

By Terri-ann Monique Thompson, Yves-Yvette Young, Tanya M. Bass, Stephanie Baker, Oriaku Njoku, Jessica Norwood, and Monica Simpson

Racism Runs Through It: Examining The Sexual And Reproductive Health Experience Of Black Women In The South

DOI: 10.1377/hlthaff.2021.01422
HEALTH AFFAIRS 41,
NO. 2 (2022): 195–202
This open access article is
distributed in accordance with the
terms of the Creative Commons
Attribution (CC BY 4.0) license.

ABSTRACT Few studies have illustrated how racism influences Black women's use of reproductive health care services. This article presents findings of a collaborative study conducted by a research team and a reproductive justice organization to understand Black women's concerns with sexual and reproductive health services. The qualitative research was conducted with Black women living in Georgia and North Carolina, using a community-based participatory research approach. Themes were developed from participant accounts that highlight how racism, both structural and individual, influenced their reproductive health care access, utilization, and experience. Structural racism affected participants' finances and led some to forgo care or face barriers to obtaining care. Individual racism resulted in some women electing to receive care only from same-race medical providers. These findings suggest a need for policies and practices that address structural barriers to reproductive health care access and improve the reproductive health experience of Black women.

Terri-ann Monique Thompson (tthompson@ibisreproductivehealth.org), Ibis Reproductive Health, Cambridge, Massachusetts.

Yves-Yvette Young, Ibis Reproductive Health, Oakland, California.

Tanya M. Bass North Carolina Central University, Durham, North Carolina.

Stephanie Baker, Elon University, Elon, North Carolina.

Oriaku Njoku, Access Reproductive Care—Southeast, Atlanta, Georgia.

Jessica Norwood, The Runway Project, Mobile, Alabama.

Monica Simpson, SisterSong Women of Color Reproductive Justice Collective, Atlanta, Georgia.

Stark differences exist in reproductive health outcomes for Black women in the US in comparison with other racial and ethnic groups. Among women ages 15–44, Black women have higher rates of unintended pregnancy and abortion¹ and are significantly more likely to contract a sexually transmitted infection than their White counterparts.² Further, Black women have higher rates of obesity, hypertension, diabetes, and cardiovascular disease—conditions that put them at increased risk for pregnancy complications.³

In the United States, reproductive health disparities occur and are sustained against a backdrop of racism. Both structural and individual racism have been identified as risk factors for poor maternal health outcomes,^{4–6} diminished and coercive contraceptive experiences,^{6–8} and delayed reproductive health screenings.⁹ In

health care, David Williams and colleagues define *structural racism* as the differential reduction of access to desired opportunities and resources due to social structures and policies.¹⁰ *Individual racism* refers to the experience of differential treatment directed at individuals by social institutions and individuals.¹⁰

Structural racism has been seen in policies that segregate Black populations into under-resourced neighborhoods, poorly funded schools, and segmented labor markets. These conditions have resulted in systematically higher concentrations of poverty, unemployment, and lower-paying jobs and greater dependence on social services in the Black community.^{11–13} Twenty-four percent of Black women are dependent on Title X programs, which provide reproductive health care services for low-income women,¹⁴ and close to a third of Black women of reproductive age (15–44) are enrolled in Medicaid.¹⁵

Research has shown that unconscious attitudes and stereotypes held by physicians—a form of individual racism—have led to disparate treatment and recommendations for Black patients, such as delayed reproductive health screenings.¹⁶ Furthermore, a history of medical experimentation, coercion, and mistreatment of Black women has fueled a mistrust of the medical system—one that shapes Black communities' engagement and satisfaction with medical care.^{17,18}

The pathways by which structural and individual racism affect health care are interrelated and mutually reinforcing. As an illustration, policies that promote the economic vulnerability of Black communities activate and fuel negative stereotypes that may further limit community social services and result in experiences of racial discrimination, both of which are tied to adverse reproductive health outcomes.^{19,20}

In this article we highlight manifestations of structural and individual racism in the reproductive health experience of Black women living in two restrictive reproductive health policy environments, Georgia and North Carolina. Our work adds to the literature by highlighting the ways in which experiences of racism affect different aspects of reproductive care.

Study Data And Methods

DATA SOURCES Between May 2019 and January 2020 we conducted six focus-group discussions and twenty-six in-depth interviews with forty-nine Black women living in Georgia and North Carolina.

A research team, community team, and research board worked together to design and implement the study. The research team consisted of researchers at a nonprofit research institution. The community team consisted of a reproductive justice organization as well as two community organizations affiliated with the work of Trust Black Women, a national partnership of Black women-led organizations and individual Black women across the US who work to transform how the country views and treats Black women.²¹ Finally, the research board served as a community liaison, consisting of five Black women who were members of a Trust Black Women partner organization, community leaders in Georgia or North Carolina, or leaders in sexual and reproductive health care.

A community-based participatory research framework²² was used to ensure that the study was relevant to the community being studied, the research appropriately designed, and the results accurately interpreted and disseminated. Consistent with this approach, the community team, research team, and research board were involved

in every research process. The community team led recruitment and data collection efforts, whereas the research team led instrument development and data analysis. The research board reviewed and helped refine the study design and instruments. In addition, the research board reviewed study findings and contributed to their interpretation and framing.

People were eligible for the study if they were ages 18–49, spoke English, self-identified as Black or African American, and had lived in Georgia or North Carolina for at least two years. Focus-group participants were recruited in urban and suburban centers via email lists, social media, health clinics, and other places where Black women in the community could be reached. Interested participants were screened via telephone by the community team, and if they were eligible, their oral informed consent was obtained. A demographic survey was then administered to all eligible participants, who were then assigned to a focus group. Focus-group participants with rich stories were invited to provide more details on their experiences in an in-depth interview. Interviews were conducted until we reached our target sample size ($N = 25$).

To ensure consistency across study sites, we used semistructured focus-group discussion and in-depth interview guides. The focus-group discussion guide covered sex education, pregnancy, family life, and preventive care. Topics were selected on the basis of extant literature and discussions with the research board. The interview guide covered sexual and reproductive health experiences and communication within social networks. These topics were selected to gain a deeper understanding of the sexual and reproductive health decision-making process. Facilitators and interviewers introduced preselected subtopic categories; however, participants could raise other topics. Descriptions of racism emerged without prompt.

Participants often discussed topics in terms of “women’s” health care. Although we use the language of the participants, we recognize that men, nonbinary people, and transgender people also use many of these services.

ANALYSIS Focus-group discussions and in-depth interviews were digitally recorded and transcribed verbatim by a third-party professional transcription company. Transcripts were thematically analyzed using the Framework Method.²³ We developed separate codebooks for the focus-group discussions and the in-depth interviews, each using the relevant instrument as a framework. Initial codes were based on broad topics covered in the focus groups and interviews and on evidence from the literature. Two members of the research team independent-

ly coded one focus-group transcript, and two members individually coded two interview transcripts. The research team met to reconcile code disparities and to collaboratively identify and define subcodes based on common themes within each topic. Codebooks were finalized based on consensus and were subsequently applied to the remaining focus-group and interview transcripts. Using definitions of *racism* from Williams and colleagues,¹⁰ excerpts coded as racism from focus-group discussions and interviews were grouped into three categories: structural racism, cultural racism, and individual racism. The research team met regularly to discuss emergent themes, subcategories, discrepancies, and any changes needed to the codebook or definitions.

All study participants received \$50 for participating in a focus group and an additional \$25 for completing an in-depth interview. One interview was excluded because of previous exclusion from another study based on concerns about data integrity. All study procedures were approved by an independent Institutional Review Board, the Allendale Investigational Review Board.

LIMITATIONS Although generalization was not a goal, important perspectives are likely missing from Black women living in rural areas. The larger number of focus groups in Georgia (four, compared with two in North Carolina) means that the perspectives of Georgia residents may be over-represented in our study. Finally, the experiences of trans, nonbinary, and gender-expansive

Black people are missing. These populations may experience racism in additional or different ways not captured in this study.

Study Results

PARTICIPANT CHARACTERISTICS Community partners conducted four focus-group discussions in Georgia and two in North Carolina, each with eight to twelve participants. Three focus-group discussions were conducted with mixed-aged adults (ages 18–49), two with adults who were younger (ages 18–24), and one with adults who were older (ages 25–49). In addition, twenty-five women—fourteen in Georgia and eleven in North Carolina—completed an in-depth interview. On average, focus-group discussions lasted 122 minutes, whereas in-depth interviews averaged 48 minutes. The median age of participants was twenty-seven, but participants ranged in age from eighteen to forty-seven. Most participants were employed, and a majority had employer-based, school, or private insurance. Approximately 45 percent and 70 percent of Georgia and North Carolina participants, respectively, reported that they had ever been pregnant (exhibit 1).

FINDINGS Experiences of racism were evident across the sexual and reproductive health life-span and across a range of reproductive health services: abortion, contraception, prenatal care, maternal care, and preventive care. Older participants, who had more sexual and reproductive

EXHIBIT 1

Characteristics of participants in the Trust Black Women Listen To Us About Our Reproductive Lives study, by state, May 2019–January 2020

Characteristics	Georgia (n = 29)		North Carolina (n = 20)	
	Number	Percent	Number	Percent
Education				
High school, associate's degree, trade, other	9	31	8	40
Bachelor's degree	12	41	8	40
Graduate school or higher	8	28	1	5
Employment				
Full time	16	55	12	60
Part time	10	34	5	25
Unemployed	3	10	2	10
Insurance type				
Public or other	10	34	6	30
Employer, school, or private	16	55	7	35
No insurance	0	0	4	20
Reproductive health history				
Ever pregnant	13	45	14	70
Never pregnant	16	55	3	15

SOURCE Authors' analysis based on data from the study Trust Black Women Listen To Us About Our Reproductive Lives. **NOTES** Column categories might not total to 100 percent because of missing values or rounding error. The median age in both groups was 27; the range was 18–47 in Georgia and 18–45 in North Carolina.

health experience, described more racist experiences than younger participants.

Participants discussed structural and individual experiences of racism and how these experiences affected aspects of their reproductive health care. Three types of impact were described: on access to care (the ability to obtain timely health care services), use of care (the quantification or use of the health care service), and experience of care (interactions with the health care system). Quotations are identified by state, whether they were recorded during a focus-group discussion or an in-depth interview, and age or age group.

STRUCTURAL RACISM

► **ACCESS:** Access to reproductive health care services was facilitated by residential location as well as income. Black women living in predominantly Black neighborhoods or low-income areas shared that reproductive health care facilities were often located outside of their communities and required having a car or other mode of transportation, which for some meant an additional cost.

Low income and its connection with lack of type of insurance coverage and resulting impact on reproductive health access was a prominent theme. Participants who were insured through Medicaid said that copayment for services proved to be an insurmountable financial barrier and resulted in delaying or forgoing care. Limited finances also led women to prioritize health care for their dependents rather than themselves.

“Prevention is expensive. I mean...not preventing is more expensive. But you know preventative care just seems like a luxury when you don't have any money, because it's like you know, I can put that off for six months, because you know that copay might be like \$35, \$50” (Georgia, focus-group discussion, mixed age group).

Further, noncoverage of a reproductive health service or limited offerings of reproductive health products made access financially and emotionally burdensome and diminished the participants' feelings of reproductive autonomy. During the focus-group discussions, participants raised, without prompt, concerns about the lack of coverage of abortion care within their states. They shared the sentiment that every woman should be “able to make their own decision” and that every person should “have a right to health care and to be able to take care of himself.”

“But it's also like two-sided. It's like ‘I don't support you getting this abortion, but I'm also not going to support you in any other health benefit for you to be able [to] safely carry a preg-

Structural racism starkly influenced the perceived quality of reproductive health care experiences.

nancy if you choose to. And also, I'm not going to supply you with a job that supports parenting” (Georgia, focus-group discussion, mixed age group).

► **UTILIZATION:** Beyond getting to care, structural racism influenced participants' use of reproductive health care services via limitations on the scope of services covered or offered free. Participants who had insurance described both feeling less worried about using services because they were covered and having more consistent use of reproductive health services. However, changes in life circumstances that caused a shift in insurance type (for example, moving from private insurance to Medicaid) disrupted reproductive health care use.

“Once I let the Blue Cross Blue Shield go, [Medicaid family planning services] no longer provided me with certain services such as...the Pap smear and things like that. It was a lot different. They can only check for [sexually transmitted infections]” (North Carolina, in-depth interview, age 24).

Participants who did not have insurance still used reproductive health services but reported that they either had to pay out of pocket or find workarounds, in the form of facilities with a sliding scale or facilities that offered free services such as mammograms.

► **EXPERIENCE:** Structural racism starkly influenced the perceived quality of reproductive health care experiences. Black women observed that the combination of being Black and receiving public assistance or having no insurance coverage had a compound negative effect on their reproductive health experience. Health facilities in the Black community were described as facilities that primarily served a high proportion of people receiving public assistance or with no insurance. Further, participants remarked that these same facilities provided lower-quality care in comparison with more expensive hospitals or facilities. One participant reflected that she was advised by a physician to avoid a specific hospital, which served primarily government-assisted

Individual racism affected reproductive health care use by undermining the patient-doctor relationship.

populations, unless she had no insurance, whereas another reflected on how much better her pregnancy care was in the “White” hospital.

“If you go a little bit further up the street, you’ve got the White hospital and they are amazing. Like I’ve been to both and because I’m pregnant, they—they check me out, get me in and out. My services are ten times better. So, I think it’s just more about the location and honestly the color of your skin and...what type of insurance you have” (Georgia, focus-group discussion, mixed age group).

INDIVIDUAL RACISM

► **ACCESS AND UTILIZATION:** Participants did not describe experiences of individual racism affecting their ability to obtain timely health care. However, participants did report that individual racism, as manifested through interactions with health care providers, negatively affected their use of reproductive health care services. To improve their reproductive health outcomes, participants relied on their support networks, found alternatives to hospital care, and prioritized finding and using race-concordant care. Medical professionals’ disbelief or dismissal of a reproductive concern resulted in participants having to engage multiple times with medical services to receive a diagnosis or care for a persistent issue. This engagement was described as labor-intensive, requiring a high level of self-direction, and costly.

The use of medical services for birthing was frequently described as “traumatic” or “horrible.” Participants recounted that their birthing support systems (partners, doulas, and so on) either were ignored or were the primary reason that they eventually received care. As one participant seeking delivery care described: “When I went [to the hospital], they were initially trying to turn me away. I’m like, ‘No, something’s wrong. I’m past due anyway.’ It wasn’t until... my mom made them hook me up to a baby monitor, and then that’s when they saw...her heart-

beat was dropping, and they were like, ‘Oh. Well, we don’t know why this is happening. We’re going to go ahead and get you in the hospital.’...If it wasn’t for my mom being there—‘We’re not leaving. Check her out. Do more.’—I feel I probably would’ve had a way worse delivery” (North Carolina, in-depth interview, age 28).

Stories of trauma during delivery as well as poor infant and maternal health outcomes among Black women also affected participants who had never been pregnant but who were, nonetheless, aware of these stories. One young woman described a fear of getting pregnant because of a seemingly pervasive disregard for pregnant Black women within the medical system. To mitigate individual racism experienced during birthing, participants reported that they sought out or recommended that others have a home birth with a midwife and doula instead of delivering at a hospital. Women also sought care at smaller medical care facilities and visited multiple reproductive health care providers in search of one that would provide good-quality care.

Individual racism also affected reproductive health care use by undermining the patient-doctor relationship. Some participants reported no longer asking questions during their visit or avoiding care altogether because medical professionals did not believe or dismissed their health concern. As one participant explained: “So, one time I had gone to the hospital because I was like overt bleeding, like really, really hard, and I shouldn’t have been. ...I feel like nothing happened. Like, I feel like I got an \$800 bill to be looked at, asked if I was assaulted, repeatedly have to tell people I wasn’t assaulted, and then be like, ‘Oh, OK, go home.’ And after that I really just stopped going to the doctor altogether because I felt like I didn’t get any kind of help at all. So, I’ve wanted to go to the doctor around this fertility thing for a while. ...I’ve wanted to go to the doctor around my [premenstrual syndrome] symptoms for a while, [but] I’m just not sure that I would even get any kind of help” (North Carolina, in-depth interview, age 23).

Many participants believed that increasing the presence and prevalence of Black medical professionals or having a more diverse medical staff could reduce individual racism within the medical system. Black medical professionals were seen as more trustworthy, more knowledgeable of Black women’s circumstances and reproductive health concerns, more empathic, and more apt to provide comprehensive health information. As such, many participants elected to receive care only from Black medical providers.

“I want to find a clinic where there are like Black people who work there, where I don’t have to advocate for myself in that way. I shouldn’t

have had to. I don't need to. I'm here. Give me what I need to go" (Georgia, focus-group discussion, older age group).

To find a Black doctor, many went through social media support groups, talked with others in their network, or did extensive research online.

► **EXPERIENCE:** Although structural racism influenced the perceived quality of health care facilities available to Black women, individual racism negatively affected the quality of individual experiences with health care providers. Many participants said that they and other Black women did not receive information on the reproductive health conditions most relevant to their lives, their experiences of pain were ignored, few resources supporting delivery or care post-delivery were offered, and they had a feeling that Black women received a disproportionate amount of reproductive care from trainees rather than attending physicians.

Finally, when discussing their experiences with medical professionals, Black women in our study described providers as unconcerned or dismissive. Common phrases attached to contraceptive services, abortion, delivery, and well-woman care were lack of empathy, lack of rapport, hard-to-understand terminology, insufficient health information, loss of autonomy, and feeling undervalued or unwelcomed within the facilities. For some participants, stereotypes about Black women as single mothers and assumptions of domestic violence and drug use were also features of their interactions with medical professionals. These stereotypes left participants feeling demoralized.

"To be sitting in a room and a nurse insinuates that the father of your child is not the father of your child, [they're] out of place. [They're] disrespectful. ...And it was like, why even be in this space?" (North Carolina, in-depth interview, age 28).

Discussion

Findings from our study add to the growing body of literature on racism and its impact on health and well-being.^{6,19,24–26} Structural racism, as manifested through residence, income, and insurance status, influenced access, utilization, and the reproductive health experience of Black women. Prior research has shown that distance from health care, limited or lack of insurance coverage, and having a low income affects health by reducing a person's ability to seek timely, needed, or continuous reproductive health services.²⁷

Individual racism, as evidenced in the activation of stereotypes in patient-provider inter-

actions and negative reproductive health care experiences, influenced three measures of health care quality: person-centered care, patient safety, and effective treatment. Person-centered care includes respect for patients' preferences, responsiveness to patients' needs, and compassion and empathy.²⁸ Often, these attributes were missing from participants' recounting of their reproductive health care experiences. A person-centered care approach has been shown to improve patient health and health care²⁸ and may be bolstered through the provision of cultural competency training, provider understanding of how clinicians tend to perceive and treat patients of different races and ethnicities, and having racial and ethnic concordance between patient and provider.^{18,28–30} Our findings complement this evidence by showing that some Black women sought out same-race doctors to increase their chances of having a more patient-centered health care experience. Patients reported that clinicians did not listen to reports of pain and illness, resulting in missed and misdiagnoses and lack of treatment. In some cases, this placed the woman's safety at risk.³¹ This was especially evident in birthing narratives. Reduced reproductive health care quality has implications not only for Black women's reproductive well-being but also for their financial well-being—for example, some participants elected to deliver in nonhospital settings or identify Black providers (care that may be out of network or far from home), and others had to seek care multiple times for the same condition.

Importantly, Black women in this study lived in restrictive reproductive health care environments. In Georgia and North Carolina, public insurance coverage of abortion care is permissible only under limited conditions;³² 31 percent of all women of reproductive age "lack reasonable access in their county to a health center that offers the full range of contraceptive methods";³³ and 26 percent and 50 percent of counties in North Carolina and Georgia, respectively, were without an obstetrician-gynecologist in 2018.^{34,35} Because Black and Brown communities tend to be overrepresented in Medicaid, public school systems, and public programs offering access to reproductive health services, the experience of structural racism may be more salient for Black women living in these states compared with Black women living in other states.

Addressing racism and its impact on Black women's reproductive health care access, utilization, and experience necessitates policy actions at the state government level and within the health care system.

Policy Actions

In our study, restrictions on public insurance coverage of reproductive health services affected access to and use of services and disrupted continuity of care. Policies that improve access to reproductive health care would enhance outcomes for this population. These policies include expanding federally funded Medicaid coverage; removing restrictive regulations such as the domestic gag rule³⁶ from federal programs that fund reproductive health care such as Title X; and enacting policies such as the Equal Access to Abortion Coverage in Health Insurance (EACH) Act,³⁷ which would require coverage of abortion for people receiving health coverage or care through federal programs and plans.

Our study supports other findings showing that underinvestment in health care provided in predominantly Black neighborhoods limits access to timely and high-quality reproductive health care. Brittany Chambers and colleagues found that Black women who lived in poor Black neighborhoods were more likely to experience racial discrimination in multiple domains and were at increased risk for preterm birth or infant death than those who lived in higher-income and more-privileged-race neighborhoods.¹⁹ These findings, combined with ours, call for greater investments in hospitals that receive supplemental payments for providing care to uninsured people as well as expanded reimbursement for doulas and midwives, who have a track record of

improving maternal health outcomes among low-income women and women of color.³⁸

Finally, our study supports findings that physician-patient racial concordance benefits reproductive health outcomes.²⁹ In our study, participants sought out same-race physicians because they believed that their experience and health outcomes would be better. Prior research has shown that a racially and ethnically diverse health workforce can promote better health care access and use among underserved populations.²⁸ To increase the number of underrepresented minorities in health care professions and maintain that presence over time, funding for federal programs dedicated to underrepresented minority participation should be mandated.³⁷

Conclusion

Our exploration of Black women's reproductive health concerns in two southern states highlighted racism as a feature of the Black reproductive health experience, affecting access to, use of, and experience with reproductive care. Policies that reduce structural barriers to reproductive health coverage and service availability and that provide resources for more culturally competent care will help improve the experience of Black women seeking reproductive health services and may ultimately improve health outcomes. ■

This work was supported by a grant through the Society of Family Planning Research Fund. The authors thank the women who shared their sexual and reproductive health stories with the study team. The authors also acknowledge the work of Cicely Paine and Brandi Collins-Calhoun, who

conducted the interviews, and Tatyana Roberts, who assisted with analysis of the in-depth interviews. The views and opinions expressed are those of the authors and do not necessarily represent the views and opinions of the Society of Family Planning Research Fund. This is an open access

article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt, and build upon this work, for commercial use, provided the original work is properly cited. See <https://creativecommons.org/licenses/by/4.0/>.

NOTES

- Haider S, Stoffel C, Donenberg G, Geller S. Reproductive health disparities: a focus on family planning and prevention among minority women and adolescents. *Glob Adv Health Med*. 2013;2(5):94–9.
- Centers for Disease Control and Prevention. Health disparities in HIV/AIDS, viral hepatitis, STDs, and TB: African Americans/Blacks [Internet]. Atlanta (GA): CDC; 2020 Sep 14 [cited 2021 Dec 8]. Available from: <https://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html>
- Tucker MJ, Berg CJ, Callaghan WM, Hsia J. The Black-White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates. *Am J Public Health*. 2007;97(2):247–51.
- Dominguez TP. Race, racism, and racial disparities in adverse birth outcomes. *Clin Obstet Gynecol*. 2008;51(2):360–70.
- Scott KA, Britton L, McLemore MR. The ethics of perinatal care for Black women: dismantling the structural racism in “Mother Blame” narratives. *J Perinat Neonatal Nurs*. 2019; 33(2):108–15.
- Rosenthal L, Lobel M. Gendered racism and the sexual and reproductive health of Black and Latina women. *Ethn Health*. 2020;25(3): 367–92.
- Thorburn S, Bogart LM. African American women and family planning services: perceptions of discrimination. *Women Health*. 2005;42(1):23–39.
- Roberts DE. *Killing the Black body: race, reproduction, and the meaning of liberty*. New York (NY): Vintage Books; 1999.
- Mouton CP, Carter-Nolan PL, Makambi KH, Taylor TR, Palmer JR, Rosenberg L, et al. Impact of perceived racial discrimination on health screening in black women. *J Health Care Poor Underserved*. 2010;21(1):287–300.
- Williams DR, Lawrence JA, Davis BA, Vu C. Understanding how discrimination can affect health. *Health Serv Res*. 2019;54 Suppl 2(Suppl 2): 1374–88.

- 11 Weller CE. African Americans face systematic obstacles to getting good jobs [Internet]. Washington (DC): Center for American Progress; 2019 Dec 5 [cited 2021 Dec 8]. Available from: <https://www.americanprogress.org/article/african-americans-face-systematic-obstacles-getting-good-jobs/>
- 12 Creamer J. Poverty rates for Blacks and Hispanics reached historic lows in 2019; inequalities persist despite decline in poverty for all major race and Hispanic origin groups [Internet]. Washington (DC): Census Bureau; 2020 Sep 15 [cited 2021 Dec 8]. Available from: <https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html>
- 13 Moffitt RA, Gottschalk PT. Ethnic and racial differences in welfare receipt in the United States. In: Smelser NJ, Wilson WJ, Mitchell F, editors. *America becoming: racial trends and their consequences*. Volume II. Washington (DC): National Academies Press; 2001.
- 14 National Family Planning and Reproductive Health Association. Title X: key facts about Title X [Internet]. Washington (DC): The Association; [cited 2021 Dec 8]. Available from: https://www.nationalfamilyplanning.org/title-x_title-x-key-facts
- 15 Sonfield A. Why protecting Medicaid means protecting sexual and reproductive health. *Guttmacher Policy Review* [serial on the Internet]. 2017 Mar 9 [cited 2021 Dec 16]. Available from: <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health#>
- 16 van Ryn M, Burgess DJ, Dovidio JF, Phelan SM, Saha S, Malat J, et al. The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Rev*. 2011; 8(1):199–218.
- 17 Thompson HS, Valdimarsdottir HB, Winkel G, Jandorf L, Redd W. The Group-Based Medical Mistrust Scale: psychometric properties and association with breast cancer screening. *Prev Med*. 2004;38(2):209–18.
- 18 Laveist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? *J Health Soc Behav*. 2002;43(3): 296–306.
- 19 Chambers BD, Arabia SE, Arega HA, Altman MR, Berkowitz R, Feuer SK, et al. Exposures to structural racism and racial discrimination among pregnant and early post-partum Black women living in Oakland, California. *Stress Health*. 2020; 36(2):213–9.
- 20 Boonstra HD. The impact of government programs on reproductive health disparities: three case studies [Internet]. New York (NY): Guttmacher Institute; 2008 Aug 6 [cited 2021 Dec 8]. Available from: <https://www.guttmacher.org/gpr/2008/08/impact-government-programs-reproductive-health-disparities-three-case-studies>
- 21 SisterSong Women of Color Reproductive Justice Collective. Our history [Internet]. Atlanta (GA): Trust Black Women; 2018 [cited 2021 Dec 8]. Available from: <https://trustblackwomen.org/our-roots>
- 22 Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. *Annu Rev Public Health*. 1998;19:173–202.
- 23 Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the Framework Method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol*. 2013;13(1):117.
- 24 Williams DR, Lawrence JA, Davis BA. Racism and health: evidence and needed research. *Annu Rev Public Health*. 2019;40:105–25.
- 25 Altman MR, McLemore MR, Oseguera T, Lyndon A, Franck LS. Listening to women: recommendations from women of color to improve experiences in pregnancy and birth care. *J Midwifery Womens Health*. 2020;65(4):466–73.
- 26 McLemore MR, Altman MR, Cooper N, Williams S, Rand L, Franck L. Health care experiences of pregnant, birthing, and postnatal women of color at risk for preterm birth. *Soc Sci Med*. 2018;201:127–35.
- 27 National Academies of Sciences, Engineering, and Medicine. *Health-care utilization as a proxy in disability determination*. Washington (DC): National Academies Press; 2018 [cited 2021 Dec 8]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK500097/>
- 28 Chaves K, Gray D, Barton B, Bonnett D, Azam I, Hahn C, et al. 2019 national healthcare quality and disparities report [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; 2020 Dec [last updated 2021 Jun; cited 2021 Dec 8]. Available from: <https://www.ahrq.gov/research/findings/nhqrdr/nhqrdr19/index.html>
- 29 Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci U S A*. 2020;117(35):21194–200.
- 30 Hardeman RR, Karbeah J, Kozhimannil KB. Applying a critical race lens to relationship-centered care in pregnancy and childbirth: an antidote to structural racism. *Birth*. 2020;47(1):3–7.
- 31 Hoffman KM, Rtwalder S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*. 2016;113(16):4296–301.
- 32 Guttmacher Institute. *State funding of abortion under Medicaid* [Internet]. New York (NY): Guttmacher Institute; 2016 [cited 2021 Dec 8]. Available from: <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>
- 33 Power to Decide. *Birth control access* [Internet]. Washington (DC): Power to Decide; [cited 2021 Dec 8]. Available from: <https://powertodecide.org/what-we-do/access/birth-control-access>
- 34 Knopf T. N.C. rural health by the numbers. *NC Health News* [serial on the Internet]. 2018 Jan 22 [cited 2021 Dec 8]. Available from: <https://www.northcarolinahealthnews.org/2018/01/22/n-c-rural-health-numbers/>
- 35 Hart A. Georgia faces rural doctor shortage. *Atlanta Journal-Constitution* [serial on the Internet]. 2018 Aug 17 [cited 2021 Dec 8]. Available from: <https://www.ajc.com/news/state-regional-govt-politics/georgia-faces-rural-doctor-shortage/JqAwfs1SLiqCwVNronKScM/>
- 36 Dawson R. Trump administration's domestic gag rule has slashed the Title X network's capacity by half [Internet]. New York (NY): Guttmacher Institute; 2020 Feb 5 [last updated 2021 Apr 15; cited 2021 Dec 8]. Available from: <https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half>
- 37 All Above All. *EACH Act fact sheet* [Internet]. Washington (DC): All Above All; [cited 2021 Dec 8]. Available from: <https://allaboveall.org/resource/each-act-fact-sheet/>
- 38 Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C, O'Brien M. Doula care, birth outcomes, and costs among Medicaid beneficiaries. *Am J Public Health*. 2013;103(4):e113–21.