist methodologies and strategies to disrupt these structural limitations to bodily autonomy. In addition, and central to the public health critical race praxis, it is critical that we share these data and findings with community advocates.

Action

Most important, public health professionals should leverage their political capital and public health training to support local and state efforts to protect and fund abortion access while uplifting reproductive justice activists and abortion funds who have been fighting these gendered racist policies and supporting people to live self-determined lives for decades. Resistance to these structural barriers has always been cultivated in Black, Indigenous, trans, immigrant, and other marginalized communities. We must work in solidarity with communities in building power to disrupt these oppressive systems and attacks on reproductive freedom to advance our field's equity-oriented goals. AJPH

ABOUT THE AUTHORS

Taylor Riley and Yasaman Zia are with the Department of Epidemiology, School of Public Health, University of Washington, Seattle. Goleen Samari is with the Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York, NY. Mienah Z. Sharif is with the Department of Epidemiology, School of Public Health, University of Washington, Seattle, and the Center for the Study of Racism, Social Justice and Health, University of California, Los Angeles.

CORRESPONDENCE

Correspondence should be sent to Taylor Riley, MPH, 3980 15th Ave NE, Seattle, WA 98195 (e-mail: striley@uw.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

PUBLICATION INFORMATION

Full Citation: Riley T, Zia Y, Samari G, et al. Abortion criminalization: a public health crisis rooted in White supremacy. *Am J Public Health*. 2022;112(11):1662–1667.

Acceptance Date: June 27, 2022.

DOI: https://doi.org/10.2105/AJPH.2022.307014

CONTRIBUTORS

Taylor Riley led the conceptualization, data analysis, and initial draft. Y. Zia, G. Samari, and M. Z. Sharif contributed to conceptualization, drafting, and revisions.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this research because no human participants were involved.

REFERENCES

1. Ross L. What is reproductive justice? Available at: https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051. Accessed December 7, 2021.
2. Nash E. State policy trends 2021: the worst year for abortion rights in almost half a century. Available at: https://www.guttmacher.org/article/2021/12/state-policy-trends-2021-worst-year-abortion-rights-almost-half-century. Accessed March 13, 2022.
3. Guttmacher Institute. The Hyde Amendment: a discriminatory ban on insurance coverage of abortion. Available at: https://www.guttmacher.org/fact-sheet/hyde-amendment. Accessed June 9, 2022.
4. Gilmore RW. *Golden Gulag: Prisons. Surplus, Crisis, and Opposition in Globalizing California.* Berkeley, CA: University of California Press; 2007.
5. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet.* 2017;389(10077):1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X
6. Alang S, Hardeman R, Karbeah J, et al. White supremacy and the core functions of public health. *Am J Public Health.* 2021;111(5):815–819. https://doi.org/10.2105/AJPH.2020.306137
7. Ross L, Solinger R. *Reproductive Justice: An Introduction.* Berkeley, CA: University of California Press; 2017.
8. Combahee River Collective. The Combahee River Collective Statement. Available at: https://www.blackpast.org/african-american-history/combahee-river-collective-statement-1977. Accessed June 9, 2022.
9. Crenshaw K. Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. Available at: http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8. Accessed June 9, 2022.
10. Agénor M. Future directions for incorporating intersectionality into quantitative population health research. *Am J Public Health.* 2020;110(6):803–806. https://doi.org/10.2105/AJPH.2020.305610
11. Aguayo-Romero RA. (Re)centering Black feminism into intersectionality research. *Am J Public Health.* 2021;111(1):101–103. https://doi.org/10.2105/AJPH.2020.306005
12. Murray M. Race-ing Roe: reproductive justice, racial justice, and the battle for Roe v. Wade. Available at: https://harvardlawreview.org/2021/04/race-ing-roe. Accessed March 9, 2022.
13. Roberts D. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* New York, NY: Pantheon Books; 1997.
14. Ross LJ. African-American women and abortion: a neglected history. *J Health Care Poor Underserved.* 1992;3(2):274–284. https://doi.org/10.1353/hpu.2010.0241
15. Washington H. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present.* New York, NY: Anchor Books; 2006.
16. Lawrence J. The Indian Health Service and the sterilization of Native American women. *Am Indian Q.* 2000;24(3):400–419. https://doi.org/10.1353/aiq.2000.0008
17. Davis AY. Racism, birth control, and reproductive rights. Available at: https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=NWSGGN75. Accessed April 9, 2022.
18. Harp KLH, Bunting AM. The racialized nature of child welfare policies and the social control of Black bodies. *Soc Polit.* 2020;27(2):258–281. https://doi.org/10.1093/sp/jxz039
19. Ghandakly EC, Fabi R. Sterilization in US Immigration and Customs Enforcement's (ICE's) detention: ethical failures and systemic injustice. *Am J Public Health.* 2021;111(5):832–834. https://doi.org/10.2105/AJPH.2021.306186
20. Messing AJ, Fabi RE, Rosen JD. Reproductive injustice at the US border. *Am J Public Health.* 2020;110(3):339–344. https://doi.org/10.2105/AJPH.2019.305466
21. Goodwin M. *Policing the Womb: Invisible Women and the Criminalization of Motherhood.* Cambridge, England: Cambridge University Press; 2020.
22. Sherman RB, Weitz T. The fall of 'Roe' was driven by our country's original sin: anti-blackness. https://rewirenewsgroup.com/article/2021/09/20/the-fall-of-roe-was-driven-by-this-countrys-original-sin-anti-blackness. Accessed September 30, 2021.
23. Beisel N, Kay T. Abortion, race, and gender in nineteenth-century America. *Am Sociol Rev.*

2004;69(4):498–518. https://doi.org/10.1177/000312240406900402

24. Interrupting Criminalization. Abortion decriminalization is part of the larger struggle against policing and criminalization. Available at: https://www.interruptingcriminalization.com/decriminalize-abortion. Accessed March 2, 2022.
25. Oishi I. Legal vigilantism: a discussion of the new wave of abortion restrictions and the Fugitive Slave Acts. Available at: https://www.law.georgetown.edu/gender-journal/legal-vigilantism-a-discussion-of-the-new-wave-of-abortion-restrictions-and-the-fugitive-slave-acts. Accessed June 12, 2022.
26. Alang S, McAlpine D, McClain M, Hardeman R. Police brutality, medical mistrust and unmet need for medical care. *Prev Med Rep.* 2021;22:101361. https://doi.org/10.1016/j.pmedr.2021.101361
27. De Trinidad Young ME, Wallace SP. Included, but deportable: a new public health approach to policies that criminalize and integrate immigrants. *Am J Public Health.* 2019;109(9):1171–1176. https://doi.org/10.2105/AJPH.2019.305171
28. Diaz-Tello F. Roe remains for now … will it be enough? Available at: https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/roe-remains-for-now-will-it-be-enough. Accessed March 21, 2022.
29. Paltrow LM. Roe v Wade and the New Jane Crow: reproductive rights in the age of mass incarceration. *Am J Public Health.* 2013;103(1):17–21. https://doi.org/10.2105/AJPH.2012.301104
30. Kasakove S. Woman in Texas charged with murder in connection with "self-induced abortion." Available at: https://www.nytimes.com/2022/04/09/us/self-induced-abortion-murder-charge.html. Accessed April 15, 2022.
31. American Public Health Association. Advancing public health interventions to address the harms of the carceral system. Available at: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/14/advancing-public-health-interventions-to-address-the-harms-of-the-carceral-system. Accessed April 13, 2022.
32. American Public Health Association. Addressing law enforcement violence as a public health issue. Available at: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence. Accessed April 3, 2022.
33. Geronimus AT, Hicken M, Keene D, Bound J. "Weathering" and age patterns of allostatic load scores among Blacks and Whites in the United States. *Am J Public Health.* 2006;96(5):826–833. https://doi.org/10.2105/AJPH.2004.060749
34. Sewell AA, Feldman JM, Ray R, Gilbert KL, Jefferson KA, Lee H. Illness spillovers of lethal police violence: the significance of gendered marginalization. *Ethn Racial Stud.* 2021;44(7):1089–1114. https://doi.org/10.1080/01419870.2020.1781913
35. National Birth Equity Collaborative. Dobbs v. Jackson brief amicus curiae. Available at: https://birthequity.org/news/black-maternal-health-amicus-brief-filed. Accessed June 9, 2022.
36. Vilda D, Wallace ME, Daniel C, Evans MG, Stoecker C, Theall KP. State abortion policies and maternal death in the United States, 2015–2018. *Am J Public Health.* 2021;111(9):1696–1704. https://doi.org/10.2105/AJPH.2021.306396
37. Hawkins SS, Ghiani M, Harper S, Baum CF, Kaufman JS. Impact of state-level changes on maternal mortality: a population-based, quasi-experimental study. *Am J Prev Med.* 2020;58(2):165–174. https://doi.org/10.1016/j.amepre.2019.09.012
38. Addante AN, Eisenberg DL, Valentine MC, Leonard J, Maddox KEJ, Hoofnagle MH. The association between state-level abortion restrictions and maternal mortality in the United States, 1995–2017. *Contraception.* 2021;104(5):496–501. https://doi.org/10.1016/j.contraception.2021.03.018
39. Stevenson AJ. The pregnancy-related mortality impact of a total abortion ban in the United States: a research note on increased deaths due to remaining pregnant. *Demography.* 2021;58(6):2019–2028. https://doi.org/10.1215/00703370-9585908
40. Gerdts C, Dobkin L, Foster DG, Schwarz EB. Side effects, physical health consequences, and mortality associated with abortion and birth after an unwanted pregnancy. *Womens Health Issues.* 2016;26(1):55–59. https://doi.org/10.1016/j.whi.2015.10.001
41. Foster DG, Biggs MA, Ralph L, Gerdts C, Roberts S, Glymour MM. Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. *Am J Public Health.* 2018;108(3):407–413. https://doi.org/10.2105/AJPH.2017.304247
42. Miller S, Wherry L, Foster DG. The economic consequences of being denied an abortion. Available at: https://www.nber.org/system/files/working_papers/w26662/w26662.pdf. Accessed April 15, 2022.
43. Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and well-being 5 years after receiving or being denied an abortion: a prospective, longitudinal cohort study. *JAMA Psychiatry.* 2017;74(2):169–178. https://doi.org/10.1001/jamapsychiatry.2016.3478
44. Gee GC, Hicken MT. Structural racism: the rules and relations of inequity. *Ethn Dis.* 2021;31(suppl 1):293–300. https://doi.org/10.18865/ed.31.S1.293
45. Chantarat T, Riper DCV, Hardeman RR. The intricacy of structural racism measurement: a pilot development of a latent-class multidimensional measure. *EClinicalMedicine.* 2021;40:101092. https://doi.org/10.1016/j.eclinm.2021.101092
46. Dougherty GB, Golden SH, Gross AL, Colantuoni E, Dean LT. Measuring structural racism and its association with BMI. *Am J Prev Med.* 2020;59(4):530–537. https://doi.org/10.1016/j.amepre.2020.05.019
47. Lukachko A, Hatzenbuehler ML, Keyes KM. Structural racism and myocardial infarction in the United States. *Soc Sci Med.* 2014;103:42–50. https://doi.org/10.1016/j.socscimed.2013.07.021
48. Mesic A, Franklin L, Cansever A, et al. The relationship between structural racism and Black-White disparities in fatal police shootings at the state level. *J Natl Med Assoc.* 2018;110(2):106–116. https://doi.org/10.1016/j.jnma.2017.12.002
49. Homan P, Brown TH, King B. Structural intersectionality as a new direction for health disparities research. *J Health Soc Behav.* 2021;62(3):350–370. https://doi.org/10.1177/00221465211032947
50. Hardeman RR, Homan PA, Chantarat T, Davis BA, Brown TH. Improving the measurement of structural racism to achieve antiracist health policy. *Health Aff (Millwood).* 2022;41(2):179–186. https://doi.org/10.1377/hlthaff.2021.01489
51. Adkins-Jackson PB, Chantarat T, Bailey ZD, Ponce NA. Measuring structural racism: a guide for epidemiologists and other health researchers. *Am J Epidemiol.* 2022;191(4):539–547. https://doi.org/10.1093/aje/kwab239
52. Agénor M, Perkins C, Stamoulis C, et al. Developing a database of structural racism-related state laws for health equity research and practice in the United States. *Public Health Rep.* 2021;136(4):428–440. https://doi.org/10.1177/0033354920984168
53. Bailey ZD, Feldman JM, Bassett MT. How structural racism works—racist policies as a root cause of US racial health inequities. *N Engl J Med.* 2021;384(8):768–773. https://doi.org/10.1056/NEJMms2025396
54. Gemmill A, Berger BO, Crane MA, Margerison CE. Mortality rates Among US women of reproductive age, 1999–2019. *Am J Prev Med.* 2022;62(4):548–557. https://doi.org/10.1016/j.amepre.2021.10.009
55. Nash E. 26 states are certain or likely to ban abortion without Roe: here's which ones and why. Available at: https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roe-heres-which-ones-and-why. Accessed April 14, 2022.
56. Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and structural determinants of health inequities in maternal health. *J Womens Health (Larchmt).* 2021;30(2):230–235. https://doi.org/10.1089/jwh.2020.8882
57. 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
58. Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *Am J Public Health.* 2012;102(7):1267–1273. https://doi.org/10.2105/AJPH.2012.300750
59. Coleman-Minahan K. Evaluating the impact of policies, disasters, and racism on abortion access: a call for mandated and standardized public health abortion surveillance. *Am J Public Health.* 2021;111(8):1379–1381. https://doi.org/10.2105/AJPH.2021.306363