Mapping The Policy Landscape For Interrupting Anti-Blackness And Indigenous Erasure: A social work public health equity analysis of reproductive health practice in Washington State during COVID-19 and beyond

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Abstract

Mapping The Policy Landscape For Interrupting Anti-Blackness And Indigenous Erasure: A social work public health equity analysis of reproductive health practice in Washington State during COVID-19 and beyond

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The failure of the United States government and medical system to equitably respond to the COVID-19 pandemic has further revealed the reality that our national information systems and response mechanisms are fractured, ill-equipped, and uncoordinated. This is especially true for marginalized populations. Prior to this global crisis that has irrevocably compromised societal health and well-being [as measured by social determinant of equity (SDOE) indicators], there were several marginalized populations whose health needs were already not being met by medical systems[1]. One such population in the US are pregnant and birthing people.

To decrease maternal mortality rates (MMR) and pregnancy related deaths (PRD), public health interventions need to address both proximal and ultimate gaps in reproductive and perinatal health care for people of color across the reproductive lifespan. The “supremacy of birth” creates an erasure of the spectrum of reproductive health needs and is a contributing factor in the myopic scope of largely clinical perinatal health interventions within public health to

address these disparities. Simultaneously, structural racism and the historical legacies of reproductive violence inherent in the field of obstetrics have created maternal mortality disparities by race with Indigenous and Black populations most significantly impacted.

Clinical and proximal interventions are not adequate to address the health disparities that exist due to a lifetime of structural oppression. In order to improve maternal mortality disparities and pregnancy related deaths, policy interventions must consider holistic reproductive health needs across three reproductive justice[2] principles: 1) the right to give birth; 2) the right to not give birth; and 3) the right to raise children in safe and healthy environments. Utilizing a social work public health praxis for equitable health policy, our policy recommendation takes into consideration health care delivery systems and coordinated response mechanisms aligned with stakeholder needs not only specific to the urgency posed by the novel COVID-19 pandemic but also in preparation for future disasters.

After carefully weighing policy options using a rigorous review of available literature and qualitative data collected using community partnered participatory practices, I am recommending the adoption of all three policy options. Each option targets different public entities, creating a multi-system approach across ecological layers. This kind of diverse approach is understood to be most effective in undoing systematic racialized policy harms[3]. Doing so is aligned with the evaluative criteria I have outlined: adopting all three options is financially responsible; addresses structural determinants of equity; centers the autonomy, pleasure, joy, and liberation of Black and Indigenous populations; and has the potential to improve intergenerational maternal child health outcomes.

I. Background

On March 11, 2020, the World Health Organization (WHO) announced that the coronavirus disease 2019 (COVID-19) had become a pandemic[4]. Since then, it has been irrevocably revealed the global systemic inequalities which impede societal health and well-being[5]. The response of the United States has been ill equipped, fractured, and resulted in collateral consequences whose disproportionate impact has been on poor, working class, and communities of color whose sociopolitical, economic conditions make it impossible and near impossible for them to protect themselves and their families[6]. As the pandemic progresses and more race/ethnicity data become available, alarming racial gaps in testing, treatment, vaccine access, morbidity, and mortality continue to become increasingly apparent[7].

During COVID-19, we are witness to an acute set of stresses for persons who are pregnant or birthing, in particular persons of color. Even prior to this moment though, pregnancy and birth in the United States was a reproductive justice issue given how amongst the wealthiest nations, the US has the highest maternal mortality and pregnancy-related death rates with Black and Native women consistently over-represented in these statistics[8 9]. Contributing to these global racial disparities are unnecessary medical interventions, lack of adequate and supportive prenatal care, implicit racial bias of providers and healthcare teams, and persistent structural racism[10].

Disasters make underlying unjust conditions worse and can result in more severe outcomes for vulnerable groups with vulnerability simultaneously a medical and sociopolitical designation[11]. In the current context, COVID-19 patient health needs are adding pressure to a healthcare system[11] already challenged at meeting the needs of pregnant and birthing persons[12 13], particularly Black and Native persons[10]. For Black and Native birthing persons, they are both medically vulnerable (from having to use the health system for perinatal health services) and socio-politically vulnerable (due to structural racism.)

This analysis follows a social work public health equity praxis[14 15 16] for disaster preparedness to determine recommendations for undoing anti-Blackness and Indigenous erasure in reproductive health practice aligned with reproductive justice values[17] and across the following equity domains[18]: (1) Valuing all populations evenly and equally more broadly; (2) Evidence-based approaches to recognize and rectify racial disparities; (3) Providing resources according to need.

a. Why focus on Anti-Blackness and Indigenous Erasure?

"Slavery is not a loss that the self experiences— of language, lineage, land, or labor—[and by extension the goal is not the recovery of these losses as sovereignty implies] but rather the loss of any self that could experience such loss." - Jared Sexton[19]

The American capitalist project and the nature of settler colonialism necessitate the devaluation and dehumanization of stolen Indigenous Africans. They also require the theft of land from the Indigenous inhabitants of Turtle Island through genocide and relocation. The legacies of this reality are understood through the concepts of "anti-Blackness" and "Indigenous erasure", which are required to maintain the functioning of capitalism and settler colonial projects. Within a settler colonial framework, the two are deeply interconnected and must be addressed simultaneously to unravel and rectify the continued legacy of structural harm[20].

In simplest terms, anti-Blackness is the resistance, disregard and rejection of Black People, Black culture, Black communities and Black values in our society[21]. In a framework of anti-Blackness and under chattel slavery Black people become "things" or nonhumans. Black communities therefore occupy the "unthought of sovereignty," and are thus categorically excluded from achieving sovereignty within a settler-colonial state. Colonization itself makes alternative conceptions of reality unthinkable[22]. The concept of antiracism is set by the state itself and often operates in ahistorical terms[22]; unless anti-Blackness is addressed within a colonial framework, true liberation cannot be realized through anti-racism alone because the stripping of humanity of the Black psyche is rooted in colonial power.

Indigenous erasure is the process for settler societies to discount and eliminate the presence of American Indian peoples, cultures, and polities. This erasure is part of a larger colonial imperative to diminish the existence of American Indians in order to access land and resources.[23] Necessary for this to occur, colonialism defines and divides the otherwise inter-related concepts of land, resources, and humanity. Simultaneously, erasure has meant that, "many Native communities have not only disappeared, but their disappearance has disappeared and their extinction cannot be mourned." Unlike slaves, Native Americans were given the option of assimilation, and "perhaps the threat of Blackness...impels Native peoples to escape into whiteness—and hence to desire simply a deferred genocide through the notion of "sovereignty"[24].

Sovereignty and anti-racist action therefore cannot simply mean control of land or resources but also mean, "the ability to articulate reality at all. The process of decolonization cannot be reduced to a 'return' to land but to an alternative reality altogether that requires radical breaks

with Western epistemology."[25] Unless anti-Blackness and Indigenous erasure are addressed as interrelated, any systemic change will only serve to further dehumanization and deferred genocide. And this change must center the humanization, and therefore the autonomy, liberation, joy, and pleasure of Indigenous and Black communities.

b. Anti-Blackness and Indigenous Erasure in Public Health

Anti-Blackness and Indigenous erasure are interrelated phenomena, and their separation is a function of and necessary to the maintenance of a settler-colonial state. A process of transforming the harms of the legacies of slavery and colonialism requires not only commitment to specific protocol, but careful practice and work[26]. Now that I have described a context and understanding of the role that anti-Blackness and Indigenous erasure play in upholding and maintaining structural racism, it is important to understand the specific ways that these phenomena manifest within public health. Policies and practices must move beyond simple declarations of racism as a public health crisis but must be coupled with meaningful action and accountability[27]. In this section, I will describe specific historical and contemporary examples relevant to the field to inform effective policy action.

i. History of Racism in Public Health

Following the end of the Civil War, freed slaves had few social and legal rights, including access to health care. While slavery was no longer legal, they were denied medical care in white institutions. The federal government denied responsibility for ex-slaves' medical care at the highest level[28]. Andrew Johnson claimed that there was no precedent for establishing medical care in the South and that such a measure would violate his constitutional authority as president. Thus, the Freedman's Bureau Medical Division was created to address the public health crisis among former slaves only once it has begun impacting the health of White Southerners[29]. This reluctant creation also gave only the minimal provisions of care. Thus the creation of the first public health care system in the US was born[30].

Between 1778 and 1868, at least 367 treaties were ratified by the federal government. The Supremacy Clause of the US Constitution establishes the Constitution, federal statutes, and treaties as "the supreme law of the land." Typical language in many of the treaties signed between the United States and tribal nations included phrases like "promise of all proper care and protection" in exchange for tribal land and natural resources[31]. The result is that there is a trust responsibility on behalf of the federal government to provide services to AI/AN persons[32]. During this time, Native Americans were facing increasing legislation which made their traditional governances and health practices illegal. Forced assimilation, forced migration, and the state sanctioned kidnapping of children into Boarding Schools to'"kill the Indian, save the

Man' was occuring during this time[33]. We see here in the nascence of public health care systems in a colonial and post-slavery state dependent upon good faith policy narratives that put into practice negligent, and often violent systems of restrictive health access and miscarriage of human rights[34].

ii. Myth of the Default Human

Within the field of public health and research, it is also important to consider these realities as sovereign from whiteness as default. The myth of a default human assumes, "that white people are the natural reference group for all others when designing scientific studies, reporting scientific findings, allocating human, money and time resources, and that the health outcomes of white people in the United States (U.S.) are the best that can be attained. Demolishing this myth starts with acknowledging that Black people are not the architects of their own destruction: the default standard of whiteness is."[35] Therefore this paper centers the narratives, words, publications, and policy analyses aligned with Black feminist thought, decolonial theory, and traditional Indigenous values.

iii. Data Genocide

According to the data, Native American populations in the United States make up only 2% of the United States population. This low number is reflective of a legacy of attempted genocide through biological warfare, relocation to reservations, cultural genocide through boarding schools and other ongoing efforts to erase Native populations[36]. One Tribal health center in Seattle, Washington was given body bags instead of the requested PPE early in the pandemic.[37]

That 2% figure is likely an underestimation because data collection often miscategorized Native Americans[38]. Historically within research, Native Americans have been left out of many studies because their small population size was not considered "statistically significant". Abigail Echohawk, the director of the Urban Indian Health Institute, named this erasure in data a kind of genocide[39]. Inaccurate data can lead to underfunded and under-resourced programs. Inaccurate data can lead to incorrect conclusions about the health and well-being of indigenous populations and under-reports cases[39].

Researcher/practitioners who conduct epidemiological studies for and by Indigenous peoples generally prioritize community collaboration in research, training more Indigenous researchers, and supporting Indigenous leadership for the field as key means of promoting equity[40]. To account for this phenomenon of data genocide, I considered the knowledge of Indigenous

experiences and concerns, and related ethical and political sensibilities of promoting Indigenous health equity when developing evaluative criteria and policy options.

II. Mapping the Policy Landscape

Racism created and maintains the conditions that led to communities of color being more vulnerable to the "collateral consequences" of the pandemic (Bailey and Robin Moon, 2020)(e.g., pre-existing health and social conditions and overrepresentation in occupations associated with poorer COVID-19 outcomes) (Krieger, 2020). Simultaneously, racism has been the underlying reason why people/communities who are less likely to be able to protect themselves from contracting the virus are also less likely to have access to quality healthcare (Bailey and Robin Moon, 2020; Krieger, 2020). In addition to these medical and occupational apartheids, white supremacy continues to engender distrust of state and public health agencies which may contribute to growing inequities in multiple COVID-19 outcomes (e.g., vaccination rates, cases, hospitalizations, and deaths).

I mapped the landscape of possibility for liberatory policy options by conducting a systemic literature review and stakeholder interviews through qualitative focus groups. I conducted the literature review using an adapted systematic model based on the Evans School Policy Analysis and Research Group (EPAR)[41]. The focus groups were conducted in partnership with the UCLA Center for the Study of Racism, Social Justice, and Health and Charles Drew University COVID-19 Equity Taskforce. The literature review and stakeholder interviews in turn inform the development of policy options and the criteria used to evaluate the potential of proposed policy options in effectively addressing reproductive health disparities.

a. Systematic Review of the Literature

The EPAR method emphasizes three key components of the process: (i) building the sample of studies to review; (ii) developing a review framework and systematically extracting information from the sample of studies using a coding spreadsheet; and (iii) using the coding spreadsheet to help analyze the evidence base and present the results[41].

Of 469219 sourced articles, 217 final papers were used to inform this literature review. I systematically selected articles through several rounds of selection based upon whether they were (1) peer reviewed; (2) relevant; and (3) informed by best-practice and having a health equity or reproductive justice focus (see Table 1). Using an extraction of key themes and practices I developed a framework to understand the causal pathways and mechanisms of reproductive health injustice. There are multiple complex pathways from racism to reproductive health disparities, but all fundamentally function through the devaluation of life

and restriction of access to fundamental resources and needs. This results in an increased vulnerability and risk to negative health outcomes while simultaneously decreasing access to high quality health care.

Prior to COVID-19, there existed a landscape of health inequity within a system of structural racism that has only been exacerbated by the pandemic[42]. Within the literature, racism has been identified as a leading risk factor for adverse maternal and infant health outcomes[43]. Chambers et.al. conceptualized structural racism from the perspectives of Black women across the reproductive lifespan and its potential impact on adverse maternal and infant health outcomes. From that they defined nine domains of structural racism: negative societal views, housing, medical care, law enforcement, hidden resources, employment, education, community infrastructure, and policing Black families[43,44].

Negative societal views impact access to respectful reproductive health care [45 46], and health education, which can lead to increased unwanted pregnancies[47] and preterm birth[48]. In BIPOC communities, unwanted pregnancies are associated with nonvoluntary first intercourse, sex trade involvement, and previous abortion highlighting the need for IUDS, oral contraceptives, and comprehensive sex education[47]. Social isolation and disconnection can lead to negative experiences of maternity care[49]. In addition, racial and socio-economic identities impact how providers package information to patients, therefore controlling autonomy and decision making[46]. Quality and respectful care involves providers recognizing their own power in patient interactions[50]. Power hoarding[51], lack of racial and cultural concordance in care providers[46], mother blame[52], and historical legacies of trauma and experimentation[48] also contribute to compromised quality of care on micro and meso levels.

While outside the scope of this paper, it is important to consider the implications of American health practice on global reproductive health policies, particularly in the context of covid-19. Racism and “epistemological claims about women’s shared identity,'' create a sense of commodification of Global South identities and experiences for the “consumption and social advancement” of the Global North[53]. Saviorism contributes to the weaponization of care, and highlights the need for community participatory processes across all levels of funding, planning, design, evaluation and research. The role of the philanthropic industrial complex in diminishing the political power of BIPOC communities[52] needs to be considered in the policy process, both domestically and globally. This will be further explored in the limitations section.

The impact of COVID-19 in exacerbating existing inequalities across the spectrum of reproductive health care is mostly unanimous in the literature. Lack of standardization of evidence-based care during the pandemic has disproportionately impacted historically

underserved populations - this includes access to respectful care[45], economic and cultural barriers to care (eg. insurance coverage, professionalization, and scope of practice)[54] differential treatment [48], and the biopolitics of care[55] within a system, "where it would seem equity is not the priority, but retaining power and control is."[42]. Perinatal mood disorders, already the most common preventable complication of childbirth and pregnancy, have increased due to increase in risk factors, such as isolation, and domestic violence [56,57]. There are higher rates reported in the literature, and in stakeholder interviews, of postpartum psychosis, as well as increased mental illness among providers[58,59]. Recommended interventions include: increased social support[60] and connection[49]; the need for coordinated care systems to decrease interruption of services[61–63], this includes addressing social determinants of health such as transportation to medical services[64], housing insecurity, education, and the other domains of structural racism[43]. During postpartum practice, recommendations include prioritizing breastfeeding, skin to skin, avoiding separation after birth, and shared decision making with patients and providers[65].

Midwifery care has been well cited in the literature as a best practice for disaster preparedness[66–68], both in terms of increasing hospital capacity and improving outcomes[69,70]. To effectively utilize this practice would involve (at a minimum): increased pathways to professionalization to increase access to culturally concordant care[71], adapted nurse midwifery training[46], inclusion of disaster preparedness into midwifery training[69], adaptation of hospital policies to develop coordinated care systems[72], and changing scope of practice and insurance coverage for provision of care outside of hospital[44]. Much of the existing evidence on midwifery as best practice for disaster preparedness comes from the Middle East, and emphasizes multidisciplinary approaches, especially prioritizing local measures[73].

b. Stakeholder Interviews

Through stakeholder interviews I explored the impact of the pandemic on reproductive health futures. From May - August 2021, three focus groups were conducted over zoom using a purposive referral sampling process to interview key informants from health care, community based, health equity and social justice community organizations in the U.S. These focus groups were conducted as part of a larger research project with the CDU/UCLA Covid-19 Taskforce on Racism & Equity at the Center for the Study of Racism, Social Justice, and Health[74] at the UCLA Fielding School of Public Health. The following guiding questions were used to create a semi-structured interview guide:

1. What are policies for interrupting racism within reproductive health practice during COVID-19?)

2. What are patient-centered practices and challenges related to racism in reproductive health practice during COVID-19? (eg. Patient-provider communication, power dynamics)
3. How can we integrate practices that: center pleasure, liberation, bodily autonomy, cultural respect?

These questions were also used to develop codes for thematic analysis using Dedoose and visualized using LucidChart. Methods for the thematic analysis are rooted in the transdisciplinary conceptual resilience framework (TCRF)[75] and aligned with the research methodology of the larger taskforce projects. The findings represented here are preliminary findings of the study. Full findings and methods are forthcoming in 2022 special issues of Ethnicity and Disease. Thematic analysis of de-identified transcripts allowed for the identification of recurrent, unifying concepts with themes drawing connections between issues of equity (such as racism and social justice), health and healthcare (such as testing and access to a provider), and social determinants of health (such as housing and employment insecurity and loss)(see Figure 1.) The codes that emerged across ecological layers further reinforced the impact of structural, institutional, and societal level forces on access to reproductive health care at the intersection of race. Illustrative quotes of emergent themes have been included in the figure.

i. Transdisciplinary Conceptual Resilience Framework (TCRF) of Contextualized Resilience for Reducing Adverse Outcomes[75]

This framework was selected to develop themes because it is a strengths-based approach, the transdisciplinary aspect mirrors the transdisciplinary 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 medicalized birth.

The framework represents six layers of resilience: a. individual (capacity) b. familial, intimate, and friends (entitlement) c. community and collective culture (resistance) d. structural and institutional (structural vulnerability and reformation) e. policy (historical oppression and manifesting) f. hegemonic discourse (embodiment and transformation).

Within these dynamic and interactive layers, the framework identifies, “resilience as a strength-based processes, praxis, and symbolic action or belief that women use as a means of claiming sovereignty over themselves"[78].

ii. Reproductive Justice

Reproductive justice (RJ) has broadly been 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."[76] This term 'reproductive justice' was coined by the Combahee River Collective[77] as a combination of reproductive rights and social justice, to "recognize the commonality of our experiences and, from the sharing and growing consciousness, to a politics that will change our lives and inevitably end our oppression."[78] Based on the reproductive health United Nations Human Rights framework developed at the 1994 International Conference on Population and Development[79] in Cairo, the reproductive justice movement was born out of the recognition that the women's rights, and pro -choice movement, led by and representing middle class and wealthy white women, could not defend the needs of women of color and other marginalized women. This movement was not only started by, but actively continues because of the work and lived experiences of Black women, primarily Black women in the South, and in solidarity with women in the Global South. That Human rights framework consists of three principles: (1) the right to give birth; (2) the right to not give birth; and (3) the right to raise children in safe and healthy environments[2]. These three principles inform the shape of policy options and considerations across a reproductive lifespan.

c. Key Takeaways

After mapping the data, the following key takeaways emerged as high priority needs that also have potential to address through policy change and coordination of care systems. These takeaways align not only with the stakeholder interview findings, but also the literature review.

i. Birth Supremacy

> *"Birthing is not the only outcome that is possible from pregnancy. The people who got their infertility treatments cut off in January or who weren't able to go back to clinics because there were no guidelines. Trying to become pregnant using fertility services is a time-limited factor. That's not right. So this whole supremacy of birth-- we need to deal with the jacked-up situation that most of the births in the United States happen in hospitals. That's a whole other jacked-up conversation. But let's not forget that there were people who needed abortion care. Let's not forget that there were people like me who have fibroids who might have needed a damn Morena ring put in to be able to deal with that. Let's not forget that people have sexually transmitted infections that needed to get treated."*

Birth supremacy is a term defined by one of our focus group participants. It is the phenomenon that public health discourse, practice, and policy focuses primarily on maternal child health

outcomes related to birth and birthing while largely ignoring or deprioritizing the full spectrum of reproductive health outcomes and needs. For example, during the pandemic fertility treatments were suspended because they are designated as “elective” procedures. This designation reflects a degree of systemic misogyny, and interrupted important, intensive, and costly medical care. Strategies used to increase access as a response to birth supremacy centered on allocation of resources. Direct funds, mutual aid, increased policy and advocacy efforts, informal community networks and care systems; essentially all increasing culturally accessible pathways to care.

ii. Community and Intergenerational Knowledge

Across all focus groups, a theme emerged around a sense of community knowledge that exists in response to the inadequacy of government to address community health needs. This was indicated by participants indicating they had launched community efforts, started diaper banks, increased midwifery and doula care, provided educational campaigns, or fundraised because they “knew that the government was not going to help them”.

iii. Mental Health

> *“I don't care who you are. I don't care what you do, right. If you have no remorse, then, in my opinion, you've got some serious problems as a human on this earth. So from where I sit, I don't think we've even begun to scrape the surface of the mental health impacts of what we've all been through.”*

> *“We cannot in our communities separate out perinatal and reproductive mental health from our community's mental health, right? Because it all impacts us and whether you're a birthing person or not, you're connected to somebody who is a birthing person.”*

Mental health impacts of the pandemic have been staggering in the general population. Participants tied mental health impacts to both reproductive health and historical legacies of racism. These same factors act as barriers to care.

> *“I don't think we can separate out reproductive or perinatal mental health. I'm going to just speak about the African-American community because the relationship to mental health for us. There's a historical perspective, right? And so in black families where black women and I'm specifically using that word, have historically been the matriarchs, the head of households, the medicine women, the aunty that everybody they go to her for X, Y, Z. For African-Americans and I can speak from this from a familial standpoint, is I had a great aunt who, if she was*

still living today, probably would have been diagnosed with bipolar. But she was very brilliant. Her job transferred her away from her family. She didn't have any children and she had a mental health breakdown. And so my grandmother and my other aunt had to go get her and bring her back home. But they did not seek institutionalized care for her because what would have happened, my grandmother worked at the mental hospital in the city is she would have been an experiment. And so I share that story because it's important in the context of I can't speak about other racial or ethnic communities. I can only speak about African-Americans. And I cannot separate out perinatal or reproductive mental health from everything else."

The following themes and issues around mental health were brought up by participants: increased postpartum psychosis, isolation, fear of racialized violence;

"A lot more postpartum psychosis, more than I've seen in the 40 years, but that's because as a practitioner, as a nurse practitioner, I punted them and sent them on as soon as the assessment was done because that was not my area of expertise. But I've been working with quite a few women who have some postpartum depression, but several that definitely have had postpartum psychosis. So it is pretty rampant. There's quite a bit. Again, 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. So really trying to stay connected with mental health providers and get folks help that they need and have actually talked through a couple of folks to being admitted even during COVID because it was definitely bad."

Mental health as a barrier to covid testing and vaccines, overall increased fear and anxiety due to the pandemic, adolescent fear of parents dying, suicide, and mental health impacts not being able to get meet basic needs. Additionally, participants spoke of the hidden mental health impacts to non-birthing parents or family members of those birthing during the pandemic.

"We talk a lot about the mental health of pregnant people, birthing people, people with reproductive capacity, but we aren't talking about their partners. And so something that's come up is the mama might be harmed, but her partner is working because they have an essential job or whatever, and there have anxiety because they feel like they're going to come home and bring COVID home. And it's

a lot of anxiety around that. We're not talking about-- so it's just another whole family system. One thing that I've just noticed about myself that I haven't really heard people talk about is a lot of stress I have for a lot of other things, right. I'm traumatized for a lot of things around this pandemic."

"But just one thing we talk about, pregnant people, lactating people, people of reproductive capacity, but not their partners or how they're being impacted by all of this, but not being able to be at the birth, feeling anxious about bringing home COVID, going off to work where their partner may have to be at home, home school and support that people need at all."

Two respondents spoke of their own mental health as Black mothers of Black children. One said her anxiety was decreased because due to quarantine, she knew her Black son was at home and safe and not at risk of police violence.

"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. We've been around each other 24/7 for a year. And this pandemic wasn't happening, he'd be out in the street, I mean, with his friends, not with me. And that anxiety about not having him around and what's going to happen. So the fact that I have more time with [my son] and I know where he is and I can keep him safe - safer, that stress in my life has gone down. So I feel like - I don't know - I want someone to talk about-- I feel like I want someone to explain that or talk about that a little bit more. I feel like we haven't really talked about that."

"The only reason my black boys haven't been shot by the police, their child hasn't been shot by the police, is because they weren't there. They weren't in that spot. That's the only reason. There is no other reason. They weren't there. George Floyd is my two boys. Tamir Rice was my two boys. And so it is really, really important, I think, 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."

A second spoke of her daughter experiencing police violence at a protest and having to be hospitalized for injuries as well as a mental health crisis.

"I mean, my individual experience last summer with living in a state that is 48 out of 50 for the worst mental health care system, and 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 way to get just basic respectful treatment, basic. Treat her like a human. She's in crisis. And from the moment we entered that hospital it was racist treatment. I had to bring in a pretend lawyer. She is a lawyer. She is a local lawyer but I had to pretend like I hired her. She played along just to get my child basic treatment."

The mental health impacts of the pandemic will be long-lasting, especially with the emergence of new variants, and the impact of historical trauma compounding the trauma of the pandemic itself. Addressing mental health and increasing access to culturally concordant mental health care will be an important and ongoing public health concern.

iv. Structural Violence

Across all key takeaways, structural violence and racism impacts access to health and well-being.

"White supremacy shows up everywhere every second of the day. And white supremacy is the structure, right? And the structure determines where we live, the structure determines if we have access of a livable wage, if we have our unequal access to environmental toxins, quality schools. So this whole idea of the ability to raise children in a safe environment, structural racism impacts all of that, right? And then if you have children to be able to parent them, right? So I think structural racism plays a-- structural racism plays a big role.

One focus group participant tied this specifically to birth disparities and hospital violence.

I think one thing that kind of-- the heightened awareness around inequities in birth outcomes and the heightened awareness around birth equity, I think what has happened and what I have seen in public spaces is that you have Black people, Black 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. And I don't think there is-- and 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 a healthy and safe birth experience, right? It shouldn't be just because you walk into a hospital and you're Black, you're going to die. We're traumatizing folks. And we're not uplifting how we can have joyous black birth."

Another spoke on the impact of racism in medical productions of knowledge and research practices.

"There will always be racism embedded in a society and structures because that's part of the policies. [As a researcher] I wanted to look at the impact of black centering, right? Racially concordant prenatal care. And the comments [from peers] were incredible. It ranged from everything from where's your white woman control group. And I'm like, dude, at what point do we decide that-- because my understanding of science is this, right? Two people have to have equitable exposure to a condition in order for you to say that they were a control group. And so I get confused when people tell me that I have to have white women control groups in my scientific studies as if they are our counterparts. And I really started saying publicly, I don't think white women in the United States are our counterparts."

These findings showed the need for research, policy, and clinical practices to be addressed concurrently through multi-sector approaches and using a critical race lens.

III. Evaluative Criteria for Policy Options

I developed the following evaluative criteria based on the findings from policy landscape mapping, as well as considerations for the historical context and equity best practice. These are the criteria that I will use to analyze the policy options discussed in the next section.

a. Addresses Structural Determinants of Equity (SDoE)

Utilizing Jones' definition, the following domains will be considered for each policy option: 1) The unequal allocation of power and resources which manifests in unequal social, economic, and environmental conditions, also called determinants of health, and; 2) Structural inequities that organize the distribution of power and resources differentially across lines of race, gender, class, and other social identities.

b. Centers Pleasure, Liberation, Bodily Autonomy, Cultural Respect (antidote to Imperialism and anti-Blackness)

Informed by stakeholder interviews, practices that center pleasure and liberation include embodiment (bodily autonomy, body literacy, and honoring humanity, and ancestral healing practices); empowerment and community-based care; and consider that high quality care can occur outside of interacting with a medical provider.

Practices that center bodily autonomy include autonomy in medical-decision making, access to information; patient-centered care; addressing family (eco)systems over individuals and acknowledging the body as part of a collective body in need of healing and care.

Practices that provide cultural respect include strengths-based approaches, culturally concordant environments; address structural racism in Black and Indigenous communities (eg. increases representation/professional pathways in care systems, undoing white supremacy culture and hierarchy of value of healing practices).

c. Financially Responsible

Cost effectiveness, while a traditional consideration in policy analysis is distinct from financial responsibility[16]. Financial responsibility uses an equity lens in particular highlighting Dr. Jones' third equity domain providing resources according to need [18]. It considers intangible individual, community, and societal costs and additionally considers how funding is allocated and creates space for equitable funding analysis, tools, and concepts of reparations and debt forgiveness[80]. This can include use of race equity budget tool, reparations frameworks, or debt forgiveness.

IV. Policy Options

Having reviewed scientific literature, policy and financial documents, legal codes, and conducted focus groups, I identified several policy options that would tangibly improve health outcomes for Indigenous and Black birthing people as well as increase the equity praxis and financial responsibility of government and health institutions:

1. **The Right to Give Birth**: Equity Audit of Maternal Mortality Review
2. **The Right to Not Give Birth**: Increased Integration of Full Spectrum Midwifery Centers
3. **The Right to Raise Children in Safe and Health Environments**: Guaranteed Basic Income

In this section I will describe each proposed policy option and offer an analysis aligned with the evaluative criteria I defined in the previous section (see Figure 2).

a. <u>Policy Option 1:</u> Equity Audit of Maternal Mortality Review Committee (MMRC) and Expansion of Scope of Practice to Include Police Violence

i. Description

Under the guidance of the CDC, Washington State has established a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington to identify factors associated with the deaths and make recommendations for system changes to improve health care services for women in this state. MMRCs determine pregnancy-relatedness and preventability, identify the medical and nonmedical contributors to the deaths, and make recommendations intended to eliminate preventable deaths. MRC recommendations can be used to prioritize interventions and can inform strategies to enable screening, care coordination, and continuation of care throughout pregnancy and the year postpartum. A recent report analyzing data from reviews in 11 different states between 2008-2017 found nearly 1 in 9 pregnancy-related deaths were due to mental health conditions. Among pregnancy-related mental health deaths with a preventability determination made by the MMRCs, 100% were determined to be preventable[81].

MMRCs represent a unique contribution—other data systems cannot capture this level of information[81]. Because of this, MMRCs are uniquely positioned to influence policy and affect meaningful change at national and state levels. An equity audit would examine practices within MMRC, build upon their current pilot of a discrimination and social determinants tool, and expand the criteria to expand the scope of practice to include police violence.

ii. Analysis

While this is primarily housed under the first reproductive justice principle[2], it has the impact to influence across all reproductive justice layers. Having the option to choose when to not have a child can reduce unwanted pregnancies, which are associated with increased maternal mortality and infant death. Simultaneously, expanding criteria and developing protocol, tools, and cultivating panel expertise to include police violence would influence the ability for parents to raise children in safe and healthy environments.

This proposed policy would improve financial responsibility by increasing MMRC scope to make systemic recommendations and broaden the scope outside of clinical interventions. Improving screening processes for preeclampsia during prenatal care will not begin to undo the toxic stress of a lifetime of environmental racism. Increasing MMRC capacity to make broader recommendations promotes long-term savings for health care by improving preventative care and decreasing expensive interventions. This simultaneously addresses SDoE by expanding the

scope the considerations for impacts of a lifetime of racism – including disproportionate access to education, reproductive health care, healthy food, transportation, etc. Addressing police violence centers the liberation, bodily autonomy, and cultural respect because it honors the humanity and dignity of birthing people of color and takes steps to allowing children of color to live in a world free of fear from state sanctioned murder.

If Washington State MMRC increases scope of practice, increases expertise through representation of Black and Indigenous community on the panel, and develops tools and protocol for addressing police violence, it could set a national standard across state MMRCs and influence and national practice at the level of the CDC.

b. Policy Option 2: Increased Integration of Full Spectrum Midwifery Centers

i. Description

Globally, birth centers and holistic perinatal teams inclusive of community midwives are seen as an effective community health solution to improving pregnancy and birth as well as strengthening the bond between patients and providers[12,70]. The United States' system has lagged in these best practices. This current pandemic lays bare our system so that we can rebuild it into one that is aligned with the needs of those it serves. Re-structuring the health system's labor and delivery practices is one of these opportunities. A public health equity response to this disaster as well as future ones would require strengthening community resilience during and before emergencies[44,69,82]. Fortunately, other healthcare evidence-based models exist to guide the development of an equity-based solution to this reproductive health and disaster preparedness problem.

Critically reviewing these models, we recommend cities/counties re-conceptualize their existing perinatal, labor and delivery services to partner, develop, or integrate with free-standing maternity homes/birth centers for low-risk perinatal health needs including low risk pregnancies, pregnancy loss, and abortion staffed with comprehensive medical teams inclusive of community-based perinatal and mental health professionals. This is a public health equity, disaster preparedness solution to improve community capacity for resiliency during emergencies for pregnant and birthing persons more generally and for communities of color more specifically.

ii. Analysis

This policy option is in alignment with the evidence-based literature on decreasing pregnancy-related deaths (PRD) and pregnancy-related trauma (PRT), considers internationally validated protocols on maximizing hospital resources during disasters, and is aligned with health equity

and reproductive justice frameworks[50,52,53,69,83]. Health affirming practices and movements in oppressed populations are mitigated by the practices and systems that perpetuate discrimination, maintain exposure to hazard, and continue grave injustices[84].

Therefore, to effectively implement this policy aligned with evaluative criteria, these health centers should include comprehensive care teams, specifically including community based full spectrum doula care and culturally concordant care. This aligns with recommendations from the literature, as well as stakeholder input that supporting existing programs and resourcing community-based projects improve health outcomes. Additionally, increasing pathways to professionalization for reproductive health providers ensures sustainability and improved access to care.

c. Policy Option 3: Guaranteed Basic Income

i. Description

Guaranteed income (GI) is a type of cash transfer program that provides regular, unconditional, and unrestricted cash transfers to individuals or households[85]. This differs from typical social safety net policies by providing a steady, predictable stream of cash to recipients to spend however they see fit without requiring that they perform specific activities—like working, going to school, or seeking employment—to remain eligible. Interest in guaranteed income programs providing continuous, unconditional cash transfers is surging, with more than 30 pilot programs in development or underway in the U.S. alone. Guaranteed income is a policy response to systemic poverty and rising inequality, particularly during a pandemic that has brutally exacerbated these problems and differs from traditional safety net policies by providing a steady and predictable flow of cash that recipients can use without limitations[86].

To combat the catastrophic disparities in maternal and infant health and economic security outcomes, several of these pilot programs specifically serve women during their perinatal year. These pilots are testing cash transfers as an economic and reproductive health strategy, demonstrating trust in mothers to make the right choices for themselves and their families. Pilot organizers and researchers hypothesize that decreasing the underlying stress of financial insecurity could reduce rates of premature birth. Preliminary results from one such pilot in Mississippi have been optimistic. Results over the past two years of the program show the undeniable impact of investing in women: 27 percent of moms were more likely to go to a doctor if they were sick, 20 percent more likely to have children performing above grade level, more than double preparing most of their food at home, recipients paying off thousands in predatory debt[87].

One key factor to consider in offering guaranteed basic income is existing enrollment in safety net programs[88]. Safety net programs are effective in reducing poverty, especially deep poverty, and many benefit recipients rely on these programs to survive. However, most of these programs have restrictive, complex, and shifting eligibility requirements around household income and assets. People relying on benefits face a well-documented "benefits cliff" problem, where even small increases in earnings or assets can result in sudden and often unexpected reductions, or even total losses, in public benefits[89]. The benefits cliff disproportionately impacts Black and Indigenous families and penalizes families for making more money or saving, and actively prevents people from achieving economic security[90].

ii. Analysis

Best practices for guaranteed basic income: target low-income individuals, provide full-package services, enhance individual agency, promote long-term economic inclusion, provide regular, not one time support, serve a long-term guaranteed income agenda.

The adoption of a state-funded guaranteed basic income across Washington, with additional legislation and coordination of care systems to support privately and publicly funded smaller scale GBI programs to support families during the perinatal year aligned with best practices would serve to improve intergenerational wealth, maternal-child health outcomes, and decrease racial disparities.

This policy primarily influences the right to raise children in safe and healthy environments, though several pilots which center pregnant families are seeing preliminary data impacts on perinatal health outcomes. This proposed policy option is financially responsible as an equity measure aligned with reparations specifically when focusing on Black and Indigenous populations.

V. Recommendation and Limitations

Based on the analysis of policy options, I believe that the implementation of all three policy options would provide a comprehensive strategy across the reproductive lifespan (see Figure 2). All policy options have medium to high alignment with the evaluative criteria, and each one adds increased dimensionality where other policy options are lacking. For instance, increasing access to full spectrum reproductive health care addresses SDoE associated with clinical care, and a Guaranteed Income increased access to housing, employment, food, etc. Addressing health disparities across equity domains increases the probability of rerouting systemic tendencies toward racial inequalities. Within Washington State, all three policy options are politically feasible with pilot programs and initiatives underway currently.

It is important to not the following limitations both of this analysis and the proposed options. I first want to acknowledge my positionality as an Indigenous diasporic person, I am both Native and settler on other Indigenous lands. This work is both an act of ancestor honoring and allyship with the Native peoples' on whose lands I am a guest. Additionally, as a non-Black person of color researching anti-Blackness, I have worked under the guidance of leading Black researchers and institutions to align myself in a good way and center the leadership of the most impacted.

The challenges of Covid-19 make these recommendations more pressing, however it also presents increased barriers to implementation. Additionally, methods for conducting the stakeholder interviews and the data collection process were impacted by physical distancing and safety protocols. With increased strain on public systems as new variants emerge and increasing economic impacts, implementation, and meaningful changes for improving community health may require inside-outside strategies with most impact coming from grassroots work outside of government and policy influence. There are limitations of academic and public health to support multi-system policy change.

Because academia and public health are situated as institutions of historical harm and oppression, meaningful change requires careful and thoughtful measures across each step of planning, design, implementation, and programming in order to not perpetuate these legacies of harm and oppression. Necropolitical philosopher Achille Mbembe describes the biopower of states in determining who is worthy of living and who of dying[91]. It is important to consider the pharmakon factor[92] – the potential for something to act both as medicine or poison – within a necropolitical framework. Within a government of targeted state sanctioned murder and violence against Black and Indigenous communities, any "anti-racist" policy has the potential to further replicate patterns of genocide and enslavement.

Lastly, for these policy options to take place on national levels, it requires as fundamental mindset shift across the general American population. These policy options will only succeed with meaningful community engagement and qualitative storytelling strategies and campaigns to change mainstream narratives and opinions around economic and health outcomes for Black and Indigenous communities.

VI. Conclusion

Narratives of personal responsibility for poor maternal health and birth outcomes among Black women are debunked by data that show that Black women's rates of severe maternal morbidity remained disproportionately high, even when adjusted for factors such as income,

level of education, obesity, geographic location, and other factors that could impact morbidity and mortality rates. Black women's lived experiences, and the toll that racism can take on their mental and physical health, are central to addressing maternal mortality. The adversities Black women face – rooted in systemic inequality – span various aspects of their life beyond health. Inequity in educational opportunities, economic gains, safe communities, and affordable, quality housing are just a few[93].

Native Americans are disproportionately impacted by maternal/infant mortality in the US, despite low overall rates of American maternal and infant mortality compared to other developed countries. Nationwide, American Indian and Alaska Native (AIAN) infants are more than twice as likely to die by their first birthday as non-Hispanic white infants. Like many traditional practices, the paucity perinatal practice and knowledge in native communities can be explained through the social determinants of equity (SDoE) of genocide, relocation, and boarding school practices enacted during the colonization of the American continent. Evidence shows that this collective intergenerational loss and the resultant behavioral and health manifestations known as Historical Trauma (HT) can be ameliorated through reclaiming traditional practices. Community-based and Indigenous led interventions for historical trauma suggest that deep engagement outside of traditional health service settings should be considered and may be particularly effective in promoting positive health behaviors in Native communities.

Holistic, multi-sector, and coordinated approaches such as those suggested in this paper are required to make any type of change that is more than simply another treaty left not honored or another bare-minimum effort to appease white-supremacist interests. Improving reproductive health outcomes in Black and Indigenous communities must be rooted in healing these historical harms and center the humanity, pleasure, joy, and autonomy of Black and Indigenous parents and birthing people.

VII. Acknowledgements

I honor and acknowledge that America rests on the occupied ancestral lands of the Indigenous peoples of Turtle Island. I pay respects to their elders past and present, for stewarding the land that we reside on. I honor that the original peoples are still here, continuing to persist and persevere to their ancient heritage despite having treaty rights honored or having yet to be justly compensated for their land, resources, and livelihood[94].

I also acknowledge that much of what we know of this country today, including its culture, economic growth, and development throughout history and across time, has been made possible by the labor of enslaved Africans and their ascendants who suffered the horror of the

transatlantic trafficking of their people, chattel slavery, and Jim Crow. We are indebted to their labor and their sacrifice, and we must acknowledge the tremors of that violence throughout the generations and the resulting impact that can still be felt and witnessed today. If we cannot collectively begin to acknowledge the historical labor that has allowed our society to get and be where it is today, then we will continue to struggle to reconcile and redress those histories and legacies[95].

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IX. Tables and Figures

Keywords searched	Total number of search results	First Cut		Second Cut
		Peer-reviewed studies	Relevant and peer-reviewed studies	Relevant, Peer-Reviewed, Best Practice, or Reproductive Justice and Heath Equity Focus
"disaster preparedness" "midwifery"	671	294	167	27
"midwifery" "hospital" "outcomes"	12,350	6740	70	22
"birth eqity" "midwives" "america"	3,199	977	3	10
"maternal mortality" "disparities"	19,974	19,974	21	20
"provider bias" "midwifery"	7250	2882	93	11
"racism" "reproductive health"	40,220	11,610	68	9
"cost effectiveness" "health justice"	263,000	79,000	9	8
"covid19" "pregnancy"	24	7	4	4
updated 6/2 "covid19" "pregnancy"	1181	514	27	27
"covid19" "abortion access"	1866	335	47	36
"covid19" "fertility treatment"	133	68	6	6
"covid 19" "reparations"	84	21	3	3
racism public health crisis	119,267	35,892	287	34
TOTAL	**469219**	**158314**	**805**	**217**

Table 1. Covid Reproductive Health Equity Literature Review Keywords and Inclusion Criteria

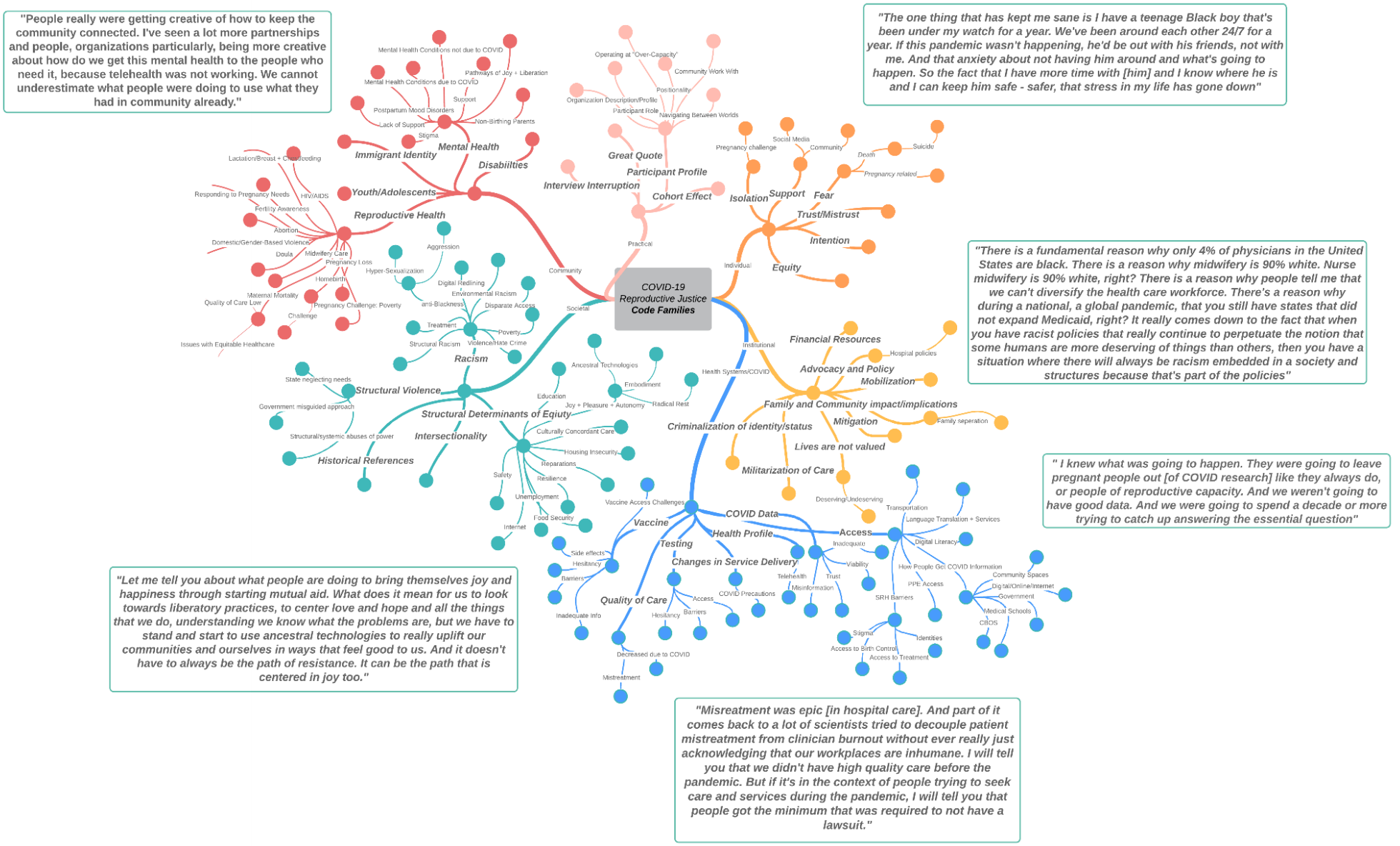

Figure 1. Map of Code Families for Thematic Focus Group Analysis Across Ecological Levels with Participant Quotes

POLICY OPTIONS			
CRITERIA	**The Right to Give Birth:** Equity Audit of MMR + Expand Scope of Practice to Include Police Violence	**The Right to Not Give Birth:** Increased Integration of Community-Based Full Spectrum Midwifery Centers into Coordinated Health Systems	**The Right to Raise Children in Safe and Healthy Environments**: Guaranteed Basic Income
Addresses Structural Determinants of Equity	**Expanding criteria and developing protocol, tools, and cultivating panel expertise to include police violence and SDoE can inform strategies to enable continuation of care throughout pregnancy and the year postpartum[9,10,81].** If Washington State develops this protocol and practice, it could determine a national standard[83,96]. **However, without deep community engagement and careful accountability rooted in healing justice and input from MMIW and BLM praxis, this policy could further entrench racist standards of invisbilizing structural harm, creating systemic gaslighting[27,97].**	This policy option considers the strain of crisis on provider[67,69,70] and patient autonomy[84]. It i**ncreases access to services and supplies; access to preventative and routine care, including abortion.** It reduces fear and uncertainty for healthcare providers[98] and clients and **meets population-based public health needs with high-quality, individualized, client-centered care[12,45,84].** This option however primarily addresses SDoE associated with clinical care and direct practice but is **limited in its ability to address factors associated with systemic racism across a lifespan.**	GI programs support access to resources that directly improve children's futures, including food, educational materials, health goods, childcare, and extracurricular activities that help create a more stable family environment. **Permanent and fully refundable GI reduces racial disparities, cuts childhood poverty, can be reparative in righting historic injustices for Black and Indigenous families[97,99]. To be implemented effectively, policies must account for the "benefits cliff"[89] by not counting GI income toward social safety net program eligibility[88].** Not doing so penalizes families for making more money or saving, and actively prevents people from achieving economic security[90].
Financially Responsible	**MMRCs have very little actionable power in terms of implementing change outside of making recommendations[96].** They do not have the power to make or implement policies on their own, rather recommendations that can influence policy[100]. While highly influential, they do not hold any financial responsibility on their own. **In making equitable recommendations aligned with SDoE it has the potential to influence budgets and reparative financial processes that consider human costs and rectify historical harms[101,102].** With the proposed policy audit and structural changes, MMRCs could advocate for reallocation of police budget into community-based alternatives, for example.	Midwifery care is more cost effective than hospital care. Additionally, creating pathways to increased community midwifery care with comprehensive continuity is reparative and financially responsible in equity terms[10]. **Mothers attended to by midwives spend less time at the hospital during birth admissions, are less likely to have interventions, instrumental births, and more likely to have exclusive breastfeeding at discharge from birth admission[84].** Additionally, **community-based and racially concordant care is associated with decreased health interventions** - reducing maternal mortality disparities while simultaneously avoiding costly and unnecessary interventions[10,35,45,84].	While not cost-effective in a traditional sense, when implemented with an equity lens and focus on racial disparities[16,103], **GBI programs can serve as a form of reparations[80] and decolonizing practice[104,105].** GI pilots across the country have proved to be successful in uplifting people out of poverty and rectify historic injustices along economic lines[87,88,99,106]. It is **a positive investment in healing intergenerational economic inequities.** While a new movement in the US, **data from other countries shows public savings in education, public health, and other social services and population health outcomes associated with SDoE[107,108].**
Centers Pleasure, Liberation, Joy, Autonomy	**Outside of direct murder of pregnant women by police, there is evidence that fatal police violence has population-level consequences for pregnancy loss, infant health, and maternal mortality[109–111]. This policy is in alignment with national movements for ameliorating maternal health disparities, from grassroots organizations[112] to Congress[113].** While accountability for police violence and addressing maternal mortality does not center pleasure, liberation, joy, and autonomy directly; it does support the conditions which would facilitate population level access to these states of being for Black and Indigenous communities.	Birth workers of color provide a culturally centered approach, suggesting **that achieving birth equity for pregnant Indigenous and Black birthing people starts by acknowledging and honoring their socio-cultural experiences[84].** Midwifery care is also associated with higher levels of autonomy in decision-making as well as respectful care when compared to physician care.[114] **Midwifery and full spectrum reproductive health are traditional practices of Black and Indigenous communities in North America. Reclaiming midwifery practice by increasing accessibility, resources, and pathways to care is an act of decolonization and reclaiming traditional practices lost due to colonization, genocide, and slavery[82,115–117].**	With the national CTC expansion[118] and dialogue for permanency, there is increased acceptability for GI on a national level[119,120]. There are currently several GBI pilot programs that center racial health disparities and pregnancy in their population – notably the Abundant Birth Project[88] in the Bay Area and Magnolia Mothers[87] in Mississippi. In WA State, Hummingbird Indigenous family services is starting the first Indigenous GBI program to center pregnant and birthing people. **Reparations through economic sovereignty is an evidence-based approach for improving community-well-being and healing historical harms[121,122]. Storytelling and other narrative projects have revealed the impact of GI on quality of life for parents and children.**
Feasibility			

KEY	LOW	MEDIUM	MEDIUM-HIGH	HIGH

Figure 2. Policy Matrix: Options for Undoing Anti-Blackness and Indigenous Erasure Using a Reproductive Justice Framework