TIME AS A RACIALIZED BARRIER: HOW MANDATORY WAITING PERIODS FUNCTION AS GATEKEEPING MECHANISMS IN ABORTION ACCESS

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Chapter 1

Introduction

Reproduction has never been a purely private matter in the United States. From the moment the first laws governing women's bodies were written into American legal code, the question of who would bear children—and under what conditions—has been answered not by individuals, but by the state. That answer has *never* been neutral. It has always been *racial.* It has been gendered. It has been wielded. And it has been wielded continuously, across centuries, through instruments that often look nothing like what they are.

The public health field has been slow to reckon with this. For decades, reproductive health disparities were framed as problems of access—gaps in insurance coverage, shortages of providers, deficits in health literacy. These framings were not wrong, but they were incomplete in a way that mattered. They described symptoms while obscuring the architecture that produced them. What the scholarship of the last two decades has increasingly made clear is that the architecture itself is structural racism—not as metaphor, not as moral indictment, but as a measurable, state-sanctioned system that produces and reproduces unequal vulnerability across racial lines. Structural racism operates through "mutually reinforcing inequitable systems" and functions as the state-sanctioned production of group-differentiated vulnerability to premature death (Gilmore 2007; Bailey et al. 2017). Abortion policy, Riley et al. (2022) argue, is not a bystander to this current system. Rather, it's a dimension of it.

Abortion criminalization aligns with the undercurrents of structural racism through both whom it disproportionately impacts and how power is wielded to suppress the livelihoods of racially minoritized communities.

The claim requires a history to stand on. The policing of Black women's reproduction did not begin with *Roe v. Wade (1973)*, and it did not begin with *Dobbs v. Jackson Women's Health Organization (2022)*. The control and governance of Black women's reproduction was economically and legally institutionalized from the era of slavery forward, when enslavers had a direct financial incentive to regulate reproduction because the law made enslaved women's children their property. The result was that Black women were, from the country's legal origins, marked as objects whose decisions about reproduction should be subject to social regulation rather than their own will. This was not a cultural attitude; it was law. And, it was built into the foundation of the American legal system before most of the country's other founding documents were finalized.

What makes this history structurally significant, rather than merely morally significant, is that it shapes the material conditions of present-day life. Institutional racism, as Bailey et al. (2017) define it, is not a synonym for prejudice and cannot be reduced to the sum of individual discriminatory acts. It describes instead the systematic production of racial inequality through the ordinary operation of institutions—policies, practices, and organizational arrangements that distribute resources, risks, and life chances unequally across racial lines, whether or not any actor within those institutions intends a discriminatory outcome. The institution need not harbor animus to produce racial injury. It needs only to operate according to rules that treat structurally unequal people as though they were structurally identical. This definition also answers the question of how institutional racism is distinguishable from class disadvantage—a distinction on which this paper's argument depends. Class-based explanations predict that racial disparities should disappear once income is held constant. They frequently do not. Syed, Gerber, and Sharp (2013) synthesized sixty-one studies on transportation as a healthcare barrier and found that African American patients faced higher travel burdens than white patients, even after controlling for socioeconomic status. When the racial gap persists after class is accounted for, what remains is race. That remainder is not noise; it is the domain this paper investigates. And in no domain is its weight more measurable—or more deadly—than maternal health.

The trajectory from that foundation to the present is not a story of discontinuity punctuated by occasional regression. It is a story of structural continuity—the same logic manifesting through different institutional mechanisms as each era demands. Prather et al. (2018) trace this arc with methodical precision, and their methodology warrants attention, because the claim of historical continuity requires evidence rather than assertion. Their analysis documents not merely that reproductive health disparities exist across historical periods, but that the same population-level hierarchy persists across each institutional transformation: Black women bearing disproportionate reproductive costs and risks, in every era, through whatever institutional mechanism that era makes available. The mechanism changes; the hierarchy does not. What connects slavery's forced reproduction to twentieth-century sterilization abuse to the procedural architecture of contemporary abortion restriction is a traceable structural logic: each era's dominant institutions have been organized in ways that subject Black women's reproductive decisions to social regulation rather than individual will, and each era's scholarship has documented the material consequences of that organization in mortality rates, morbidity outcomes, and differential access to care. The claim this paper makes is not that slavery causes waiting periods. It is that the structural position of Black women in American reproductive healthcare—their relative vulnerability to policy-imposed burden—was established in the slavery era and has been continuously reproduced through successive institutional arrangements, a continuity Prather et al. (2018) establish empirically rather than rhetorically. History is not prologue here; it is the operating system.

The empirical record bears this out with uncomfortable clarity. Vilda et al. (2021) constructed a composite index of eight abortion-restricting policies—among them mandatory waiting periods, mandated counseling, ultrasound requirements, gestational age restrictions, and Medicaid coverage prohibitions—and examined their association with maternal mortality across a four-year period from 2015 to 2018. States with a higher score on the abortion policy composite index had a seven percent increase in total maternal mortality compared with states with fewer restrictions, after adjusting for state-level covariates, including poverty, unemployment, and Medicaid expansion status. Individual policies carried even starker mortality costs: states with a licensed physician requirement had a fifty-one percent higher total maternal mortality, and states with restrictions on public funding for abortion had a twenty-nine percent higher total maternal mortality than states without those policies. Restriction kills. That is not a rhetorical claim; it is a finding.

The structural argument sharpens further when the same restriction is examined through a racial lens. Mosley et al. (2022) analyze Georgia's gestational age limit and demonstrate that a facially neutral policy—one law, one threshold, applied uniformly—does not produce uniform results. The decrease in abortion ratios at twenty-two weeks or later was significantly steeper for Black patients than for White patients following the law's full implementation. The authors are explicit about why: Black and Latinx individuals are more likely to be unemployed, live in households headed by a single woman, or experience poverty-related barriers to accessing abortion services. The same restriction, landing on unequal ground, produces unequal injury. This is not incidental variation in outcomes; it is the mechanism by which neutral-looking policy does racialized work.

Taken together, these four bodies of scholarship establish something important and reveal something incomplete. They establish that the history of reproductive control in the United States is racially constituted; that structural racism operates through policy as well as through individual discrimination; that abortion restriction is measurably associated with elevated maternal mortality; and that the same restriction produces demonstrably worse outcomes for Black patients, with poverty-related barriers named explicitly as the pathway. What they do not establish—and what no existing scholarship has yet systematically provided—is a framework for understanding how, specifically, a procedural abortion restriction embeds structural inequality into its design. The disparities are documented; the history is traced, but the precise architecture through which a facially neutral, time-based restriction generates cascading, racially unequal burdens has not been named, typologized, or analyzed as a coherent theoretical system.

This is the gap this study aims to fill.

Chapter 2

Literature Review and Theoretical Framework

Understanding that abortion restrictions produce racialized outcomes is necessary, but it is not sufficient. The existing literature tells us that Black patients are disproportionately harmed. It does not tell us, with analytical precision, *how the policy accomplishes this*—through which specific architecture, along what specific fault lines, by activating what specific structural vulnerabilities that were already present before the law ever took effect. That is the question this study investigates through the lens of a particular restriction: the mandatory waiting period.

Waiting periods are, on their surface, the most procedural of abortion regulations. They do not prohibit, and they do not criminalize. They simply require that a patient wait—typically twenty-four to seventy-two hours between an initial consultation and the procedure itself. The language of the policy is temporal, while the logic of the policy, its proponents posit, is deliberative: time to reflect, time to be certain, time to choose freely. What this framing obscures, deliberately or not, is that time is not free. Time costs money; money requires employment; employment requires schedule flexibility; schedule flexibility requires job security; job security is shaped by race; and race, in the United States, is shaped by centuries of deliberate structural disadvantage that no waiting period was designed to remedy and that no waiting period is neutral with respect to.

The empirical groundwork for this claim already exists in pieces. Gerdts et al. (2016) documented the four concrete resource burdens that waiting periods impose on patients navigating restrictive abortion environments: lost wages, childcare costs, transportation expenses, and overnight stay costs when same-day return is not feasible. These are not hypothetical inconveniences; they are quantifiable financial injuries suffered by real patients seeking to exercise a legal right.

Syed, Gerber, and Sharp (2013), synthesizing sixty-one studies on transportation as a healthcare barrier, found that vehicle access is the strongest predictor of healthcare utilization—and that transportation is a racially patterned barrier independent of income. Race and geography compound in ways that income alone does not capture. Schneider and Harknett (2021) add a third layer: schedule unpredictability is not an individual misfortune but a structural condition systematically imposed on hourly workers, more than half of whom receive less than two weeks' notice of their schedules. The inability to plan two appointments around a work schedule that cannot be planned is not a personal failure of organization. It is the predictable consequence of a labor market that distributes precarity unequally along racial and class lines, and then a policy that treats that precarity as invisible.

What the existing literature has not done is synthesize these strands into a unified theoretical account of how waiting periods, as a policy mechanism, translate structural inequality into differential access. The resource burdens have been documented; the racial patterning of those resources has been documented. What is missing is the connective tissue: a typology that names the specific pathways through which a time-based restriction catalyzes pre-existing structural vulnerabilities, shows how those pathways compound rather than operate independently, and locates that compounding within the broader theoretical frameworks of color-blind racism and reproductive stratification. That is the original contribution of this analysis.

Color-blind racism, as theorized by Eduardo Bonilla-Silva (2003) in *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States*, describes the ideological machinery by which racial inequality is produced and maintained through mechanisms that never explicitly mention race. It operates not through overt hostility but through what Bonilla-Silva calls abstract liberalism—the deployment of race-neutral language, individualistic framing, and procedural logic to justify outcomes that are structurally racialized. A policy need not name race to do racial work. It need only be silent about the conditions race has already produced.

The analytical purchase of this framework depends on a distinction this paper will carry forward throughout: the distinction between discriminatory intent and racially disparate institutional outcome. These are not the same thing, and conflating them has produced decades of policy analysis that mistakes the absence of animus for the absence of harm. Institutional racism, as this paper uses the concept, does not require that legislators who drafted waiting period statutes harbored racial hostility toward their constituents. It requires only that the policy's embedded assumptions—about patient resources, schedule flexibility, transportation access, and economic reserves—map onto structural conditions that are themselves racially distributed, producing outcomes that are therefore racially unequal. Intent is a question about actors. Outcome is a question about systems. This paper is concerned with the latter, and the evidence it assembles is evaluated accordingly.

Reproductive stratification theory, developed by scholars including Roberts (1997), offers the complementary lens: it describes the systematic, historically continuous regulation of reproduction along racial and class lines—the social sorting of whose fertility is encouraged, whose is penalized, and whose is simply made impossible by the quiet accumulation of procedural obstacles. Where color-blind racism explains the ideological cover under which racialized policy operates, reproductive stratification explains the population-level outcome that cover produces. Together, they reveal what the policy data confirm: waiting periods do not merely delay; they filter, sort, and gate. And the logic of that gate—who passes through and who does not—is neither accidental nor new.

This study argues that mandatory waiting periods function as racialized gatekeeping mechanisms by embedding assumptions about patient resources—economic reserves, employment flexibility, transportation access, and childcare availability—that map directly onto structural inequalities distributed along racial lines; that these burdens operate not as parallel hardships, but as cascading ones, in which each delay activates and amplifies the next. This cascading structure reproduces a documented historical pattern of reproductive stratification through procedurally neutral language, making waiting periods not an accidental barrier to marginalized communities, but a structural one.

Chapter 3

Methods

This paper employs qualitative meta-analysis as its primary methodological approach—a mode of inquiry suited to research questions that existing empirical literature has addressed in pieces but never assembled into a coherent theoretical account. Where quantitative meta-analysis aggregates numerical findings across studies to produce a pooled estimate, qualitative meta-analysis synthesizes the interpretative and descriptive findings of multiple studies to produce new conceptual knowledge. The goal is not to rerun the numbers but to read across the scholarship—to identify patterns, name mechanisms, and build a framework that no single study, bounded by its own design and scope, was positioned to construct alone.

The studies drawn upon in this analysis were selected according to three criteria. First, each study had to address, directly or substantively, at least one of the resource burdens this paper identifies as constitutive of the waiting period's gatekeeping structure: economic reserves, employment flexibility, transportation access, or childcare availability. Second, each study had to engage explicitly or implicitly with the differential distribution of those burdens across racial and class lines. Third, each study had to be methodologically credible within its own design—whether quantitative survey research, systematic review, or ecological analysis. No study was excluded on the basis of design type, as the argument this paper makes is strengthened, not weakened, by the convergence of evidence across methodological traditions.

The analytical procedure followed is a thematic coding logic. Each study was examined for the specific mechanisms it documented—not merely its conclusions, but the pathways through which restriction translated into burden and burden translated into unequal access. These mechanisms were then organized into the typology presented in the following sections. The typology did not precede the reading, but rather, it emerged from it.

The coding procedure operated in two stages. In the first stage, each study was read for mechanism—not for its conclusions about whether waiting periods are harmful, but for the specific structural conditions its findings revealed as operative. A study documenting that patients who did not return for a second appointment lived farther from the clinic was coded not as a finding about distance but as a finding about the relationship between geographic position and procedural compliance. A study documenting that workers with unpredictable schedules were twice as likely to experience material hardship was coded not as a finding about scheduling but as a finding about the structural distribution of temporal flexibility across the labor market. This mechanism-focused coding practice is what distinguishes a qualitative meta-analysis from a narrative summary: it reads studies for what they reveal about underlying structures rather than for what they conclude about surface outcomes.

In the second stage, coded mechanisms were organized by their point of activation within the procedural sequence of the waiting period. Some mechanisms are activated at the moment of scheduling—the patient cannot make an appointment because she does not know her work schedule. Some are activated at the moment of travel—the patient cannot get to the clinic because she has no vehicle and no childcare. Some are activated at the moment of institutional contact—the patient cannot safely interact with a formal healthcare institution because her presence in it carries legal risk. This sequential mapping of activation points is what produced the three-cluster structure. The clusters are not thematic categories imposed on the literature from outside. They are the structural sequence that the literature, coded at the mechanism level, revealed from within. Table 1 presents the resulting typology, including its lead pathways, compounding variables, and evidentiary bases for each cluster. The three clusters that structure the analysis—economic precarity, logistical burden, and the cascade in motion—represent the recurring architecture that the literature, taken together, reveals. A cluster, as this paper employs the term, is an analytically distinct set of structural mechanisms that share a common activation point within the procedural sequence of the waiting period and that compound with one another in ways that mechanisms across clusters do not. Clusters are not thematic groupings of related topics; they are structural sequences. Each cluster describes a set of conditions that are activated together, that intensify one another, and that produce a burden greater than the sum of their individual parts. That compounding structure is what distinguishes this typology from a list of barriers: a list treats each hardship as discrete, while a cluster demonstrates that the hardships are entangled, and that the entanglement is itself the mechanism of exclusion. The clusters did not precede the reading of the literature; they emerged from it, through the mechanism-level coding procedure described above.

Two methodological limitations warrant acknowledgment at the outset. First, the studies synthesized here were not designed to study waiting periods in isolation. Several examine clinic closures, gestational age limits, or broader restriction environments. The inferential move this paper makes—that the burdens documented under those conditions are the same burdens waiting periods impose, as waiting periods structurally require multiple clinic visits across a mandated time interval—is logical and defensible, but is an inference, not a direct measurement. Second, the racial comparative analysis in this study is constrained by the available data. Studies of Asian women navigating abortion restriction environments are especially sparse, and where they do exist, they often aggregate across a category—Asian—that conceals more than it reveals. Where the literature is thin, this paper says so, and treats that thinness as itself analytically significant.

A third methodological consideration requires direct address, as it represents the most significant epistemological challenge to a structural racism argument: the question of falsifiability. If race-neutral policy language can be characterized as racist in its effects, what evidence would count against that characterization? The answer this paper proposes is precise. The structural racism claim advanced here is falsifiable in the following sense: if the burden disparities documented across all three clusters disappeared when income and class were held constant—if race added no explanatory power beyond socioeconomic status—the structural racism framework would be weakened, and a class-based explanation would be more parsimonious. That is not what the evidence shows. Across multiple studies synthesized in this analysis, racial disparities in transportation access, scheduling precarity, and healthcare utilization persist after controlling for income. The race effect is not absorbed by class. It survives it—and that survival is the empirical signature of structural racism as analytically distinct from economic disadvantage. This pattern holds across multiple domains. In the transportation literature, Syed, Gerber, and Sharp (2013) find that African American patients face higher travel burdens than white patients after controlling for income. In the scheduling literature, Storer, Schneider, and Harknett (2020) find that the racial gap in schedule quality is explained not by human capital differences but by firm-level segregation and racial discordance between workers and managers—a mechanism that operates independently of class position. In the healthcare utilization literature, Sheldon, Ely, and Rouland (2021) find that residents of the most economically disadvantaged zip codes face disproportionate non-return rates, but that mean clinic distance—a racially patterned variable—compounds that disadvantage in ways that income alone does not predict. The convergence across these methodologically distinct bodies of evidence is not coincidental. It is the signature of a structural condition that income controls cannot fully capture.

The framework would also be weakened if the structural vulnerabilities that waiting periods activate bore no systematic relationship to race—if they were randomly distributed across racial groups. The evidence assembled here demonstrates that they are not. The argument is not circular; it is cumulative, and it is evaluated against evidence that could, in principle, have come out differently.

Cluster I	**Cluster II**	**Cluster III**
Economic Precarity	Logistical Burden	Cascade in Motion
Lost wages	No vehicle access	Documentation risk
No paid leave	No childcare	Medicaid exclusion
Schedule unpredictability	Provider distance	Institutional surveillance
⟶ *compounds into* ⟶		
Racialized Gatekeeping: Differential ability to comply by race, class, geography, and documentation status		

Table 3.1: Cascade Structure of Waiting Period Burdens by Cluster

The sections that follow work through each cluster in sequence, moving from the point of first activation in the patient's encounter with the policy to the point at which all pathways converge.

3.1 CLUSTER I: ECONOMIC PRECARITY—WHEN TIME BECOMES A TAX

The economic precarity cluster is grounded in a convergent evidentiary base drawn from three bodies of research. Schneider and Harknett (2021) and Storer, Schneider, and Harknett (2020) document the racial distribution of schedule unpredictability across the hourly service sector. Gerdts et al. (2016) quantify the out-of-pocket costs imposed on patients navigating multi-visit abortion restriction environments. And the broader labor economics literature on paid leave access establishes that the financial reserves a waiting period assumes its patients possess are distributed unequally along racial and class lines in ways income alone does not explain. What these studies share is not a common subject matter, but a common structural finding: the resources that waiting period takes for granted are the resources that race and class have been distributing unequally for generations.

The mandatory waiting period speaks the language of time. It asks patients to wait—typically twenty-four to seventy-two hours between an initial consultation and the procedure itself—and frames that wait as procedurally neutral, a pause built into the process equally available to all who pass through it. What the policy does not say, because it does not need to, is that time costs money. And money, in the United States, is not distributed equally. It is distributed along lines that race and class have been carving for generations.

The first and most direct economic burden the waiting period imposes is the cost of the visit itself—not the procedure, but the logistics surrounding it. Gerdts et al. (2016), in their study of Texas abortion patients navigating a post-HB2 restriction environment, documented these costs with precision: out-of-pocket expenses associated with accessing abortion care included lost wages from missed days of work, childcare and elder-care arrangements, transportation, and overnight stays when distance made same-day return impossible. These are not incidental costs. They are the structural tax that any multi-visit requirement levies on patients whose lives do not have slack in them—patients for whom a day away from work is not merely an inconvenience, but a missed paycheck, and in turn, a missed rent payment.

The magnitude of this burden sharpens considerably when examined through the lens of compounding hardship. Among women in the clinic-closed group in the Gerdts et al. (2016) study—women facing the greatest logistical disruption—twenty-four percent experienced three or more simultaneous hardships, compared to four percent of women whose nearest clinic remained open. This is the cascading structure made visible in data: restriction does not impose a singular cost; it activates a cluster of costs that arrive together, each one making the others harder to absorb. The waiting period operates by precisely this logic. It does not add one appointment to a patient's life; it adds one appointment on top of a material situation that, for many patients, has no room for it.

The second economic pathway operates through the labor market, and it is here where the racialized architecture of the burden becomes most legible. A waiting period requires that a patient be able to schedule, plan for, and appear at two separate clinic appointments within a defined time window. For a patient with a salaried job, flexible hours, and a supervisor who does not scrutinize her calendar, this is an administrative inconvenience. For a patient in the service sector—retail, food service, domestic work, care work—it may be structurally impossible. Schneider and Harknett (2021), in an analysis of over thirty-seven thousand hourly service sector workers, document what this impossibility looks like in practice. Fifty-four percent of all hourly workers receive less than two weeks' notice of their work schedules. More than two-thirds report lastminute changes to shift timing. Workers with the most unpredictable schedules were twice as likely to experience material hardship compared to their counterparts with stable, predictable employment. Schedule unpredictability, the study demonstrates, is not a personal misfortune or a temporary condition. It is a structural feature of the low-wage labor market—a feature that employers have deliberately engineered to transfer risk onto workers, and one that is distributed with unmistakable racial and class regularity.

The service sector is not a racially neutral employer, and the temporal precarity it generates is not distributed equally across racial lines. Storer, Schneider, and Harknett (2020), in a matched employer-employee analysis of service sector workers, document this distribution with precision: non-white workers face significantly higher exposure to precarious scheduling practices than their white counterparts, and this gap is explained not by human capital differences but by firm-level segregation and racial discordance between workers and managers. Non-white employees with supervisors of a different race or ethnicity reported a seven percent higher likelihood of canceled shifts, difficulty getting time off, and back-to-back closing and opening shifts. The inequalities are compounded for women of color, who experience the largest and most consistent gaps in schedule quality across the service sector. What this means for the waiting period analysis is precise: the assumption of schedule flexibility embedded in the policy's design is not merely a class assumption. It is a racial assumption — one that maps onto documented patterns of differential treatment within the very labor market contexts where women of color are most concentrated. The middle-to-upper-class white woman, who functions as the waiting period's implicit assumed subject, typically works in an environment where schedule flexibility is available, where paid time off exists, and where the social capital to manage a two-appointment medical process without financial catastrophe is simply part of the landscape she inhabits. For her, the waiting period is a delay. For a Black woman working a fluctuating retail schedule with a manager whose scheduling decisions are themselves shaped by racial dynamics the law does not recognize, it is a structural prohibition dressed in procedural language.

This is color-blind racism operating precisely as Bonilla-Silva (2003) theorizes it: not through animus, not through explicit exclusion, but through the deployment of race-neutral language—the waiting period asks only for time—that renders invisible the conditions it exploits. The policy need not mention race; it only needs to remain silent about the labor market, and that silence does all the work.

The racial comparative picture across this cluster is not monolithic, and flattening it would reproduce the very analytical error this paper is arguing against. Black women and Latina women share the disproportionate burden of hourly service employment, but their experiences diverge in ways that matter. Latina women, particularly recent immigrants and those with precarious documentation status, face economic precarity compounded by surveillance vulnerability—a dimension addressed fully in Cluster III—which produces a distinct and often, more severe barrier profile than economic precarity alone can account for. Indigenous women, concentrated in rural areas with both high poverty rates and geographically limited provider access, face economic precarity compounded by the distance multiplier: a waiting period that is already financially punishing becomes exponentially more so when the clinic is hours away, and transportation is neither reliable nor affordable. Asian women present the most heterogeneous picture across this cluster, and that heterogeneity itself is analytically significant. The structural experiences of a working-class Hmong woman in rural Minnesota and a middle-class Korean American woman in an urban center are not interchangeable, and treating them as such would diminish real differences in how economic precarity operates across communities that share a demographic label but not a material position. Where the data on Asian women is thin—and it frequently is—this paper treats that thinness as a finding rather than a gap, as it is evidence of who the research infrastructure was built to see, and who it was not.

What the economic precarity cluster establishes, then, is this: the waiting period assumes a patient who has money in reserve, time she controls, and an employer who will not penalize her for using it. That patient exists; however, she is more likely to be white, more likely to be salaried, and more likely to occupy a structural position that the American economy has built over centuries by extracting labor from the communities it now leaves least equipped to absorb procedural delays. The waiting period does not create that inequality; it inherits it and then uses it to deepen the disparity in lived experiences.

3.2 Cluster II: Logistical Burden—When Space Compounds Time

The logistical burden cluster draws its evidentiary base from four bodies of research: the synthesis by Syed, Gerber, and Sharp (2013) of sixty-one studies establishing vehicle access as the strongest predictor of healthcare utilization across racial lines; clinic-level data from Ely et al. (2019) and Sheldon, Ely, and Rouland (2021) on Tennessee's forty-eight-hour waiting period documenting geographic and economic barriers to procedural completion; De Londras et al. (2022), in a systematic review of thirty-four waiting period studies; and Arnold (2014)'s analysis of the structural foreclosure of the IHS pathway for Indigenous women. The shared finding across this literature is that geographic distance from a provider, absence of reliable transportation, and unavailability of affordable childcare are not randomly distributed. They are racially patterned—shaped by decades of infrastructure disinvestment and provider concentration that the waiting period's neutral language declines to acknowledge and that its two-visit requirement forces patients to navigate twice.

If Cluster I establishes that time costs money, Cluster II establishes that space costs time—and that space, like money, is not distributed equally. The waiting period's requirement of multiple clinic visits does not operate in a geographic vacuum. It operates in a country where abortion providers are concentrated in urban centers, where rural and exurban communities have watched their nearest clinics close over the past two decades, and where the question of whether a patient can physically get to a clinic—once, let alone twice—is answered before she ever makes an appointment by the neighborhood she lives in, the car she does or does not own, and the childcare she does or does not have access to. The most direct evidence of how waiting periods specifically interact with logistical burden comes from research conducted within the restricted environments this paper analyzes. Ely et al. (2019) examined the Tennessee mandatory waiting period—a forty-eight-hour requirement between counseling and procedure, necessitating two separate clinic visits—and found that rural residents were significantly more likely than urban residents to travel farther to access abortion services. While geographic location and distance traveled alone were not predictive of whether a patient returned for the second appointment, the study documents the logistical weight the requirement places on patients who must solve a complex transportation problem twice under a mandated time constraint. The study's findings on rurality are particularly important: in a state where provider geography concentrates abortion access in a small number of urban centers, the waiting period effectively requires rural patients to make two long-distance trips rather than one. The burden is not merely additive. It is multiplicative. Sheldon, Ely, and Rouland (2021) provide the most direct empirical link between waiting period requirements, geography, and economic disadvantage. Using clinic data from Tennessee's forty-eight-hour waiting period, they found that rates of non-return for the second appointment—the procedural appointment—were forty-four to ninety-one percent higher among residents of the most economically disadvantaged zip codes, including neighborhoods where at least twenty-five percent of the population lived below the federal poverty level and where median annual household income fell below thirty-five thousand dollars. Mean clinic distance was consistently greater among patients who did not return. This is the cascade in measurable form: economic precarity and geographic distance are not independent variables producing independent effects. They are compounding conditions, and the waiting period activates both simultaneously. De Londras et al. (2022), synthesizing thirty-four studies on mandatory waiting periods published between 2010 and 2021, found that the health and non-health harms of waiting periods are well established across the literature, and include delayed abortion, opportunity costs—lost wages, transportation expenses, childcare costs, and overnight stays—and disproportionate impact on the most marginalized patients. The World Health Organization (WHO), drawing on this body of evidence, has recommended against mandatory waiting periods, recognizing them as barriers to accessing sexual and reproductive healthcare. International human rights bodies have similarly called for their repeal. The consensus of the systematic evidence is not ambiguous: waiting periods do not produce neutral delays. They produce structured burdens that fall unequally. Transportation is the load-bearing beam of the logistical burden cluster. After synthesizing sixty-one studies on transportation as a barrier to healthcare access, Syed, Gerber, and Sharp (2013) found that vehicle access was the single strongest predictor of healthcare utilization across the literature—stronger than distance, stronger than insurance status, stronger than income in many study contexts. The racial patterning of vehicle access is not incidental to this finding. It is the finding. Across studies that controlled for socioeconomic status, African American patients faced higher travel burdens than white patients even after income was held constant. Native American and Alaska Native patients were nearly three times more likely than white patients to delay care due to transportation problems. In a survey of cancer patients across Texas, Hispanics reported the greatest transportation barriers, followed by African Americans, followed by whites—a gradient that maps onto the racial hierarchy of structural disadvantage the United States has maintained across its institutional life. What Syed, Gerber, and Sharp (2013) establish is that transportation is not simply a logistical problem that can be solved by resourcefulness. It is a racially patterned structural condition that precedes the patient's encounter with the policy and determines the terms on which she meets it. A waiting period imposed on top of that condition does not merely inconvenience the patient. It requires her to overcome a structural barrier twice. The second pathway within the logistical burden cluster is childcare availability, and it compounds the transportation problem in ways that are structurally predictable and racially patterned. A patient who must make two clinic visits does not simply need transportation twice. If she has children, she needs childcare twice—arranged, reliable, and affordable childcare for each visit, across a time window she may not have been able to plan for precisely because her own work schedule was not disclosed to her with precision. Gerdts et al. (2016) explicitly include childcare and elder-care arrangements in their accounting of out-of-pocket costs, naming them alongside transportation and lost wages as components of the total burden that abortion restrictions impose on patients. Their data shows these costs accumulating on top of one another, not alongside one another—which is precisely what a waiting period's multi-visit requirement produces. The racial dimension of childcare access follows the same structural logic as the transportation and economic clusters. Black women are more likely than white women to be single mothers, to work in jobs without paid leave, and to rely on informal childcare networks that are themselves subject to the same schedule instability and economic precarity that Schneider and Harknett (2021) document. When a Black single mother working a fluctuating retail schedule needs to arrange childcare for a clinic visit, she may not have been able to schedule more than a few days in advance, she is not navigating one problem. She is navigating the intersection of her employment precarity, her childcare network's availability, and her transportation access simultaneously—and the waiting period has just required her to navigate all of it twice. For Indigenous women, the cascade operates through a specific and historically grounded structural arrangement that no other group in the American reproductive healthcare landscape faces in quite the same form. Arnold (2014), in her analysis of abortion access for Native American women using Indian Health Service facilities, establishes the baseline condition: the IHS is typically the sole provider of reproductive health services for Native populations, and yet the Hyde Amendment—enacted in 1976 and renewed annually by

Congress (United States Congress 1976), it prohibits the use of federal Medicaid funds for abortion services in all but the narrowest circumstances—applies to IHS directly, meaning that the institution entrusted by treaty obligation to serve Native women's health needs is legally prohibited from providing the full scope of abortion care in most circumstances. In twenty years of IHS recordkeeping, the agency performed only twenty-five abortions nationally. For an Indigenous woman seeking abortion care, the IHS pathway is effectively foreclosed before she encounters any waiting period requirement. She must travel to a private provider, at her own expense, with no insurance coverage through her primary healthcare institution. A waiting period then requires the journey to be taken twice. Documentation risk compounds this for some Indigenous women in border communities or those with complex tribal citizenship and insurance status questions. The result is not a series of separate barriers but a structural condition in which every pathway to care has been narrowed or closed before the policy's procedural demand even arrives. Latina women, particularly those in mixed-status families or communities with elevated immigration enforcement activity, face an additional dimension within this cluster that white patients and many Black patients do not. Public transportation—the primary alternative for patients without vehicle access—requires navigating public space, interacting with institutions, and in some geographic and political contexts, encountering law enforcement. For undocumented Latina women or women in communities where immigration enforcement is active, the calculus of getting to a clinic is not only logistical. It is a risk assessment. This is the documentation dimension that Cluster III addresses in full, but it surfaces here because it compounds the transportation burden in ways that vehicle access data alone does not capture. Asian women require disaggregated analysis rather than categorical treatment. Transportation barriers operate differently across Asian communities, depending on geography, generational status, and documentation status. A first-generation immigrant woman in an urban enclave community may have access to public transit but face language barriers in navigating healthcare systems, which compound the logistical burden in ways that vehicle access data does not measure. A Southeast Asian woman in a rural agricultural community may face transportation barriers nearly indistinguishable from those facing Indigenous women in similar geographic contexts. The category is too wide to hold a single finding, and this analysis treats it accordingly. The logistical burden cluster establishes that the waiting period's geographic and temporal requirements do not lie on a flat surface. They land on a terrain already shaped by decades of racially unequal infrastructure investment, provider distribution, and childcare policy—a terrain on which the distance between a patient and the care she needs is already longer for some women than for others, and the waiting period extends it further. Sheldon, Ely, and Rouland (2021) put it plainly: residents of the most economically disadvantaged zip codes are rendered less able to return for the abortion procedure than residents of less disadvantaged neighborhoods. The waiting period did not create that disparity. It revealed it and then used it.

3.3 Cluster III: The Cascade in Motion—Documentation, Compounding, and the Architecture of Exclusion

The first two clusters of this typology have established, pathway by pathway, that mandatory waiting periods embed assumptions about patient resources that are unequally distributed along racial lines. Cluster I showed that the economic burden of multiple clinic visits falls most heavily on patients in the hourly service sector, where schedule unpredictability is a structural condition and paid leave is a privilege distributed by race and class. Cluster II showed that the logistical burden of getting to a clinic—twice, across a mandated time interval—is shaped by vehicle access, childcare availability, and provider geography, all of which are racially patterned in ways the policy's neutral language does not acknowledge. Cluster III does something different. It does not introduce a new pathway so much as it demonstrates what happens when all the pathways converge—and it introduces the dimension that makes the cascade most dangerous for the most vulnerable patients: documentation status and the surveillance risk it attaches to every interaction with a formal institution.

The documentation cluster is the thinnest in direct empirical measurement and the most severe in structural consequences—a combination that is itself analytically significant. Its evidentiary base draws on Gerdts et al. (2016) for the exclusion of undocumented patients from Medicaid coverage and the resulting cost burden; on Prather et al. (2018) for the historical and contemporary documentation of medical institutions as sites of surveillance and harm for communities of color; and on Schneider and Harknett (2021) for the labor market position of undocumented workers as one of near-total employer discretion and zero legal recourse. Where direct empirical measurement of documentation-specific abortion access barriers is absent—and it frequently is—

this paper treats that absence as a finding about the research infrastructure rather than as evidence of the absence of harm.

Documentation status is not a resource burden in the same sense as economic reserves or transportation access. It is a vulnerability multiplier. For undocumented patients, or patients in mixed-status families, or patients in communities where immigration enforcement is active, every institutional interaction carries a risk calculus that documented patients do not face. A clinic visit requires providing information—name, address, contact information—to an institution whose data practices the patient may have no reason to trust and no ability to verify. A waiting period requires two such interactions, across a mandated time interval, during which the patient's information is held by an institution she has had to trust without evidence. For Latina women in particular, and for undocumented women of any background, this is not a paranoid calculation. It is a rational response to an enforcement environment in which medical institutions have been weaponized, in which personal information has been used against patients, and in which the history Prather et al. (2018) trace—the history of medical institutions as sites of surveillance and harm for communities of color—is not abstract but lived. The documentation dimension compounds each of the burdens documented in the previous clusters in specific and traceable ways. Economic precarity is compounded because undocumented patients are typically excluded from Medicaid coverage under federal law (United States Congress 1996), meaning that the out-of-pocket cost of abortion care is borne entirely without the insurance backstop that documented low-income patients may access. Employment flexibility is compounded because undocumented workers are disproportionately concentrated in informal or cash-economy employment, where schedule negotiation is entirely at the employer's discretion and where taking time off for a medical appointment carries the risk of job loss without legal recourse. Transportation is compounded because, as established in Cluster II, moving through public space to reach a clinic is not a neutral logistical act for patients whose presence in that space is itself legally precarious. Childcare is compounded because informal childcare networks in undocumented communities may themselves be disrupted by enforcement activity, and because the social ties that buffer economic and logistical precarity are themselves under surveillance pressure. The waiting period does not create any of these vulnerabilities. It activates all of them simultaneously, in a patient population that is already navigating a structural position the policy was never designed to account for—because the policy was never designed to serve her. This is the cascade in motion. It is worth rendering it concretely, because abstraction has a way of softening what is, in practice, a lived experience of compounding impossibility. Consider a patient who is an undocumented Latina woman, working in an informal domestic employment arrangement, living in a community with active immigration enforcement, without a vehicle, with a child at home, and without the economic reserves to absorb unexpected costs. She receives no schedule notice because her employment is informal. She has no paid leave because her employment is informal. She has no vehicle. She depends on public transit or on rides from community members, each of whom is navigating the same enforcement environment she is. Her childcare network is informal and subject to disruption. Her access to insurance-covered abortion care is legally foreclosed. And the waiting period requires her to navigate all of this twice—once for the consultation and once for the procedure— within a mandated time interval during which she must hold her plans, her childcare, her transportation, her employment, and her documentation in suspension simultaneously. For this patient, the waiting period is not a pause. It is a wall. And the wall is not visible in the policy's language, because it says nothing about documentation, nothing about informal employment, nothing about public transit deserts, nothing about childcare. It says only: wait. The neutrality of that instruction is the mechanism. Color-blind racism, as Bonilla-Silva (2003) theorizes it, does not require malice. It requires only that the policy speak the language of universal proceduralism while remaining silent about the conditions that determine who can comply with it. Reproductive stratification theory, as developed by Roberts (1997) and elaborated through the reproductive justice framework that Ross and Solinger (2017) systematize, provides the historical frame within which this cascade must be understood. The sorting of whose reproduction is facilitated and whose is obstructed is not a contemporary phenomenon produced by a particular political moment. It is a continuous structural condition that has expressed itself through different institutional mechanisms across American history—through forced reproduction under slavery, through coerced sterilization under the eugenics programs of the twentieth century, through the Hyde Amendment's targeted defunding of abortion care for Medicaid recipients, and now through the procedural architecture of the waiting period. What changes across these moments is the language. What does not change is who bears the cost. The cascade typology this paper has constructed—economic precarity compounding into employment inflexibility, transportation scarcity compounding into childcare impossibility, documentation vulnerability compounding into institutional risk across every pathway—is not a description of exceptional circumstances. It is a description of the ordinary structural position of patients, for whom waiting periods serve as gatekeeping mechanisms. The middle-to-upper-class white woman navigates none of these clusters in their compounding form. She may face the waiting period as an inconvenience, a delay, an imposition on her time. She does not face it as a cascade. The patients who do face it as a cascade are the patients whose structural position—shaped by race, class, immigration status, geography, and labor market location—the policy's neutral language was designed, whether deliberately or through the operation of color-blind ideology, to ignore. This is what it means to say that mandatory waiting periods function as racialized gatekeeping mechanisms. It does not mean that the policy was written with racial animus. It means that the policy embeds assumptions about patient resources that map onto structural inequalities distributed along racial lines, and that those inequalities are not accidental features of the American landscape but the accumulated product of a documented history of reproductive stratification. The gate is not locked for everyone. It is locked for the patients who were never given a key, and the waiting period, in its procedural neutrality, simply declines to notice.

Population	**Primary Cluster Activation**	**Key Compounding Factor**	**Distinctive Barrier Profile**
Middle-class White women (baseline)	None in compounding form	Schedule flexibility, vehicle access, and paid leave available	Waiting period experienced as delay, not cascade
Black women	Cluster I + Cluster II	Disproportionate concentration in hourly service sector; single-parent household rates; informal childcare reliance	Economic and logistical burdens compound; no documentation risk layer
Latina women (documented)	Cluster I + Cluster II	Language barriers in healthcare navigation; higher rates of informal employment	Similar to Black women profile with added healthcare navigation burden
Latina women (undocumented)	All three clusters	Documentation vulnerability activates surveillance risk at every institutional contact point	Full cascade; most severe barrier profile in typology
Indigenous women	Cluster II + structural funding exclusion	IHS as sole provider; Hyde Amendment applies to IHS directly; reservation geography	Geographic compounding is primary; funding exclusion forecloses IHS pathway before waiting period arrives
Asian women (disaggregated)	Varies by subgroup	Internal heterogeneity: geography, generation, documentation, and language barriers differ substantially across communities	No single profile applicable; analytical category too broad; data thinness is itself a finding

Note. Barrier profiles reflect structural position, not individual circumstance. The baseline comparison is not a normative standard but an analytical anchor representing the patient the policy's design implicitly assumes. Sources: Bonilla-Silva (2003); Syed, Gerber, and Sharp (2013); Arnold (2014); Prather et al. (2018); Roberts (1997).

Table 3.2: Racial Differentiation of Cascade Burden by Population Group

CHAPTER 4

CONCLUSION

This paper set out to answer a question the existing literature had documented but not fully explained: not whether mandatory waiting periods harm Black patients and other patients of color disproportionately—that much the data established—but how, specifically, the policy accomplishes this. Through which architecture? Along what fault lines? By activating the structural vulnerabilities that were present before the law ever took effect?

The analysis has produced a three-cluster typology of cascading burden. Economic precarity establishes that the waiting period's temporal demand collides most severely with patients in the hourly service sector, where schedule unpredictability is a structural condition, paid leave is a class and racial privilege, and the assumption of financial slack embedded in any multi-visit requirement is precisely inverted by the material realities of low-wage employment. Logistical burden establishes that the geographic and caregiving demands of two clinic visits compound the economic burden in ways that are racially patterned through vehicle access, provider distance, and childcare availability—conditions shaped by decades of infrastructure disinvestment that the policy's neutral language declines to acknowledge. The cascade in motion describes what happens when those conditions converge and are amplified by documentation vulnerability: a structural position in which every pathway to care carries institutional risk, and the waiting period's procedural demands require that risk to be navigated twice.

What connects these clusters is not their subject matter but their logic. Each demonstrates that the waiting period embeds assumptions about patient resources that map directly onto structural inequalities distributed along racial lines. Each demonstrates that those inequalities are the accumulated product of a documented history—of slavery's reproductive exploitation, of twentieth-century sterilization policy, of the Hyde Amendment's targeted defunding of reproductive care for Medicaid recipients. And each demonstrates, through evidence that persists after controlling for income, that the burden is racial as well as economic: race adds explanatory power that class alone does not exhaust. That remainder—the racial gap that income controls cannot close—is the empirical signature of structural racism as this paper defines it, and it is the evidentiary standard against which the argument should be evaluated. The theoretical contribution of this typology is to provide the connective tissue that existing scholarship had assembled in pieces but not synthesized. Color-blind racism explains the ideological mechanism: race-neutral language that remains silent about the conditions race has already produced. Reproductive stratification theory explains historical continuity: the persistent social sorting of whose reproduction is facilitated and whose is obstructed, expressed through different institutional mechanisms across every era. Together, they reveal that the waiting period is not an anomaly in American reproductive policy. It is a contemporary iteration of a very old architecture, operating through new language toward similar ends.

The persistence of the pro-life movement's political salience—its continued capacity to enact and defend procedural restrictions despite a documented record of racialized harm—is explicable through the same theoretical apparatus this paper has deployed.

Abstract liberalism, as Bonilla-Silva (2003) theorizes it, does not merely protect policy from racial scrutiny; it protects movements. When the pro-life movement deploys the language of "informed consent," "deliberation," and "protecting life," it occupies ideological terrain that is nearly impossible to contest without appearing to oppose the liberal democratic values—autonomy, deliberation, protection from coercion—that anchor the American political tradition. The movement need not claim racial neutrality; it claims moral universalism. And moral universalism, in Bonilla-Silva (2003)'s framework, is the most politically durable form of color-blind ideology precisely because it forecloses the racial critique before it can be fully articulated.

The specific attachment to procedural restrictions—rather than outright prohibition—is not incidental. Waiting periods survive rational basis review precisely because they can be articulated in the language of informed consent rather than restriction—a framing the Supreme Court endorsed in *Gonzales v. Carhart (2007)*, where the majority opinion deployed the deliberative pause logic to uphold an abortion restriction on grounds of women's emotional wellbeing. They are politically defensible at the legislative level: a representative who votes for a waiting period need not defend a ban; she need only defend a pause. And they align with widely shared liberal democratic norms about deliberation and choice, which allows them to recruit support across constituencies that would reject more overtly restrictive legislation. The "marriage" to procedural burdens is, in this reading, a rational political strategy—one that produces maximum structural harm at minimal political cost, because its costs are borne by the communities whose experiences the policy's neutral language was designed to render invisible.

The Latinx community presents the most analytically significant case of this dynamic. The documented over-representation of Latina women—particularly undocumented and working-class Latina women—among those who face the full cascade exists alongside a genuine and substantial strand of social conservatism within Latino communities, rooted in Catholic religious tradition and patterns of political socialization that cross-cut material interest. Survey data document this cross-pressure concretely: Latino Catholics express significantly more restrictive views on abortion access than Latino adults without religious affiliation, a gap the pro-life movement has mobilized with deliberate effectiveness in electoral contexts (Krogstad, Edwards, and Lopez 2022).

This cross-pressure is not incidental to the movement's coalition structure. It is the mechanism by which color-blind ideology operates not merely as analytical blindness but as active political recruitment—the simultaneous erasure of racialized harm and the harnessing of constituencies of color to defend the policies that harm them. The salience of the pro-life movement is not sustained in spite of its racial consequences. It is sustained, in part, by the ideological architecture that makes those consequences invisible—the same architecture that makes the movement's appeal legible across racial lines, and the same architecture this paper has named.

The evidentiary argument this paper has made is complete. What remains is what it means—not only for understanding mandatory waiting periods specifically, but for the broader project of identifying how procedurally neutral policy does racialized work. The typology's contribution extends beyond its own empirical boundaries. That claim requires honest accounting of what this analysis can and cannot establish, and this paper has been transparent about its inferential limits throughout.

The studies synthesized here were not designed to study waiting periods in isolation, and the claim that burdens documented under broader restriction environments are the same burdens waiting periods impose is logical and defensible, but it is an inference rather than a direct measurement. Future research should address this gap by using study designs that isolate waiting-period effects from concurrent restrictions—tracking patient populations before and after waiting-period implementation in states where other restriction variables remain stable. The racial comparative analysis is also constrained by available data; the literature on Asian women navigating abortion restriction environments remains too sparse and too aggregated to support population-level claims, and the literature on undocumented patients is thinner still. Both gaps concern the research infrastructure rather than the populations themselves, and both represent urgent priorities for future scholarship. The gate is not locked for everyone. It never has been. What this paper has done is name the mechanism by which it stays locked—trace the architecture through which a procedurally neutral policy does structural work, and locate that architecture within a history long enough and a literature deep enough to establish that what looks like procedure is, in practice, a system. The waiting period tells patients one thing: 'wait.' What this analysis demonstrates is that for the patients who face it as a cascade rather than a delay, that instruction does not describe a pause. It describes a wall—built from the accumulated material of American structural inequality, dressed in the language of procedural neutrality, and maintained by an ideology that does not merely fail to see those people, but that recruits others to defend their exclusion.

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