RACIAL DISPARITIES IN INFANT AND MATERNAL CARE IN THE UNITED STATES: A HISTORY OF EXCLUSION AND MISTREATMENT

By

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A THESIS

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Black women and their children are subject to disparate maternal and birth outcomes in the United States due to barriers preventing access to quality and equitable prenatal and postnatal maternal and infant care. The history of maternal care in the United States is rooted in the mistreatment, abuse, and exclusion, of Black mothers and Black health care workers from medical progress. This thesis examines the history of public health initiatives addressing high infant and maternal mortality rates, the removal of lay African American midwifery, the history of the Eugenics movement, and the ramifications of these events, and their segregationist frameworks, on the racial disparities that continue to exist in prenatal and postnatal maternal and infant care today for Black mothers and their children. This thesis is a literature review that evaluates the origin of the following persisting barriers to equitable maternal care for Black women: distrust between Black women and their doctors, implicit biases held by doctors, lack of Black representation in the medical field, proximity to quality care, and monetary barriers restricting access to care.

In conclusion this thesis evaluates current existing models of holistic care created by Black women for Black women, and additionally includes a reflection on the importance of allyship, specifically what it means to be an ally and to use ones privilege to elevate and listen to the voices of the oppressed in order to advocate and support the reproductive and birth justice frameworks to work towards improving birth and maternal outcomes for Black women and their families.

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A Note About the Language

Throughout my thesis I strive to use both inclusive and accurate language. When I refer to women and mothers, I am including all pregnant individuals. I recognize that not all people who are pregnant individuals identify as either women or mothers. For the purpose of the language used in my thesis, I am choosing to use the term “mothers” and “women” throughout each component following the language used in the resources that I used and analyzed. Additionally, in order to be as inclusive as possible, I will be using the term “Black” instead of “African American” throughout my thesis since not all persons who identify as Black in the United States are of African descent. The only exception for this will be when referring to Lay African American midwives.

Initial Literature Review: A History of the Mistreatment and Reproductive Abuse suffered by Black Women

The Long-Lasting Impacts of America's Racist History

The maternal care crisis in the United States is not of contemporary origins, yet remains the product of a culmination of atrocities that have been plagued against Black Women, their children, and families for centuries. Black scholars have put forth much effort to document and bring to light this history of medical abuse suffered by Black Americans at the hands of White physicians and politicians that has been further perpetuated by legislation and public policies since the 18th century (Washington, 2006, p. 7). In Harriet A. Washington's *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*, she articulates the idea of "Black iatrophobia", or the fear of White doctors by the Black community as a result of a history of mistreatment and exploitation (Washington, 2006). This distrust that has prevailed today constitutes the aftermath of years of horrific nonconsensual experimentations performed on Black bodies. From the forced experimental surgical operations on slaves, to the well-known Tuskegee Syphilis Study, to the popularized practice of negative eugenics in the twentieth century, a racialized social order constructed on the basis of White supremacy allowed for the continued mistreatment and exclusion of Black people from receiving quality and equal health care in the United States.

In the interest of the direction of my thesis project, I will delve briefly into the well-researched history of the reproductive injustices imposed on Black women in the

United States with the intention of providing for a deeper understanding for the foundation of the institutionalized racism that exists in the maternal care system and contributes to the disparities between Black and White mothers today. Through my research, I focused mainly on the history of the maternal and infant care in the vernacular South, and Virginia specifically, in the interest of narrowing my scope and understanding and situating the maternal care crisis occurring in Virginia today, as I was inspired to write this thesis based on the disparities in birth outcomes experienced by Black mothers and their Children in my hometown, the City of Norfolk, VA. The disparities in maternal and infant mortality between Black and White mothers have long been acknowledged as public health crises. However, historical interventions introduced by White male physicians and politicians rarely took into account contributing socioeconomic issues, such as class status or the impacts of racism, and inherently served to neither diminish nor curb the racial disparities in maternal and birthing outcomes (Fraser, 1998; Washington, 2006; Ross & Solinger, 2017; Smith, 1995; Roberts, 1997).

Enslaved Women and Mothers

Dána-Ain Davis, Professor of Urban Studies and Anthropology, writes in her book *Reproductive injustice: Racism, pregnancy, and premature birth,* that there has "never been a time when Black women's reproduction was treated respectfully in the United States," given the ideologies and racist practices that have continued to "permeate" Black women's reproductive lives from the antebellum period into present day (Davis, 2019, p. 169). In the early 19th century, American gynecology arose from White male physicians exerting control on enslaved Black women's reproductive bodies

through experimentation and medical practices that enslaved women were unable to resist (Owens, 2020). Dr. J. Marion Sims of Montgomery, Alabama, known as the father of gynecology, repeatedly experimented on 11 enslaved women's genitalia to identify a surgical fix for vesico-vaginal fistulas (tears between the vagina and bladder), without anesthesia, for a period of four years (Washington, 2006, p. 64). This painful birthing complication disproportionality afflicted enslaved women, but remained a condition that impacted all women who survived difficult childbirths (Washington, 2006, p. 57). Sims capitalized on the opportunity to pioneer a surgical cure to the ailment through non-consensual and painful experimental surgeries on the 11 enslaved women by utilizing the social power he held as a White male physician over them (Fraser, 1998, p.101). Sims was not the only White male physician of his time completing pioneer gynecological experiments on enslaved Black women. Dr. Francois Marie Prevost used enslaved Black women to perfect cesarean sections while Dr. Ephraim McDowell performed the first ovariotomy (removal of an ovary) on an enslaved woman (Washington, 2006, p. 70). As analyzed by Harriet Washington, "forced experimentation was the standard of care [for Black women] (Washington, 2006, p. 70)". Once perfected on enslaved women, these surgical techniques could be used on White patients (Fraser, 1998, p. 100).

Dr. Sims was known to allude to the popular belief that Black people did not feel pain in the same way as White people, and refused to administer anesthetics to the enslaved women during surgical repair on their vaginas even though the anesthetic abilities of inhaled ether were well articulated at the time (Washington, 2006, p. 65). Other physicians recruited by Sims abandoned the project early on as they could not

bear the horror of the tortures forced upon the enslaved women through Sims' unpromising process of surgical trial and error (Washington, 2006, p. 65). As concluded in a meta-analysis of several studies conducted by Janice A. Sabin, PhD of the Association of American Medical Colleges (AAMC), this disturbing belief has been found to prevail into the 21st century, with "40% of first- and second-year medical students endors(ing) the belief that 'Black people's skin is thicker than White people's'," feeding a bias that continues to prevent adequate treatment of minoritized people's pain (Sabin, 2020). Washington refers to the belief promoted by scientific racists that "Blacks did not feel pain" as a "necessary medical fiction" that served to make "Blacks attractive as experimental subjects (Washington, 2006, p. 58)."

Experimentation was not limited to enslaved women; early medical records regularly identified all Black people as experimental subjects, especially in the slaveholding states (Washington, 2006, p. 57). Washington notes that through "physicians' recollections, medical journals, and institutional records" that a "a pattern of abusing African Americans" is more than evident and that it "was supported by custom and sometimes law", since Black people were "without legal protection and thus unable to hamper physicians' activities (Washington, 2006, p. 57)." For the purpose of the scope of my thesis, I will only focus specifically on the history of abuses suffered by Black women. Black Scholars such as Harriet Washington, Dorothy Roberts, Gertrude Jacinta Fraser, Darlene Clark Hine, Cooper Owens and Loretta J. Ross, have uncovered, researched, and documented a wealth of scholarship on the intricacies of a medical history of the mistreatment and abuse suffered by Black people that had been swept under the rug. Histories that have been replaced with memorials for White physicians,

symbolizing an untarnished remembrance for their great contributions to the developing medical field despite their paralleled contribution to the health disparities suffered by Black people today. Across all medical practices, Black Americans are subject to inequality in terms of the medical treatment and care that they receive (Williams et al., 2009, Taylor, 2019). Health care disparities, as defined by the Institute of Medicine, are disparities that are seen as "differences above and beyond those that can be explained by differences in health status between groups (Bryant et al., 2010)." Without acknowledgement these medical practices that disproportionately affect Black Americans will persist without improvement. The work that these Black female scholars, and other scholars in similar fields have completed, has resurfaced the dark histories that have systemically shaped the distrusting relationships that remain between Black Americans and their medical practitioners, reframing a White washed narrative of the United States medical system in hopes for acknowledgement, improvement, and change.

When Harriet Washington began her journey of writing and researching for her critically acclaimed book, *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*, she was deterred by a U.S. medical school professor who stated that Washington's book idea would only serve to "make African Americans afraid of medical research and physicians", additionally emphasizing that she "cannot write this book (Washington, 2006, p. 22)!" It seems odd that a medical school professor would vouch to continue to silence a history that has already been silenced and removed from the county's history books, and dually disturbing that she would wish for the truth of medical

experimentation on Black people to remain tucked within the archived journal notes of a racist nineteenth century medical professional. Social problems as great as the disparities and injustices inflicted by the institutionalized racism in the United States healthcare system cannot be solved or even addressed without knowing of and recognizing their origin. Washington's research, for the first time, brought to the academic forefront a comprehensive understanding of the origin of the glaring health deficits that are suffered by Black people today.

In Washington's chapter titled *Profitable wonders,* Washington concludes that the knowledge of the cruel and inhumane nature of Sims' and his contemporaries' experiments "fed an aversion to the health system" amongst Black people at the time, while additionally "strengthening a perception of (Black people) as appropriate human fodder for research (Washington, 2006, p. 73)." As these dark histories of medical experimentation have been unearthed, physicians such as Sims, once revered physicians of their time have been righteously stripped of their present day memorialization in efforts to acknowledge and combat their *legacies* that largely contributed to the institutionalized racism that exists in the United States medical system today. In 2006, University of Alabama Birmingham's Center for Advanced medical studies removed a painting of Sims from their wall of "Medical Giants of Alabama", on account of medical and racial ethics (A 19th century doctor, 2006). In the same vein, in 2018, New York City Mayor, Bill De Blasio, ordered for the removal of a statue of J. Marion Sims from Central Park in response to a series of protests citing Sim's work as part of the United State's long history of medical racism (Lockhart, 2018).

While these performative acts symbolize a changing tide towards medical and health equity, they cannot reverse the impacts that physicians such as Sims have had on physician's relationships with Black mothers, and the lives of Black mothers and children that have been lost due to lack of cultural humility held by White physicians, and the survival of racist stereotypes that were promulgated by Sims and those like him (such as the belief that Black people can not feel pain). As resounded from Washington's groundbreaking work, other literature emphasizes that since "gynecology advanced from American Slavery means that Black people have always had a precarious relationship to the field and its practitioners (Owens & Fett, 2019)." This origin of distrust is critical to understanding current flaws, and areas for improvement in the modern field of maternal and infant health care. Further along, I will discuss the implications of this distrust today, however for now I want to emphasize a strong comprehension of the history that has shaped the contemporary maternity care system. It is easy for present-day prominent figures and their following to dismiss the existence of systemic racism today, such as Texas Senator Ted Cruz, citing systemic racism as a "tool used by democrats to smear law enforcement officials," or former President Trump simply stating "I don't believe that," when asked about his stance on the impacts of systemic racism in the U.S. Hence, I am putting forth an effort to promote the argument that its existence in United State's institutions is undeniable, wielding detrimental effects on people of color in all aspects of life, and remains chiefly responsible for disproportionate rates of poor birth outcomes faced by Black mothers today.

The Cornerstone of Black Maternal And Infant Health Care: The Memory of Lay African American Midwives

Throughout most of the twentieth century, lay African American midwives were the pillars of reproductive health care in poor southern Black communities, attending to 80 percent of Black births and 30 percent of White births (Follet, 2019). These midwives provided their services to both Black women and White women from the times of slavery straight through the Civil Rights era (Nichols, 2016). Lay African American midwives, with their wealth of knowledge of women's reproductive health, were indispensible to slave owners, as more healthy babies meant more slaves (The granny midwives who birthed untold numbers of babies in the rural South, 2017). These midwives would regulate birth timing in order to benefit the health of the mother and not the slave owner, and were highly respected and valued in their communities (The granny midwives who birthed untold numbers of babies in the rural South, 2017). As stated by historian Molly Ladd-Taylor, "in northern primarily White urban communities, women and children's health was attributed to economic conditions, however in the South, 'the large number of negro maternal deaths' was instead blamed on 'the fact that negroes were attended by negro midwives (Ladd-Taylor, 1988, p. 258 as cited in Fraser, 1998, p. 34).'" African American midwives held little economic or political power and remained an easy target, in comparison to physicians, to blame for the South's higher infant and maternal mortality rates. 20th century researchers identified "conditions connected with childbirth," as "housing, economic status, birth attendants, parental attitudes, cultural beliefs, and other explicitly nonmedical variables that potentially affected the outcome of pregnancies (Fraser, 1998, p. 130)."

However, by scapegoating midwives, public health officials could avoid challenging the medical establishment or altering the economic and or living conditions of the South's rural population, hence avoiding these prescribed socioeconomic influences on the health of poor mothers and their children (Smith, 1995, p. 124).

The Removal of Lay African American Midwifery in the South

20th Century Southern Public Health Efforts to Address Infant and Maternal Mortality

The rural South was plagued by the customs and policies of segregation from as early as the 19thcentury. In light of the Civil War, racial politics stunted the development of public health in the South as a hierarchal White supremacist ideology acted to suppress any public welfare programs that had the potential to benefit Black people (Smith, 1995, p. 4). In the 20thcentury, the denial of health services to Black people in the South contributed to the vicious cycle of an increase in health needs for Black people as the poverty and discrimination limiting opportunities for health services remained unalleviated (Smith, 1995, p. 4). As stated by Historian Edward Beardsley, early southern public health "Failed (its) Black patrons by a wider margin than any other group (Fraser, 1998, p. 32)." The written history on health reform for Black women is riddled with gaps, as underscored by Susan L. Smith, in her book *Sick and tired of being sick and tired: Black women's health activism in America, 1890-1950.* Smith attributes the gaps to much of the existing 20th century public health history having focusing on expanding cities while excluding rural areas, where the majority of Black people lived through World War II (Smith, 1995, p. 3). The title of Smith's book is itself a tribute to civil rights activist and leader, Frannie Lou Hamer, who spoke the famous words "we are sick and tired of being sick and tired" at a civil rights rally to garner the public's attention to the pain inflicted by poverty and violence on Black people in the Jim Crow South (Hamer, 1964).

The rural areas where the majority of Black people were living in the early 20th century were characterized by inadequate living situations that were detrimental to their health. With the lack of access to modern amenities, Black communities faced a range of health problems, including malaria, venereal disease, malnutrition, and high infant and maternal mortality rates (Smith, 88). In parallel, within the first decade of the 20thcentury, Black people living in the segregated urban city of Atlanta faced similar inadequacies in their neighborhoods contributing to Black mortality rates that were 70 percent higher than White mortality rates, especially for infant mortality and tuberculosis (Smith, 1995, p. 29). The discriminatory practices of segregation in the Jim Crow era South affected the health of Black people and the mortality of Black infants despite residency in rural or urban areas. Public Health emerged in the South as a concept in the 20th century, as poor maternal and infant health began to capture the attention of state medical societies and local health officers (Fraser, 1998, p. 32).

Sheppard-Towner Act

At a national level, the Sheppard-Towner Act of 1921 was the first federally funded social welfare program in the United States, and was inspired on the account of the need to standardize care for children and to bring infant and maternal mortality rates in the United States into line with other industrialized countries (Ross and Solinger, 2017, p. 36). Sponsored by the federal U.S. Children's Bureau, the Sheppard-Towner funds were expected to go towards reducing infant and maternal mortality rates and improving morbidity statistics (Fraser, 1998, p. 34). Prior to the passing of the act, the U.S. Children's Bureau had conducted several studies indicating that infants born in areas affected by poverty had a higher mortality rate and simultaneously experienced a

lack of access to nurses and hospitals (Madgett, 2017). These findings constituted the early efforts that gave way to the eventual passage of the National Maternity and Infancy Protection Act (also known as the Sheppard-Towner Act). This act was unprecedented in that it specifically targeted the rural poor (majority Black people) for education about pre and post-natal care, family health, hygiene and family planning (Fraser, 1998, p. 33). Historically referred to as "Granny Midwives" by White health officials (a controversial term today), these women were responsible for birthing the majority of rural Black babies following the emancipation of slaves in 1863 (Smith, 1995, p. 119). Because of this, midwives became the main recipients of the core instructional programs funded by the Sheppard-Towner Act (Fraser, 1998, p. 33). The passage of this act led to the establishment of 3,000 prenatal clinics, 180,000 Infant care seminars and over three million home visits by traveling nurses (Madgett, 2017). While the Sheppard-Towner Act and local funds were used to create a local health department in every county in the state, it remains unclear how these departments served their Black people and poor patients (Fraser, 1998, p. 36).

In order to appease the American Gynecological Society and the American Medical Association, who feared that the Sheppard-Towner act would lead to socialized medicine, funds were made out to be solely dedicated to educational and preventative health programs, with no provision of medical care (Madgett, 2017). Infant mortality did decrease during the years that the act was in effect, however due to opposition from the American Medical Association and several conservative senators, the act failed to be renewed and was dismantled completely in the year of 1929 (Madgett, 2017). While some states continued the programs that had been established under the act, with the

lack of federal funding and the onset of the Great Depression in the 1930s, most infant and maternity welfare programs ultimately met their end (Madgett, 2017).

Elizabeth County Case Study

In Virginia, birth registration campaigns were utilized to remove midwives from the birthing scene completely, leaving Black women and poor women with a significantly reduced access to reliable assistance during childbirth (Fraser, 1998, p. 55). W.A. Plecker, a public health officer who was "concerned" about the high mortality rate among poor mothers, established a pilot midwifery supervision and vital statistics program in Elizabeth City County (today Hampton) Virginia between the years 1900-1912 (Fraser, 1998, p. 61-63). This program served the interest of keeping track of midwives and comparing their work to that of doctors' in addition to developing a standardized means of keeping track of birth and infant mortality rates in order to discover methods for improving birthing practices and addressing the high rates of infant and maternal mortality (Fraser, 1998, p. 61-63). The midwifery supervision programs implemented in the Elizabeth City Case Study failed to address the unequal access to health care that Black women and their children were facing, and instead served to control and work towards the elimination of the lay African American midwife, the *perceived* cause of the mortality crisis (Fraser, 1998, pg. 69).

By focusing on the birth event itself, and implementing public health rules such as the requirement "to practice cleanliness", and forbidding the midwives to "make vaginal examinations," to prevent risk of puerperal infection, the underlying social and economical issues of poverty and lack of access to prenatal care were left overlooked and unaddressed (Fraser, 1998, pg. 69). The Elizabeth County Case Study introduced

the formal requirement for birth and death certificate completion (vital statistics), which eventually became adopted statewide at the end of the program through the vital statistics law (Fraser, 1998, pg. 63). At the end of the case study, The Bureau of Vital Statistics was officially instituted under the State Board of Health, creating a scientific bureaucracy for managing reproduction, with Plecker nominated to lead the Bureau under the title "State Registrar (Fraser, 1998, pg. 66)." Within the same decade, legislation was implemented requiring that all midwives were to obtain their license from the Bureau of Vital Statistics in order to legally practice (Craven, 2010, p. 63). In order to obtain licensure midwives were required to participate in educational programs, follow standards of dress, ensure that they were referring clients to physicians for screening, refrain from conducting internal exams, and comply with reporting procedures (birth and death certificates) (Follet, 2019). "Granny" midwives who were unable or unwilling to comply with state implemented guidelines and requirements for licensure were quickly forced out of practice (The granny midwives who birthed untold numbers of babies in the rural South, 2017). The Virginia Board of Health allocated the power to public health officials to request for a midwife's permit to be revoked if they saw her as "unfit" to practice (Fraser, 1998, p. 68). Older, often illiterate midwives were forced to retire due to their inability to comply with written evaluations required for state-mandated midwifery permits, as midwives' reputations in general became eroded within their communities by association of their continued practice occurring outside of legal behavior (Craven, 2010, p. 65).

Twenty-five years after the beginning of the Elizabeth City County case study, Plecker released his "comparative work" between the births assisted by physicians and

those assisted by midwives, and chose to omit the full results of the study (Fraser, 1998, p. 63). While Plecker and other health officials blamed midwives' *uncleanliness* for high infant and maternal mortality rates in the South, evidence found in contemporary studies proves that maternal mortality rates were in reality lower where the percentages of midwives were higher **(**Smith, 2010, p. 124). Plecker chose to also discredit his work displaying that through enforcing the rule that midwives were not to enter the birth canal, maternal and infant deaths in Black communities had declined from seventy-six in 1922 to fifty-five in 1924, while White physicians, who were still permitted to make vaginal examinations of their White patients, experienced trends of mortality rates attributed to puerperal infections at the same rates with no improvement (Fraser, 1998, pg. 71). Puerperal infection is caused by bacterial infection of the genital tract, and has historically been one of the leading causes of maternal mortality and morbidity in the United States, and though trends in puerperal genital tract infection have decreased since the 20th century, puerperal infection still accounts for 11% of pregnancy related deaths in the United States today (Karsnitz, 2013).

Plecker's findings displayed that African American midwifes were not the dirty, untrainable, disease-bearers that White physician's deemed them to be, yet Plecker reflected on these statistics by stating "Those not familiar with the habits of these untrained and dirty midwives may not appreciate the importance of this requirement (forbidding vaginal examinations) and of the difficulty if not impossibility of teaching them the practice of aseptic methods (Fraser, 1998, p. 71)." Although Black women in Virginia were dying at a higher rate from 1900 to 1940, they were dying at a lower rate from puerperal infections in comparison to White women in both rural and urban areas

(Fraser, 1998, p. 83). Plecker's attitude and rhetoric towards African American midwives can be attributed to his racial bias against Black female identifying health care providers based on his racist assumptions of Black people as "dirty" and incapable of providing adequate care to mothers in the way that he and other White male physicians could.

Despite research from the Elizabeth County Case Study that largely proved otherwise, Plecker continued to argue that midwife traditions and child birthing techniques were outdated and not suited to handle complicated births, regardless of experience (Fraser, 1998, p. 61). Plecker's rhetoric derailed midwives' reputations as safe, experienced, and capable birthing assistants, and served to justify and promote the movement towards medical science in childbirth (Fraser, 1998, p. 61). Discouraged by surveillance, the need for literacy, and the medicalization of birthing, many practicing midwives were pushed to stop practicing (Fraser, 1998, p. 63). Because few physicians wanted to practice in rural areas amongst a population unable to pay for their medical services, Plecker and other physicians saw the African American Midwife as a "necessary evil" that could not be immediately eliminated, so instead policies were enacted to regulate and restrict the midwife, with the intention of eventually phasing her out of the realm of legal birthing practice with the White-dominated medicalization of birth (Fraser, 1998, p. 59).

A History of Blaming Black Mothers

Plecker was not alone in blaming Black mothers and midwives for the spread of disease and the increased rates of infant mortality on the basis of a false and factually unsupported narrative. Dr. J. Marion Sims blamed enslaved mothers for the high death

rates of their infants, even going as far to attribute the condition of neonatal tetanus (caused by bacterial infection) to the "filth" and "moral and intellectual failures of enslaved mothers (Washington, 2006, p. 62)." Neonatal tetanus is a fatal malady caused by a bacterial infection of *Clostridium tetani*, which comes from animal manure and thrives in the wounds of healing umbilical stumps (Washington, 2006, p. 62). By blaming tetanus on the shortcomings of enslaved mothers, Sims refused to acknowledge the real contributing factor to high rates of neonatal tetanus amongst enslaved mothers, which were the living conditions of enslaved people. Enslaved women were forced to live in shacks that were often built near animal dwellings (i.e. horse stalls) and instead of suggesting the relocation of these living quarters to prevent the prevalence of the disease; Sims continued to scapegoat enslaved mothers. Sims additionally blamed enslaved mothers and African American midwives for the deaths of Black infants that he attempted "skull modifying" procedures on. His justification for these "skull modifying" procedures pivoted on the scientific myth that Black infants' skulls grew together faster than appropriate for a brain to grow and develop (Washington, 2006, p. 63). Several infants died at the expense of Sims "skull modifying" experiments, and instead of taking responsibility for killing them, he turned to scapegoating the "ignorance of their mothers and the Black midwives who attended them" for the reason of their deaths (Washington, 2006, p. 63)."

The Medicalization of Birth: Leaving Black Mother's Behind

The trend of White physicians blaming Black mothers and Black midwives for the circumstances in which they were constrained to by their society, instead of taking responsibility for their, as well as the system's failures, is one that would continue to define the national health care response to the issue of racial disparities in infant and maternal mortality. Dr. Gertrude Jacinta Fraser, associate anthropology professor at the University of Virginia, presents this phenomenon in her book *African American midwifery in the South: Dialogues of birth, race, and memory*, which details the introduction of public health initiatives in the South that sought to curb infant and maternal mortality. Fraser discusses in depth how these initiatives spearheaded the attack and slow elimination of midwives in order to socially encourage the shift from midwife-assisted births to physician assisted hospital births that relied on an understanding of biomedicine instead of midwifery culture and tradition. Other scholars have termed this shift as the "medicalization of birth," in which birth became viewed as a medical event instead of as a natural process (Smith, 1995, p. 119). In Fraser's words, early public health efforts in the South aimed to "secularize" traditional midwifery (Fraser, 1998, p. 57). The introduction of public health in the South in efforts to reduce mortality rates across the board for rural Black persons and poor Whites was afflicted by the fear held by private physicians, who were "distressed about improving rural midwifery services" fueled by an "element of professional territorialism" as improving health care for Black people threatened the "money in their pockets (Fraser, 1998, p. 30)." This is a disturbing analysis of a history of racialized capitalistic greed that impeded public health efforts that may have served to alleviate disparities in maternal

and infant care between Black and White mothers. The slow phasing out of the African American midwife, sustained by the power held by White physicians to revoke professional licenses, implement barriers to their ability to practice (such as literacy tests), and ultimately the powerful use of their platforms to reinforce rhetoric blaming midwives for high rates of infant mortality, has detrimentally impacted the healthcare system that exists in the South today.

Introduction of Prenatal Care

By 1928 in Virginia, a prenatal care itinerary had been established by physicians, during which a pregnant mother would be monitored and informed over the course of her pregnancy to watch for "danger signals (Fraser, 1998, p. 51)." However, Black women who had limited access to either physicians or medical care until the 1960s were instead blamed by physicians for high rates of infant and maternal mortality in Virginia on the account that they had failed to "read the danger signs of their pregnancy (Fraser, 1998, p. 51)." With the introduction and emphasis on prenatal care in the 1920s, and the social and political persuasion to dissociate from 'non traditional' practitioners (midwives), mothers and families who were unable to "raise themselves out of poverty, to take the advice of experts, to avail themselves of medical care, or to dissociate themselves with nontraditional practitioners" were labeled as "inadequate, ignorant or incompetent (Fraser, 1998, p. 131)." What physicians and politicians failed to recognize in this 'pull yourself up by your bootstraps' conviction were the socioeconomic conditions that prevented equal access and opportunity to achieving these standards and receiving adequate prenatal care for persons of every race and social class. The *solutions* of prenatal care and the professionalization of childbirth

overlooked the socioeconomic, race, and class conditions that constitute the basis of poor maternal and infant health (Fraser, 135; Roberts, 1997; and Washington, 2006). Fraser identifies the 'ideology of prenatal care' as pinpointing "good advice and cleanliness," as the key to solving all prenatal health problems faced by rural, poor women, further perpetuating the notion that Black mothers were disproportionately suffering from poor birth and maternal outcomes due to the "racist assumption that African Americans" were "indifferent or bad mothers (Fraser, 1998, p. 134)."

Following the 1920s, a study on maternal and infant mortality rates in the Virginia's capital (Richmond) was conducted, yielding results demonstrating that despite the establishment of the *solution* of prenatal care, high rates of Black maternal and infant mortality persisted (Fraser, 1998, p. 132). From a sample of a Richmond hospital's patients, researchers conducting the study concluded that at this hospital Black women had a death rate four times greater than White women, a stillbirth rate ten times that of White women, and fewer Black women used the segregated hospital facilities available to them (Fraser, 1998, p. 131). These disparities were attributed to the "indifference of Negro women to prenatal care and to medical care at the time of delivery (Fraser, 1998, p. 131)." Instead of assessing the ways the system was failing Black mothers, Black mothers were blamed, and began to become ordained as 'indifferent' and 'careless' in medical and public health journals (Fraser, 1998, p. 131). The stereotypes of Black mothers that were produced and sustained throughout our nation's history, having advanced from the roots of racism and slavery, continue to systemically contribute to the same disparities in maternal and infant care that can be analyzed nationally today. Solutions to the racial disparities in infant and maternal care

today must address the multifaceted crisis posed by current race and class relations, and recognize the way past solutions have failed and worsened this health crisis afflicting Black women, and other poor women and their children.

During the 1950s, health departments began to require physician distributed authorization cards to approve midwife-assisted births, further limiting poor women's access to midwives due to the mandatory cost of prenatal doctor visits (Craven, 2010, p. 66). In fact, the majority of poor women came to the clinic only during their final trimester in order to ensure that they would be able to have the appropriate funding authorization for the hospital (Fraser, 1998, p. 135). This exacerbated the racial divide in maternal and infant health care for Black women who relied on African American lay midwives for their only reliable and affordable form of maternal and infant pre- and postnatal care. Birth was transformed into a medical crisis for Black Americans and poor women, who did not have equal access to prenatal care due to barriers including cost, elimination and regulation of the use and availability of midwives, and the segregation of childbirth clinics (Fraser, 1998, p. 134). Virginia's public health and medical leaders had promoted the issue of prenatal care and the threat of unsanitary high-risk births to further their argument against the use of midwives, eventually resolving their demise (Fraser, 1998, p. 134).

The medicalization of childbirth resulted in "some impressive gains for White women and their children" in Virginia, although it resulted in a greater disparity in maternal and infant health for Black Americans who "still lagged far behind (Fraser, 1998, p.128)." Programs, such as the Elizabeth Case Study and the Sheppard-Towner act, that were developed and supported by physicians and the state of Virginia failed to

address the ‘root causes’ of poor maternal and infant health for Black people, which Fraser prescribes as poverty and an unequal access to resources (Fraser, 1998, p. 128). The introduction of prenatal care as a required phase of childbirth was framed as a means of ensuring a desired and safe birth outcome while simultaneously serving to further alleviate the ‘midwife problem’ (Fraser, 1998, p. 128). Evidence for the intended function of prenatal care can be assessed in a statement made by Plecker in which he references the purpose of prenatal care as to “try to impress on these women... that they must stay away from midwives, and then we urge them to place themselves under the care of a physician as soon as they discover that they are pregnant (Plecker, 1993 pg. 84 as cited in Fraser, 1998, p. 128,).” By eliminating midwifery, reproductive control could be achieved over both White and Black women’s bodies by placing their bodies under the care of physicians (Fraser, 1998, p. 129). The expansion of prenatal care and the distribution of information on how to monitor for ‘danger signals’ to expecting mothers was seen as a solution that would serve to reduce certain risks associated with childbirth (Fraser, 1998, p. 131). The ideology of prenatal care as well as the medicalization of birth ignored the economic conditions that existed at the basis of poor maternal and infant health, and further increased the disparity in maternity care available for Black mothers and their children (Fraser, 1998, p. 135).

The Transition to Hospital Births

While traditional midwifery greatly decreased in the Northeast and Midwest over the first half of the twentieth century, midwives continued to play a pivotal role in reproductive health care in the South, especially amongst Black families (Ettinger, 2006, p. 139). In the face of government regulation, prior to their decline in the 1950s,

Black midwives took the opportunity to become health workers beyond the scope of midwifery, providing health services to poor rural women, and health education to their communities via promotion of clinics, immunization programs, and prenatal and postnatal medical examinations (Smith, 1995, p. 118) On the account of these contributions, they deserve to be largely credited for their help in the implementation of the modern public health care system (Smith, 1995, p. 119). Black people have a history of opposing medical segregation and racism by developing their own spaces to care for their communities (Gamble, 1995 cited in Smith, 2005). Lay African American midwives saw themselves as important intermediaries between poor Black mothers and White professionals, and further sought to make the medical systems in the 19th and 20th centuries more responsive to Black women's needs (Smith, 2005).

Following the 1930s, southern women of higher status were making the transition to physician-assisted hospital births, following the path already begun by women in the North, in pursuit of "safer, cleaner, more scientific, and painless births (Fraser, 1998, p. 92). Public health personnel in Virginia argued that "delivery by a physician, preferably in a hospital is [ultimately] more desirable than midwife service", and while previously the midwife had served as a vessel connecting Black people to medicine, she would soon be eliminated as an intermediary (Fraser, 1998, p. 92). In reality, hospital births were more dangerous than home births, as new mothers were exposed to the germs of other patients, and the physicians often engaged in interventionist approaches increasing the risks associated with birth (Ettinger, 2006, p. 9). Valerie Lee reiterates this in her book *Granny midwives and Black women writers: Double-dutched readings,* that as "babies began to be delivered into the hands of men

(male physicians), a number of surgical procedures and instruments became popular (Lee, 1996, p. 27).” Interventions included bloodletting and chloroform for accelerating labor and relieving pain, forceps to deliver babies in prolonged difficult labor and caesarean sections just to name a few (Ettinger, 2006, p. 7).

Out of fear of African American midwives practicing obstetrics, physicians advocated their ability to provide painless and safe childbirth in contrast to midwives-assisted births, which were publicly portrayed as involving long labors often resulting in puerperal deaths (Fraser, 1998, p. 84). Access to these technological interventions, which were promoted as birthing necessities, required access to a nursing and anesthesiology staff that could only be provided in hospitals (Ettinger, 2006, p. 8). While these interventions did not cause a crisis in the majority of births, historians have shown that the overeager and excessive use of forceps caused an increase in injuries, spread of infection, and death for mothers and their babies (Leavitt, 2016, p. 47 cited in Ettinger, 2006, p. 9).

Throughout the beginning of 20th century into the 1930s, Virginia doctors curated their arguments to appeal towards an audience of White women who could afford their fees, arguing that to give birth without pain-relief medication (an intervention technology) was the “most inhumane and unkind thing;” aside from this argument however doctors simultaneously refused to offer their services to poor, mostly Black women, unable to pay for physician services (Fraser, 1998, p. 96). Additionally the strict compliance with segregation laws, poverty, and long distances stood as obstacles discouraging Black women and midwives from entering White hospitals or clinics for services, lessons, or training (Hine, 2011, p. 109; Fraser, 1998, p. 35).

Aligning with the timeframe that women began giving birth in hospitals, maternal mortality rates increased from 61 deaths per 10,000 live births in 1915 to 70 in 1929 (Ettinger, 2006, p. 9). Federally sponsored public health programs and the heightened policing of midwives by public health officials, physicians, and local registrars, led to the overall decline of midwifery during the mid 1900s (Craven, 2010, p. 65). This trend was reflected across the entire United States, and by 1951 lay African American midwives were nearly completely pushed out of practice, with 90% of births taking place in the hospital (Brodsky, 2008). The stigma that became attached to receiving care from an "uneducated" midwife in the mid 1900s has been deemed to have influenced Black women to feel ashamed with the stigma of using a midwife, even though they faced continued exclusion from hospital care (Yoder and Hardy, 2018).

Virginia did not keep official records of midwives at the turn of the 20th century, however as observed by a Virginia physician in 1928, "splendid work" had been accomplished by "reducing the number of midwives in the state from nine thousand very *ignorant* and *dirty* creatures to four thousand eight hundred and forty, only one thousand two hundred and thirty-three of who are really active", falling to approximately 600 by the 1960s corresponding with national trends (Craven, 2010, p. 65). Urban and rural affluent, and middle class White women were the first in Virginia to choose physicians over midwives, followed by urban Black women (as allowed), while rural, poor, Black women and White women continued to use midwives through the mid 1900s (Craven, 2010, p. 66). Claudine Curry Smith, the last practicing African American lay midwife of the lower Northern Neck in Virginia, assesses the racialized class distinctions that shaped and continue to shape the racial divide in health care in

her biography *Memories of a Black lay midwife.* The same racialized class distinctions that Dorothy Roberts too analyzes in regards to the race and class biases that served to define women of color as the target for sterilization procedures in the mid twentieth century and beyond. Smith explains that while most "White people had their doctors come to the house-they had money to pay the doctor" while "Black people just didn't have doctor's money (Smith & Roberson, 1994, p. 23)."

In Fraser's book *African American midwifery in the South: Dialogues of birth, race, and memory*, Fraser documents the ethnographic fieldwork and interviews that she conducted in Green River County, a rural area in Virginia, where she studied the "the local experience of reproductive transformation" as remembered by those who witnessed the disappearance of midwives in the 20th century. Fraser documents that her 'informants' from the Green River County Black community express "ambivalence" about the transition to hospital births, however they also "believed that the acceptance of medical science was for the individual and collective good (Fraser, 1998, p. 129)." Fraser additionally argues that the efforts to eliminate midwifery contributed largely to an overall movement that aimed to control the entirety of the 'reproductive sphere (Fraser, 1998, p. 129).' The stereotypes of African American midwives shaped and cultivated by the racially charged rhetoric of Virginia's physicians, who referred to these women as "primitive, dirty, and potentially dangerous," served to socially promote the policies made against these women, as Black Americans wanted to "distance themselves from these negative images" of the midwife, leading to the eventual rejection of "the cultural practices and beliefs associated with midwifery" and the *inclusion* in the "benefits of medical progress (Fraser, 1998, p. 129)."

Black women were led to believe that by partaking in placing their bodies under the care of physicians that they were extended the opportunity of benefiting from medical progress, however with the reduction in midwives, medical facilities still remained unavailable to most Black women (Fraser, 1998, p. 129). Following the Civil Rights Act of 1964, ending the segregation of childbirth clinics, and the introduction of Medicaid reimbursement for physician assisted births in 1965, the reliance on midwives diminished in many areas given the new opportunity for women of color and poor women to access hospital provided health care (Craven, 2010, p. 65). Ultimately by forcing the midwife out of the healthcare sphere, the roles they filled failed to be replaced with an easily accessible and "considerate" alternative for the women they served (Fraser, 1998, p. 135). Instead Black mothers and poor mothers became subject to the "resentful" care of physicians, who viewed these mothers as irresponsible instead of as confined by their socioeconomic status (Fraser, 1998, p. 51). The state of Virginia measured medical progress by the decline in practicing midwives, despite the paralleled decrease in available medical care for Black women and poor women (Fraser, 1998, p. 129). Federally funded hospitals became mandated to provide care regardless of race, ethnicity or income level with the passage of the Civil Rights Act of 1964, although this did not eliminate the issue of segregation completely (Friedman, 2014). It is important to acknowledge that this history of discrimination towards Black people in the United States health care system is not as far away as we often imagine it to be. Which is why the effects of these racist systems are still so rampant today, amidst the numerous other shortcomings of the United States healthcare system.

Ethnic studies professor Dr. Julia Chinyere Oparah and Sociology professor Dr. Alicia D. Bonaparte write in their book *Birthing justice: Black mothers, pregnancy, and childbirth* that "the starkest birth injustice is the systemic eradication of the Black midwife from her community by the Eurocentric patriarchal medical system (Bonaparte & Oparah, 2015, p. vi)." At the basis of the current United States maternal healthcare system exists a historical framework of White physicians, such as Dr. Sims and Plecker, who have devalued and mistreated Black mothers on the account of their skin color, and a government that has failed to sustain and support federally funded social programs aimed at addressing maternal health inequities, such as the Sheppard Towner Act, in fear of the *threat* of socialized medicine. The avoidance of addressing the real social ills linked to high rates of maternal and infant mortality for Black mothers and their children is a contemporary trend that can be traced back to initiatives such as the elimination and destruction of midwives and prominent Black female health care providers, in order to "curb" infant and maternal mortality rates.

Lay African American midwives were not the only Black health care workers excluded from scientific medical practice. In the 1920's, through the Sheppard Towner Act, Southern states hired public health nurses to regulate midwives (Hine, 2011, p. 121). Even in Southern states with a majority Black population, it was nearly impossible for Black nurses to get hired for positions in county health departments, with only twenty-nine total Black public health nurses recorded in the entire South in the 1920s (Hine, 1989, p. 227 cited in Fraser, 1998, p. 266). Local White officials discouraged hiring Black public health nurses in fear that these women would "transgress segregation policies through their association with White co-workers or

patients (Fraser, 1998, p. 34).”White public-health nurses and practicing obstetricians often maligned Black “granny” midwives, as they viewed their practices as the culprit for the South’s high infant and maternal mortality (Hine, 2011, p. 109). The majority of Black Americans did not have access to affordable medical care even after the passage of the Sheppard-Towner Act and lobbying efforts made by the Children's Bureau (Fraser, 1998, p. 132). Because lay African American midwives attended such a high percentage of births in the South, the U.S. Children's Bureau funded the opening of the Tuskegee School of Nurse-Midwifery in Tuskegee in 1941 and the Flint-Goodridge School of Nurse-Midwifery in New Orleans in 1942 to train Black nurses to become licensed nurse-midwives and supervise the “grannies (Ettinger, 2006, p. 139).” However, due to problems with “racism, funding, and the recruitment of Black nurses,” both programs only survived a few years (Ettinger, 2006, p. 139).

The motives of the mainly White politicians and physicians in their campaign against midwives during 19th and 20th centuries can be classified as racist, sexist, classist, and rooted in their fear that these women would take up space in a profession that they were not *qualified* to practice in given the contextualization of their race, gender, and social class. As gynecological and obstetric medicine emerged as “male-dominated, professionalized specialties, traditional women-centered knowledge and experience could be sidelined and officially outlawed,” leaving African American midwives “discredited and their age-old traditions degraded or lost (Ross & Solinger, 2017, p. 17).” The wealth of birthing knowledge and experience retained and passed down through generations of African American midwives was destroyed, leaving a

lasting negative impact on the health and well being of Black mothers and their children that I will discuss further in a later section.

Darlene Clark Hine, an author and professor known for her expertise in the field of African-American history, emphasizes that there exists a present urgency to research and analyze the impact of 'southern states' neglect of Black health care, the failures of American medicine, and the seemingly intractable inadequacies of social welfare policies (Hine, 2011, p. 102)." The elimination of midwives, and the following racist and sexist policies and practices in the United State's not so distant past continues to plague the present and can be seen as the root causes of the disparities in maternal and infant health seen today. In order to propose solutions that may serve to decrease the gaps that exist in maternal and infant outcomes between Black women and White women, as stated by Hine, first an examination of the past must be made in order to address the problem at the source.

Persistent Policies Restricting Midwives in Virginia

In 1962, the Virginia Department of Health (VDH) became responsible for regulating the practice of midwifery, limiting their practice to "rural, underserved areas, minority women, and poor, uninsured women (Craven, 2010, p. 67)." In order to qualify for a VDH granted midwifery permit, aspiring midwives needed two letters of reference from practicing physicians, who have both observed and assisted with ten or more hospital deliveries, passed an exam and have performed with "acceptable moral reputation" and "adhered to standards for personal cleanliness, neatness, and demeanor (Craven, 2010, p. 67)." These requirements grew more stringent in the following decade, with the VDH restricting applications for midwifery permits to "registered

nurses in good standing" who graduated "from a school of midwifery accredited by the American College of Nurse Midwifery (Craven, 2010, p. 67)." In 1976, the General Assembly introduced legislation intended to limit the practice of non-nurse midwifery to those who received permits from the VDH prior to January 1, 1977, only allowing non-nurse midwives who had received permits prior to the change in regulations in 1974 to be "grandmothered in" and allowed to legally practice (Craven, 2010, p. 67). In order to replace lay midwives, legislation regarding the licensure of nurse-midwives as CNMS was correspondingly introduced in 1976 (Craven, 2010, p. 68). Most nurse-midwives were White women, who had the financial and social means to complete both nursing school and a master's degree in nurse-midwifery, following the demographic trend of White public health nurses that had been responsible for "training African American midwives" in the early 20th century (Craven, 2010, p. 68).

Unlike most other states, Virginia legislature did not allow CNMs to practice without a physician's supervision, therefore CNMs could only practice in areas with local physicians who were willing to supervise their practice (mostly confining their practice to within hospitals), which was not an easily feasible accomplishment given Virginia physicians' mass resistance to CNMs (Craven, 2010, p. 68). In the late 1990s, CNMs were forced to close practices and were unable to continue their practice in many parts of Virginia, including the Tidewater area, which encompasses the city of Norfolk, as the local physicians were "not willing to supervise their birth center, homebirth, or even hospital practice (Craven, 2010, p. 69)." Despite this opposition, the number of CNMs in Virginia increased in the 1990s, practicing primarily in hospital clinics that provided care for impoverished patients, before middle class and affluent patients began

demanding access to CNMs as a birth choice further urbanizing the practice (Craven, 2010, p. 69). However, birth centers and home-based practices run by CNMs declined overall in Virginia during the 1990s due to issues such as the inability to secure the support of physicians willing to supervise these practices in order to keep them running in line with the law, leaving nearly one-third of Virginia CNMs consequently practicing outside of their chosen profession in the year of 1991 (Craven, 2010, p. 69). The state of Virginia additionally increased investigations and began prosecuting underground midwives as well as those who assisted them, functioning to increase the fear surrounding these increased investigations which further discouraged midwives from providing home births outside of legal boundaries (i.e. without a licensure and the additional supervision of a physician) (Craven, 2010, p. 72). The actual statistics on the number of deliveries attended by midwives are hard to ascertain, given that homebirth families in Virginia are unlikely to report the attendants at their births in order to protect midwives practicing outside of the law as direct-entry midwives (midwives who have not received a nursing degree) (Craven, 2010, p. 70).

Following this 1976 legislation, Virginia families were no longer legally allowed to opt for a homebirth assisted by a midwife who had not been "grandmothered in" or registered as a nurse-midwife to practice (Craven, 2010, p. 68). As defined by the Code of Virginia, a midwife is defined as a birth attendant that receives compensation for assistance in "delivery and postnatal care by affirmative act or conduct immediately prior and subsequent to the labor attendant to childbirth in conjunction with or in lieu of a member of the medical profession (Craven, 2010, p. 68)." Therefore any non-nurse

midwife wishing to be to be compensated for her services or by accepting anything of value (such as gifts or money) was practicing outside of the law (Craven, 2010, p. 68).

By 1999, only five lay midwives with permits remained in Virginia and by 2001 the last practicing lay midwife retired and moved out of the state (Craven, 2010, p. 67). This 1976 legislation remained the precedent until 2005, when a bill was passed allowing for the legal licensure of certified professional midwives (CPMS) (also known as direct-entry midwives) and the decriminalization of the practice of home-based midwifery, making it legal for mothers to seek midwifery care without having to first be seen by another healthcare professional (Craven, 2010, p. 81). CPM certification allows for "multiple education routes of entry (into the field of midwifery), including apprenticeship, self-study, private midwifery schools, college- and university- based midwifery programs and nurse-midwifery (Craven, 2010, p. 82)." Under this same legislation, CNMs can only treat patients if they have obtained an agreement with a licensed doctor outlining the "availability of the physician for routine and urgent consultation on patient care (Masters, 2021)." One drawback of the bill is that it banned the possession and or administration of controlled substances (such as oxygen) that national groups such as the North American Registry of Midwives (NARM) recommend in homebirth settings (Craven, 2010, p. 96). Additionally in order to attain licensure, CPMs must complete a clinical component of at least a year to achieve an equivalent of 1,350 contact hours under the supervision of one or more approved instructors, pass a written and clinical examination, and they must renew their recertification every three years (Craven, 2010, p. 82). Essentially, the component of "physician supervision" which prevents the out-of-hospital practice of many nurse-

midwives in Virginia no longer affects CPMs (Craven, 2010, p. 95). Since the passage of this 2005 legislation, CNMS have lobbied and successfully obtained changes to supervision requirements in 2006, loosening restrictions on physician supervision in some rural areas, though CNMs are still working towards an expansion in legislation that will allow for their autonomous practice throughout the state (Craven, 2010, p. 174).

This was not an easy feat; public debates in Virginia involving mothers, legislators, and physicians were heighted in the decade leading up to the bill's ratification. Propositions to oppose the standing 1976 legislation that made it illegal for everyone except for CNMs and those grand-mothered in to practice non-nurse midwifery faced strong medical opposition, with physicians such as Dr. John Partridge, a representative of the VA OB/GYN society, arguing that "Birth is by nature a medical event" and home births are " a slippery slope, like driving a car without brakes (Craven, 2010, p. 84)." This of course, is an age-old debate that can be observed throughout the 20th century, with physicians seeking to phase out midwives on the account that hospital births are *safer* and the *moral* choice for mothers to make for both their health as well as the health of their children. The argument to continue the ban on autonomous midwifery and the reinforcement of their supervision by a physician, was resolved on the belief that state and medical officials of Virginia were more competent than mothers in regards to deciding the way a mother should give birth in the "best interest" of their children's health (Craven, 2010, p. 88). Partridge's argument hinges on this historical stance taken by physicians in Virginia, a mindset that has survived into the 21st century. However, the question and understanding of the quality of physician assisted hospital

births in terms of birth and maternal outcomes, differed and continues to differ greatly depending on the color of the mother's skin.

CNMs have achieved the elimination of physician supervision as a condition for licensure however, supervision remains a requirement for prescriptive authority, further limiting CNMs ability to run out-of hospital practices (Craven, 2010, p. 140). With maternal health disparities coming more and more under public scrutiny in Virginia, as well as nationally, there has been a larger political incentive to address the problem (Master, 2021). Despite access to a history providing a wealth of insight and understanding of the existence of the racial disparities that exist in maternal care in the United States, as of 2021, Virginia's General Assembly passed legislation forming a task force responsible for collecting data on maternal health, and endorsing a bill removing *some* restrictions on midwives. As of June 10, 2020, in the face of the Covid-19 Pandemic, Virginia's governor Ralph Northam passed an emergency order allowing for CNMs and nurse practitioners to treat patients in the absence of an agreement with a licensed physician, which is usually required in Virginia (Masters, 2021). In the article "A Growing Focus on Maternal Health Disparities Prompts Lawmakers to Remove Barriers for Nurse Midwives," published by the Virginia Mercury, author Kate Masters addresses the current concerns involving the lack of access to CNMS and the linked maternal disparities that are currently being faced by predominantly Black communities in Virginia, as brought to light by the Covid-19 pandemic. In response to concerns from expecting mothers in the early months of the pandemic, Nicole Wardlaw, a CNM, took advantage of Northam's emergency order, and opened the first and only independent practice run by a Black CNM in the Hampton Roads region (Masters, 2021). "My

concern is that Black women are dying in childbirth and from childbirth-related issues, and since I opened my practice, I'm getting calls from far north of here because women want someone who looks like them," said Wardraw, who is also a legislative chair for the Virginia Affiliate of the American College of Nurse-Midwives (Masters, 2021). The Covid-19 Pandemic has lead to more Black mothers looking to home midwife-assisted births as both a way of avoiding the coronavirus, and to avoid a health care system that places them at being 3 to 4 times as likely to die of childbirth-related causes in comparison to White women (Scheier, 2020). Co-founder of the National Black Midwives Alliance, Jamarah Amani stated for a KHN news article *Black Women Turn to Midwives to Avoid COVID and 'Feel Cared For',* that "every midwife I'm talking to has seen their practice double or sometimes triple in the wake of COVID (Scheier, 2020)."

In Christa Craven's research in her book *Pushing for midwives: Homebirth mothers and the reproductive rights movement*, she concludes that the contemporary movement for more accessible homebirths assisted by midwives in Virginia illustrates "little personal memory of African American Midwives" despite the majority of midwifery supporters being well ept in "the history of medical opposition to midwifery since the early 1900s (Craven, 2010, p. 78)." Many Americans in general associate midwife-assisted home births as backwards and scary, or solely a "practice of privileged White women," despite the history of lay African American Midwifery (Scheier, 2020). Further Craven reflects on Virginia's Medical and state officials reliance on the image of "bad midwives" and the "bad mothers" who would consequently have "bad babies" when formulating their arguments against homebirths and the use of midwives

(Craven, 2010, p. 79). This is a common narrative in the history of Virginia's politicians and physicians seeking to regulate the reproductive capacity of women, a narrative that has also been racialized to promote eugenics and sterilizations as the favored form of birth control for those deemed "unfit" to reproduce and be mothers.

20th Century Eugenics Movement: A Continued History of Abuse and Exploitation of Black Women and Mothers

Eugenics

> "Across the nation, Black women who trusted obstetricians to deliver their children were being surreptitiously sterilized and this revelation poisoned relationships between them and their doctors."- Harriet Washington, *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present* (p. 204).

Scholars like Gertrude Fraser believe that the national push for prenatal care, and "improved maternal health in the early twentieth century," through the regulation of midwives in Virginia, uncoincidentally occurred during the same time period that Whites were growing concerned with the notion of "race suicide (Fraser, 1998, p. 125)." W.A. Plecker's, the physician behind the Elizabeth County Case Study, held a strong interest in birth registration and vital statistics that was ultimately fueled by his predisposition as a White supremacist who strongly endorsed the practice of Eugenics, a movement that sought to prevent interracial breeding and the threat of "race suicide" (the threat of White racial extinction) (Fiske, 2004). Eugenicists supported weeding out those who were "undesirable", physically, mentally, or morally by preventing the birth of children with "bad" genetic profiles, or in other words, those that were born unhealthy and poor, further "confusing concepts of biological heredity fitness with those of class and race (Washington, 2006, p. 191)".

Following his acceptance of the state registrar position in 1912, Plecker worked towards “purify(ing) the White race in Virginia" by forcing all “Indians and non-Whites to classify themselves as Black (Fiske, 2004).” The requirement of birth certificates to be filled out immediately following birth served to introduce once personal information regarding child, marital, occupational status, as well as racial identity, into official county records, allowing for stigmas attached to unmarried mothers (illegitimacy) to become institutionalized and for Plecker and other Eugenicists to monitor and control race-mixing (Fraser, 1998, p. 66). In North Carolina, as recent as the 1960s, public health nurses refused to treat Black women who were pregnant with a second child and unwed, forcing women to marry in order to receive prenatal care (Fraser, 1998, p. 66). Plecker’s efforts to maintain White racial purity led to the eventual passage of the 1924 Racial Integrity Act in Virginia, an act that “criminalized interracial marriage” and “required that every birth in the state be recorded by race, with the only options being “White” and “colored” (Heim, 2015).”

On the same day that the Racial Integrity Act was passed, Virginia passed the 1924 Eugenical Sterilization Act (Virginia Eugenics, n.d.). By 1940, thirty states had passed laws to prevent interracial marriage, in line with the eugenic agenda to eliminate the “biological inferiors" that would result from “Black and White intermingling that would deteriorate the White race (Roberts, 1997, p. 71).” The United States Supreme Court affirmed the new Virginia law through the ruling in Buck vs. Bell in May of 1927, in which Charlottesville, Virginia native Carrie Buck was involuntarily committed to a state facility for being “feebleminded,” and court sanctioned to be forcibly sterilized (Virginia Eugenics, n.d.). The supreme court ruled that the state's law

allowing forced sterilization of "any patient afflicted with hereditary forms of insanity, imbecility, &..." for the greater welfare of society was not in violation of the constitution's guarantee of equal protection under the law by the 14th amendment (Wong, 2013). In the face of Eugenics, many midwives quit their practice, as through reporting children of a mixed race on their birth registration, midwives were inadvertently incriminating members of the Black community and putting those person's lives at risk (Craven, 2010, p. 63). Further, by not reporting or falsifying such information, midwives were committing a felony and could receive up to a year in the state penitentiary (Craven, 2010, p. 63).

When Black women were admitted to segregated clinics, they were fearful of the Eugenic sterilization that was being forced upon women of color at the time (Craven, 2010, p. 65). Second to California, Virginia is where the second highest number of sterilizations took place between the years of 1932 and 1941 (Ross and Solinger, 2017, p. 35). Between the years of 1924 and 1979, more than 8,000 Virginians were sterilized (Hardin & Lombardo, 2015). Sixty two percent of total sterilized individuals in Virginia were female, and 22 percent were Black (relatively equal to the population in the state at the time) with ⅔ of those sterilized identifying as Black women (Virginia Eugenics, n.d.). Most people sterilized were not informed that they were to undergo a sterilization surgery, and instead were told they were receiving an unrelated operation (Virginia Eugenics, n.d.; Wong, 2013).

Suppressing Black Fertility

Dorothy Roberts is a social justice advocate, a scholar of race, gender and law, and the author of the book *Killing the Black body: Race, reproduction, and the meaning of liberty.* This book analyzes the reproductive rights of Black women, and exposes the systemic abuse that Black women's bodies have suffered throughout America's history. I rely heavily on this book to fill in the gaps in my thesis regarding the eugenics movement and its role in suppressing the reproductive justice of Black women and how this abuse, and continued White control of Black women, has contributed to the current racial disparities that are apparent in the maternal and infant care system in the United States today. Moreover, this section allows for more critical analysis of how the eugenics movement further tainted the relationship that exists between healthcare providers and Black mothers, and the development of the contemporary biases held by health care professionals.

Roberts offers a crucial analysis on race and class relations, and works through the complexities of divulging perspectives regarding debated issues such as Margaret Sanger's questionably racist intentions with the "Negro Project," as well as the context and implications of the introduction of birth control into Black communities. Margaret Sanger developed Planned Parenthood in alliance with eugenicists and through initiatives such as the Negro Project, by exploiting Black stereotypes to reduce the fertility of Black people (Washington, 2006, p. 196). The Negro Project was one of the first major campaigns in the new birth control movement taken on by the new Birth Control Federation of America (BCFA) (Newsletter #28, 2001). The BCFA was a

league, today known as Planned Parenthood Federation of America, founded by Margaret Sanger in 1921, that emerged from the combination of Sanger's Birth Control Clinical Research Bureau with the American Birth control league (Newsletter #28, 2001). At the time, official segregation meant that all birth control facilities that were established in the South were designated for White women only (Roberts, 1997, p. 77). Segregated health services proved to be a barrier in improving Black people's access to contraceptives. The 'Negro project' was largely influenced by both the eugenics movement and the progressive welfare programs of the New Deal Era, and today it can be analyzed to have had largely racist intentions that were based on an equally racist framework (Newsletter #28, 2001). In Rickie Solinger's book *Pregnancy and Power: A Short History of Reproductive Politics in America* she writes that Planned Parenthood contributed to the initial attempts at defining motherhood as a class privilege by giving "force to the idea that poor women, especially women of color" should be the targets of "planned reproductive control, not bearers of reproductive rights (Solinger, 2005, p.142)."

In the late 1930s, following the demise of the Sheppard Towner Act, birth control activists began focusing on the high birth rates and poor quality of life in the South. The intentions of these largely White female activists differed from the approach taken by the public health nurses hired through Sheppard -Towner act. The Sheppard-Towner Act had aimed to reduce the South's infant and maternal mortality rates by improving and promoting the medicalization of birth practices via initiatives such as the regulation of midwives. While the Sheppard-Towner Act addressed the birth event itself to curb these statistics, the eugenic-based birth control movement focused on the

prevention of Black births as a whole. Birth control was promoted by White women who viewed birth control as a means of pursuing careers and higher education, goals that existed out of reach of the poor regardless of their access to birth control (Gordon, 2002, p.158). Feminism at the time was defined as aligning with the aspirations of more privileged White women in society which follows in suit with pro-birth control eugenicists promoting the idea that poor people had a "moral obligation to restrict the size of their families, because large families create a drain on taxes and charity expenditures of the wealthy and because poor children were less likely to be 'superior' (Gordon, 2002, p. 158)." Following the economic crisis of the Great Depression in the early 1930s, the practice of sterilization as a form of birth control became of heightened interest for preventing the birth of children that would require public assistance (Roberts, 1997, p. 70). Following the Great Depression, White women were under social pressure to reproduce, and those who did not were "targets of harsh disapproval (Ross & Solinger, 2017, p. 38)."Around this time Sanger sent field workers into the rural South to test for the cheapest and easiest to administer birth control options for the poor women living there to use (Newsletter #28, 2001).

Through these research initiatives, persons like Hazel Moore, a veteran lobbyist and health administrator, found that Black women in several Virginia counties were responsive to birth control education (Newsletter #28, 2001). Following the Civil War, Black women used folk methods of contraception and abortion long before the birth control movement began (Roberts, 1997, p. 82). Sanger hoped to secure funding under New Deal legislation to establish birth control services as part of state and federal public health programs in impoverished Southern states and to further demonstrate to

bureaucrats that contraceptive clinics were essential in such regions and had promise to be implemented in other regions as well (Newsletter #28, 2001). In order to secure large monetary donations for this initiative, Sanger and the secretary of the BCFA drafted a report that included racially coded language directed towards appealing to eugenicists who wanted to reduce the Black birth rate (Newsletter #28, 2001). Statements from the report included the assessment that

> "[N]egroes present the great problem of the South," as they are the group with "the greatest economic, health and social problems," and outlined a practical birth control program geared toward a population characterized as largely illiterate and that "still breed carelessly and disastrously,"- *Newsletter #28 Fall 2001 Birth Control or Race Control? Sanger and the Negro Project*

In the South, medical professionals were often concerned with the South's "backwardness," previously quantified by the presence of midwives in place of hospital births, and often linked to the perception and indication of the South's association with poverty (Fraser, 1998, p. 89). Eugenicists argued that by suppressing Black fertility, poverty could be combatted (Solinger & Ross, 2017, p. 32). Black people in the South were viewed as being especially unfit to reproduce based on a eugenicist theory known as "Selective Migration", that stated that more intelligent Black people tended to migrate North leaving the "less intelligent ones behind (Roberts, 1997, p. 79)." Between the years 1910 and 1930, many Black women seeking sexual safety and protection from the threat of everyday violence of White supremacy and the sexually predatory White men who rarely faced repercussions or consequences for assaulting women of color, moved North during the first phase of what is referred to as the Great

Migration (Ross & Solinger, 2017, p. 27). During this 20th century time period of Jim Crow, following emancipation, poverty was greatly afflicting the health of Black sharecroppers in the South (Roberts, 1997, p. 71). The fertility of Black women had decreased by nearly a third, 1 in 3 Black children were dying before they reached the age of 10, and Black mothers were expected to die before their youngest was old enough to leave the home (Roberts, 1997, p. 71). As this poverty was left ill addressed, entering into the 1930's, the high birth rates, poor quality of life in the South, and the alarming rate of Southern poverty became the focus of birth control activists (Newsletter #28, 2001). Eugenicists believed that "public policies and medical practices could be used to promote the reproduction of the "best examples" of humanity and to eradicate "negative expressions" of human life," similarly to how they sought to fix the *midwife problem* (Ross & Solinger, 2017, p. 28).

Sanger's application of negative eugenics through the distribution of birth control was backed by numerous Black writers and leaders at the time, such as the first Black president of Fiske University, Charles S. Johnson, Martin Luther King Jr., and W.E.B. Du Bois, whose writing Sanger often quoted to garner monetary support from those who were fearful of unchecked Black fertility (Washington, 2006, p. 197). Du Bois had suggested that by approaching Black churches, and through promoting birth control propaganda in "Negro newspapers" the issue he described in his own words as "the mass of ignorant Negroes still breed carelessly and disastrously, so that the increase among Negroes, even more than the increase among Whites, is from that portion of the population least intelligent and fit, and least able to rear their children properly," could be curbed (Washington, 2006, p. 197). Before establishing these

clinics, Sanger advocated that in order to gain support and ensure the involvement of the Black community that Black doctors and staff needed to be hired to work at the establishments (Washington, 2006, p. 197).

In a letter to Clarence Gamble, a physician and eugenicist who funded and supervised several birth control initiatives in the rural South, Sanger emphasized the importance of Black leadership to yield a successful project by directly quoting W.E.B. Dubois stating, "We do not want word to go out that we want to exterminate the negro population and the minister [as the head of the project] is the man who can straighten out that idea if it ever occurs to more rebellious members (Newsletter #28, 2001)." This phrase has been extracted repeatedly throughout literature as evidence and in argument that Sanger's intentions were calculated and made in an effort to reduce the Black population much in alignment with the united effort of eugenicists in seeking to reduce the population of eugenic misfits who they saw as the poor, uneducated, and oftentimes Black (Newsletter #28, 2001;Washington, 2006; Roberts, 1997).

Roberts points out that Sanger, like other Whites in the birth control movement, saw Black leaders and health professionals as facilitators of their own intentions amongst Black communities (Roberts, 1997, p. 88). In order to hire Black staff, Sanger convinced the BCFA that the staff (including physicians, nurses, and social workers) would hold limited positions and be chosen based on their "tractability (Washington, 2006, p. 197)." At a Black clinic in Harlem, the staff protested against their lack of autonomy, resulting in the retraction of BCFA support and the closing of the clinic (Washington, 2006, p. 197). In South Carolina, the BCFA hired only two Black nurses

for the purpose of encouraging Black women to visit birth control clinics, however solely White doctors had the ability to dispense contraceptives (Newsletter #28, 2001).

Sanger's plans to first gain the trust and support of the Black community by investing in the training of Black physicians and ministers on the practicalities and demand for supplying mothers with contraceptives was bulldozed through by White medical and public relations men who were in charge of the BCFA (Newsletter #28, 2001). The BCFA did away with plans to make permanent community-based, Black-staffed demonstration clinics, and set up temporary clinics intended to fulfill a short-term purpose and yield quick results (Newsletter #28, 2001). While the BCFA was quick to lay claim to the great success of the Negro Project following this method of pursuit, few women visited the clinics set up in the rural South and dropout rates were high given that many women were not inclined to return to White doctors for follow-up exams (Newsletter #28, 2001). However, clinics run by Black nurses in Nashville and South Carolina proved to have higher rates of success (Newsletter #28, 2001). Representation and better health outcomes has since been heavily researched, yielding highly significant results of concordance between Black doctors providing better health outcomes for Black patients. I will further discuss these findings in a later section, however I want to acknowledge the lack of cultural humility and unbiased competency between Black patients and their White medical providers that has prevailed without improvement, deterring Black women from keeping up with prenatal care checkups, and further exasperating the disparate poor birth outcomes faced by Black mothers. Today the same trends exist as they did just short of a century ago, with White physicians dominating all medical professions.

Today there exists an ongoing argument as to whether or not the Negro Project was entirely a racist endeavor, citing that Sanger had intended to be inclusive through efforts to raise the health and economic standards in poor Black communities (Newsletter #28, 2001). However through the perspective of Black authors, historians, and researchers, Sanger's covert intentions were not guided by a longing for racial equality. Roberts identifies in her book, *Killing the Black body: Race, reproduction, and the meaning of liberty,* that although Sanger's original defense for birth control was feminist, it eventually succumbed to the promotion of birth control as a method of achieving coercive reproductive policies (Roberts, 1997, p. 58). Throughout my research it has been reestablished numerous times the ways in which the Black narrative, specifically the Black female identifying narrative, has been expunged from the retellings of United State's history. Researchers such as Harriet Washington and Dorothy Roberts, have dedicated their careers to piecing together this lost narrative and reframing history so that the systemic issues that exist today can be appropriately addressed, and acknowledged. This narrative must be elevated in order for institutions to recognize the origins of their unacknowledged biases and discriminating practices that continue to plague the health and wellbeing of Black Americans and other minorities. For this purpose I will be supporting the narrative that Sanger's work through the BCFA, specifically through her involvement in the "Negro Project," was not fueled by a passion for social justice, yet a method of employing and furthering the practice of negative eugenics on poor Black communities. Roberts points out that Sanger is not responsible for all of the blame as she was not capable of single handedly shaping the ways in which birth control became a vehicle for reproductive oppression,

yet her "shifting alliances" reflect her ideology as aligning with that of eugenicists who saw birth control and sterilization of Black Americans as a solution to the social problems such as poverty (Roberts, 1997, p. 58). Sanger's rhetoric regarding birth control can be analyzed to correspond more with eugenics and less with feminism (Roberts, 1997, p. 72). While Sanger's personal views may have not aligned completely with her eugenicist colleagues, she did promote the idea that the right to reproduce hinges upon one's "fitness" as prescribed by social status and as dictated by race, thus she encouraged and backed policies that inevitably served to reduce Black women's fertility (Roberts, 1997, p. 81).

Sanger's "experiment of addressing Black social ills with the application of negative eugenics via Black birth control clinics was so successful that it still persists today in the form of the birth control pill (Washington, 2006, p. 198)." Ross and Solinger argue in their work "*A Reproductive Justice History*," that public health officials developed birth control clinics for poor African Americans with the prominent goal of serving the "public good" by reducing Black fertility (Ross & Solinger, 2017, p. 33). The birth control pill as well as other forms of birth control such as Norplant arm implant, were made readily available to poor Black women free or cheaply from the government sponsored Planned Parenthood clinics that remained in central urban areas as the "progeny of Sanger's negro project clinics (Washington, 2006, p. 198)." Coercive reproductive drug testing on poor women of color was common, and forced these women to "bear the brunt of any health risks that emerge," contributing to an overall distrust for the medical community (Washington, 2006, p. 202). Black women embraced birth control more so than Black men, who were much more likely to

denounce it (Washington, 2006, p. 201). Urelia Brown, a Black social worker in the year 1972, ascertained that while Black women embraced "contraceptive choice they warily eyed those who offered it (Washington, 2006, p. 201)." When birth control clinics became available to Black communities, Black people in disproportionate numbers were utilizing their services (Roberts, 1997, p. 82). While some literature attributes the decline in Black fertility in the early 20th century to poor health, other literature describes this decline as reflecting an increase in the use of contraceptives (Roberts, 1997, p. 83). Roberts explains that prominent Black leaders who supported birth control promoted its use as a way of toppling the oppressive social structure that eugenicists hoped that it would reinforce (Roberts, 1997, p. 86). Birth control was seen as a vehicle for aiding in the transformation of the unequal economic and political relations between Black and White people, as birth control was capable of curbing high rates of infant and maternal mortality that existed due to social and economic barriers (Roberts, 1997, p. 86). However, there remained an air of distrust within the Black community with conflicting perspectives on Birth control. Birth control clinics were often viewed as promoting race suicide, and while some Black people believed that their progress relied on "numerical proliferation", others feared that White doctors would use them to test new experiments (Roberts, 1997, p. 86). Birth control itself had progressive potential, but instead it was utilized in order to promote racist agendas and achieve class exploitation (Davis, 2003, p. 354) By merging birth control to become a game piece in the eugenic movement, the progressive potential of birth control became stripped and replaced with the racist strategy of population control (Davis, 2003, p. 361).

This fear of exploitation and experimentation at the hands of White doctors arose from the beginning of our nation's history, in which White control over Black peoples' bodies during antebellum slavery set a disturbing precedent for the relationship that would persist between White doctors and Black people in present day America. While during antebellum slavery, White slave masters forced Black women to have children for profit, following the emancipation of the slaves, policies became enacted to decrease Black women's fertility, following the "needs of society" (Roberts, 56; Solinger, 6).

Sterilization: The Continued Development of Poor Relationships between Black Mothers and their Available Medical Practitioners

"We don't allow dogs to breed, we spay them. We neuter them. We try to keep them from having unwanted puppies, and yet these women are literally having litters of children…" –Barbara Harris, Founder of Children Requiring a Caring Kommunity 1990 (Washington, 2006, p. 215).

In Harriet Washington's Book *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present,* she explains that within the parameters provided by the United Nations, the proliferation of birth-control initiatives directed towards the Black population that occurred in the mid 20th century can be described as an attempt of racial genocide since their purpose was to "selectively reduce (Black) births (Washington, 2006, p. 200)." Washington also points out that these clinics were both numerous and well funded, whereas health advocates and politicians failed to acknowledge or address more pressing Black health issues such as poor "nutrition, poor control of infectious disease, high infant mortality, low life

expectancy, poor quality healthcare and even a lack of access to hospitals and physicians," indicating that the erection of these birth control clinics were not supported and funded with the *health* of Black people in mind (Washington, 2006, p. 201). Roberts echoed this analysis, stating "It is amazing how effective governments- especially our own are at making sterilization and contraceptives available to women of color, despite their inability to reach these women with prenatal care, drug treatment, and other health services (Roberts, 1997, p. 95)."

The development of federal programs to aid poor mothers and their children was ultimately a move that enforced government control over the decisions these women were making in regards to their personal reproductive health and served to promote racial exclusion, racial difference, and racial separation, by solely addressing the legitimate need of mainly White women (Ross & Solinger, 2017, p. 36). While women of color, including Black, Puerto Rican, and Native American women, were being pressured into sterilizations, White women found it nearly impossible to receive a sterilization procedure, as they were required to obtain the endorsement of multiple physicians, including a psychiatrist, in order to even qualify (Roberts, 1997, p. 95). Because of this, White birth control advocates sought to make it easier for White women to obtain voluntary sterilizations, without examining the ways in which such advocacy would continue to proliferate the sterilization abuse suffered by women of color at the time (Roberts, 1997, p. 96). Groups such as the National Abortion Rights Action League and Planned Parenthood testified against guidelines proposed by the Committee to End Sterilization Abuse that were designed to prevent coercive sterilization (Roberts, 1997, p. 96). Roberts emphasizes that by "focusing on the

obstacle the regulation would pose to middle-class White women, they ignored the ravages on minority women's bodies that (this guideline) would help to prevent (Roberts, 1997, p. 96)." The interests of middle-class White women who wanted to secure their ability to be consensually sterilized overshadowed their desire to understand and aid the movement against sterilization abuse that women of color faced (Roberts, 1997).

Because of this, organizations with a majority makeup of middle class White women, such as the Women's Liberation movement, championed the legalization of abortions, even though the success of the Supreme Court's ruling in Roe vs. Wade did not represent an intersectional achievement for all women (Davis, 2003, p. 354). Prior to the decriminalization of abortion, Black and Puerto Rican Women made up 80 percent of deaths caused by illegal abortions in New York State, and immediately following the legalization of abortion women of color received close to half of all the abortions being performed in the country (Davis, 2003, p. 354). Angela Davis, an American political activist for civil rights, and author of *Women, Race, and Class,* explains that while these women of color were in favor of 'abortion rights,' their personal experiences with abortion greatly reflected a dissuasion of bringing a child into the world on the account of the "miserable social conditions" that defined their own lives (Davis, 2003, p. 355). Black women have been aborting their children since the beginning of slavery in order to protect their children from living the life of a slave. Davis emphasizes that the premise of the abortions rights campaign assumed that legal abortions would solve the problems created by poverty, that "having fewer children would create more jobs, higher wages, better schools…" thus failing to provide a voice

for women who "wanted the right to legal abortions while deploring the social conditions that prohibited them from bearing more children (Davis, 2003, p. 355)."

Within four years of the passage of Roe vs. Wade. The Hyde Amendment was passed in congress, mandating the withdrawal of federal funding for abortions, leaving women of color, along with impoverished White women, to be essentially deprived of the right to legal abortions (Davis, 2003, p. 356). While federal funding to make abortions more affordable and available to poor and oppressed women of color was curtailed, Surgical Sterilizations, funded by the Department of Health, Education and Welfare, remained free, forcing more poor women to agree to permanent infertility given the absence of affordable and more reliable preventative options (Davis, 2003, p. 356). As perfectly stated by Angela Davis, there lacked a campaign that defended "the reproductive rights of all women-especially whose economic circumstances often compel them to relinquish the rights to reproduction itself (Davis, 2003, p. 356)." White feminists ignored, or simply remained ignorantly blind, to how the birth control movement had led to the compulsory sterilization of women deemed socially 'unfit' based on their race and class, and failed to incorporate a condemnation of sterilization abuse in their campaign for abortion rights in the early 1970s (Davis, 2003, p. 361; Fraser, 1998, p. 129)

The Medicaid Act of 1965 served to introduce a new health care system that drew on a combination of federal and state money to provide medical services for low-income pregnant women who had previously lacked access to expensive medical care (Ross & Solinger, 2017, p. 47). Following this era of progressive politics ensued new laws such as the Supreme Court decision Loving vs. Virginia of 1967, which ended the

criminalization of interracial marriage (Ross & Solinger, 2017, p. 48). The civil rights movement had been successful in that several legislative reforms had been achieved, granting Black Americans greater access to housing, jobs, welfare benefits as well as political participation (Roberts, 1997, p. 89).

Virginia's sterilization law, which lasted longer than any other similar legislation in the United States, was not repealed until 1974 (Wong, 2013). During this time, in the early 1970s, following the repeal of state sterilization laws across the nation, Black women remained subjected to sterilization abuse at the discretion of government-paid doctors (Roberts, 1997, p. 89). The rate of sterilization of Black women in the South increased so dramatically, that it became a "common belief among Blacks in the south that Black women were routinely sterilized for no medical reason (Roberts, 1997, p. 90)." Today Black women are still more likely than White women to be misled into sterilization, this trend tripled between 1970 and 1980, an increase that tiered on hysterectomies being offered as the "*only* curative option for ailments" such as fibroids and endometriosis (Washington, 2006, p. 205). During the peak of the Civil Rights movement, the maternity, sexuality, and reproduction, of women of color became the targets of conservative politicians that sought to promulgate an image of these women as being unfit and 'disqualified' from being mothers for their 'bad decisions' of becoming pregnant while poor, further resulting in the establishment of multiple sterilization programs in hospitals serving communities of color (Ross & Solinger, 2017, p. 50). Black mothers were portrayed as "reproductively unnatural," and as having babies in order to "get on welfare" not out of "maternal feeling or out of the desire to make a family," and thus they utilized this argument to "reduce welfare costs,

reduce taxes, and slow the population growth of minorities in the United States (Ross & Solinger, 2017, p. 148)."

Link Between Welfare and Sterilizations

In the year of 1973, a lawsuit was filed by the Relf family, a poor Black family from Alabama whose youngest daughters had been sterilized without informed consent, demanding a ban on the use of federal funds for sterilizations (Roberts, 1997, p. 93). The suit opened up an investigation that uncovered statistics indicating upwards of 150,000 poor women, like the Relf daughters, had been sterilized under federally funded programs, with half of the women sterilized being Black (Roberts, 1997, p. 93). Sterilization remained the only readily accessible publicly funded birth control method for poor women of color, with the racial disparities in sterilization "cutting economic and educational lines" (Roberts, 1997, p. 97). In a National Fertility Study conducted in 1970 by Princeton University's Office of Population Control, twenty percent of all married Black women had been permanently sterilized, and over forty three percent of women sterilized through federally subsidized programs were Black (Davis, 2003, p. 363). Today, sterilization remains the most commonly used form of birth control for Black women and the current government funding policy encourages this trend through its provision of paying for sterilization procedures under Medicaid for poor women while not providing for information or access to other contraceptive techniques and abortion (Roberts, 1997, p. 97).

Eugenicists became drawn to the potential that birth control held in perpetuating White control over Black women's reproductive bodies, as it allowed for them to bolster their agenda to decrease the birth rates of those that they deemed "unfit (Roberts, 1997, p. 56)." Eugenics was appropriated in order to "label Black women as sexually indiscriminate and as bad mothers who were constrained by biology to give birth to defective children (Washington, 2006, p. 191)." In the 1940s the practice of eugenics had been disproved and redefined as bad science that served as an excuse for racial discrimination and attempts a racial genocide (Roberts, 1997, p. 88)." Demonization of Black mothers has had a long history, as I have strived to account for, from the times of antebellum slavery to present day (Washington, 2006, p. 191). Throughout this history, Black mothers have been characterized as unfit, and have additionally been stereotyped, labeled, and controlled by government policy, and left unprotected.

In the South, the non-consensual sterilization of Black women while unconscious during surgery was such a common procedure it came to be known as a "Mississippi appendectomy" (Washington, 2006, p. 204). In South Carolina, obstetrician Dr. Clovis Pierce actively sterilized Medicaid recipients with two or more children, insisting that mothers on welfare should have to submit to sterilization if they wished for him to deliver their babies, stating "(I'm) tired of people running around and having babies and paying for them with my taxes (Davis, 2003, p. 363)." Sterilization abuse was not exclusively occurring in the South. In 1973, medical students from Boston City Hospital and Columbia University came forward to protest against their school's policy of performing unnecessary hysterectomies on Black women in order to

provide their residents *practice,* as well as against the commonly used coercive methods for obtaining consent and the falsification of medical records for their Black patients (Washington, 2006, p. 204). Examples of this included forging consent forms, or curating medical records to display an appendectomy or gallbladder removal, thus rendering current medical records as unreliable in terms of determining how many Black women were nonconsensually sterilized (Washington, 2006, p. 204).

In 1995, in many major New York City teaching hospitals it was "unwritten policy to do elective hysterectomies on poor Black and Puerto Rican women" in order to *train* residents (Roberts, 1997, p. 91). A chief of surgery in a northeastern hospital admitted that "a girl with a lot of kids, on welfare, and not intelligent enough to use birth control is better off being sterilized", in substitution for this coded language, "not intelligent enough to use birth control" can be understood as meaning 'Black' or 'poor' (Roberts, 1997, p. 92). Other Black women suffered from ultimatums, the risk of losing their welfare benefits or receiving any form of medical care at all, if they did not agree to a sterilization procedure (Roberts, 1997, p. 92). The state of Virginia tried (and failed) to pass compulsory sterilization legislation that would require welfare mothers to be sterilized if they continued to have children out of wedlock (Roberts, 1997, p. 94).

Eugenicists believed that sterilization would serve to improve society by removing "inadequate members", while simultaneously arguing against social programs that were designed to improve the living conditions of the poor (Roberts, 1997, p. 70). Harvard geneticist Edward East, complained that "the provision of prenatal care and obstetric services to the poor through clinics and hospitals was unsound biologically" as it "nullified natural elimination of the unfit (Roberts, 1997, p. 65)." Politicians,

including liberals, physicians, policy makers, and others promoted reproductive control as a fix to social problems in the country, which lead to an increase in the number of birth control clinics providing for contraceptives, pregnancy and maternity care to jump from 145 in 1932 to 357 in 1937 (Ross & Solinger, 2017, p. 35). Eugenicists opposed social programs such as adequate medical care, improvement of living conditions for the poor, better working conditions, and minimum wages, as these measures enabled inferior persons to live longer and have more children (Roberts, 1997, p. 65).

In 1983, "Blacks constituted only 12 percent of the population, yet 43 percent of the women sterilized in federally funded family planning programs were African Americans (Washington, 2006, p. 203)." In multiple studies conducted in the 1970s, women of color, Medicaid recipients, and women who received welfare benefits were sterilized at much higher rates in comparison to women who fall outside of these categories (Ross and Solinger, 2017, p. 50). In fact, for several decades, peaking in the 1970s, government-sponsored family planning programs often coerced Black women into being sterilized. This largely contributed to the distrust and fear of the intentions of medical care providers held by poor people, mostly Black Americans or immigrants, who were perceived as "eugenic misfits (*uneducated, feebleminded, criminals*)" that would only reproduce "unfit" children that were harmful to society (Washington, 2006, p. 191).

The history of medical experimentation in the 18th and 19th century followed by forcible sterilization fueled suspicions that the federally financed birth control clinics in predominantly Black neighborhoods were attempts at discovering "the best way to limit or even to erase the Black presence in America (Washington, 2006, p. 198)." In 1972,

40% of Blacks people surveyed by the American Journal of Public health saw birth control clinics as a genocidal tactic, while dually expressing a large distrust for sterilization programs, abortion clinics, and any birth-control program run by White people (Washington, 2006, p. 199). While genocidal fears were often dismissed as paranoia, prominent White physicians "had long advocated for a reduction in Black births as a means of pinching off the race (Washington, 2006, p. 199)." Birth control, specifically in the form of sterilization, has accentuated the mistrust that exists between Black women and their doctors as sterilization, and the legislation surrounding it, allowed for the perpetuation and continued control and non-consensual exploitation of Black women's reproductive bodies following the precedent of care and mistreatment during antebellum slavery. The debates surrounding sterilization frame and contribute to the racist notions of who is perceived as fit and qualified enough to be a mother, a mindset that has become stereotypically ingrained into the way many shape their thoughts on the same matter today, contributing to the biases held by current practicing physicians.

Black Motherhood in the United States

The War on Motherhood (1960s and 1970s) excluded many women from "legitimate motherhood", most notably poor, unwed women of color (Ross & Solinger, 2017, p. 43). The 'welfare queen' is an idea promulgated by politicians seeking to scapegoat all poor single mothers as women of color and dependent on public assistance (Ross and Solinger, 2017, p. 43). Reproductive ability and maternity became politicized in order for conservative policy to overcome and restrict any form of progressive social

change, and further solidify and maintain White political and economic power (Ross and Solinger, 2017, p. 46).

In the late 19th and 20th century, the government became more involved in setting standards for "mothering," as welfare and immigration officials began to scapegoat mainly women of color as being 'unfit' mothers in order to promote social and political initiatives (Ross & Solinger, 2017, p. 28). Public programs, funded and supported by state and federal governments, valued White maternity, fertility, and reproduction while devaluing the same aspects for poor women of color, whose children were seen as social ailments, responsible for increased tax expenditures funded by the wealthy and all socioeconomic issues related to poverty (Ross & Solinger, 2017, p. 29; Davis, 2003, p. 358).

In 1935, the government added the Aid to Dependent Children (ADC) under the Social Security Act, which excluded children of "immoral" unmarried mothers, and most women of color (Ross & Solinger, 2017, p. 36). Black women and other women of color were portrayed as hypersexual, with a lack of economic or intellectual resources to be good, 'fit' mothers (Ross & Solinger, 2017, p. 39). Public officials utilized racist rhetoric that cited the "high birthrates of negros [who] reproduced beyond the capacity of the economy to handle" as being responsible for escalating welfare costs, the of overcrowding urban schools, and the high rates of urban crime (Ross & Solinger, 2017, p. 40). These public officials ignored the poor educational systems in poor neighborhoods, the labor system that forced Black people into agricultural and domestic work (referred to by some authors as the apartheid labor system), poor educational systems in poor neighborhoods, and low quality medical care as the main issues

contributing to the poverty these person's were suffering from (Ross & Solinger, 2017, p. 40).

Black mothers were blamed for being hypersexual, having "excessive fertility" and continuing to have "unwanted babies" that cost the taxpayers too much (Ross & Solinger, 2017, p. 40). Public provision for poor mothers has continued to be a major political issue, and the ADC only continued to perpetuate the cycle of poverty entrenched deeply in a history rooted in racism by only providing poor mothers, often of color, enough money to keep them poor, without the provision of child-care services or the facilitation of job training or employment, in an effort that some may understand as reinforcing a racist class system that further fuels capitalist systems (Ross & Solinger, 2017, p. 40). The ADC program "routinely denied public assistance to mothers of color," and the "apartheid-like labor practices" guaranteed poverty for these mothers (Solinger, 2005, p. 142). Additionally, up to ⅓ of all Black people and half of all Black children in the United States were recorded to be living in poverty with Black women having been five times more likely to live in poverty and to be on welfare, and three times more likely to be unemployed in comparison to White women (Roberts, 1997, p. 111). Thus, according to these statistics, Roberts concludes that any policy directed at women on welfare would disproportionately affect Black women, and that welfare programs have a greater direct impact on Black people as a whole, since a large portion of Black people are poor (Roberts, 1997, p. 111). Roberts points out that it is important to acknowledge that class distinctions are racialized, inevitably connecting race and class in the development of welfare policy and reform (Roberts, 1997, p. 111).

With the introduction of the reproductive technology the birth control pill, first emerging in the 1960s, the media promoted its usage as a revolutionary protective method for the sex lives of White college girls, while simultaneously as the '*social duty'* of the scapegoated Black 'welfare queen' (Ross & Solinger, 2017, p. 46). Class bias and racism characterized the birth control movement from the very beginning, as it became assumed that poor women, such as Black and immigrant women, were "morally obligated" to restrict their family size through the provision of birth control, whereas birth control was defined as a "right" for the privileged (Davis, 2003, p. 358). The welfare queen was and remains a rhetorical tool of politicians who seek to portray all single mothers as women of color who both take advantage of and depend upon public assistance (Ross & Solinger, 2017, p. 46). This tactical use of rhetoric is not just a racist and sexist mechanism of the past, but remains in use today by politicians who seek to appeal to a White electorate to maintain political and economic power (Ross & Solinger, 2017, p. 46).

In Robert's research published in her book *Killing the black body: Race, reproduction, and the meaning of liberty*, published in 1997, the data at the time displayed that the majority of families on welfare were not Black, but Black families disproportionately relied on welfare to support their children (Roberts, 1997, p. 111). In fact, Black women made up only 6% of the population at the time, and represented ⅓ of ADC recipients (Roberts, 1997, p. 111). Even though most people on welfare were not Black, many Americans came to associate welfare payments to single mothers with the '*mythical*' welfare queen, someone who "deliberately becomes pregnant in order to increase the amount of her monthly check" (Roberts, 1997, p. 111). The media and

politicians propagandized the ‘welfare queen’ to be affiliated with representation of laziness and an economic burden paired with images of Black mothers when publicly discussing or referencing public assistance (Roberts, 1997, p. 111). This has served to cement the link “between race and welfare” in “American’s minds (Roberts, 1997, p. 111).” Roberts additionally discusses the dog whistles such as the word “underclass” and its ties to ‘social pathologies’ such as “crime, drug addiction, violence, welfare dependency and illegitimacy” which can be further recognized as “depravities associated with Black culture (Roberts, 1997, p. 112).”

In 1978 the Department of Health, Education, and Welfare (HEW) issued rules that restricted sterilizations performed under programs that received federal funds (including Medicaid and ADC) (Roberts, 1997, p. 96). These rules included informed consent, thirty day waiting period requirements; the prohibition of hysterectomies performed for the purpose of sterilization, and put a ban on the use of federal funds to sterilize minors, the mentally incompetent, and the institutionalized persons (Roberts, 1997, p. 97). These regulations did not, however, prevent sterilization abuse as they lacked legislation to enforce these measures, such as criminal sanctions or even a monitoring mechanism (Roberts, 1997, p. 97). Additionally, there are currently no regulations preventing or deterring health care workers from coercing women of color to consent to sterilization in place of other methods of birth control (Roberts, 1997, p. 97). Within a year of these guidelines being implemented, the American Civil Liberties Union’s Reproductive Freedom Project discovered that 40% of teaching hospitals that they surveyed were not aware that new regulations or guidelines had been issued by HEW, while only 30% of the institutions were even trying to follow the new rules

(Davis, 2003, p. 364). With a lack of checks and balances to enforce policies aimed at protecting Black women from medical experimentation and abuse, our country's lack of progress, and overall regression in addressing disparities in health and medical mistreatment of Black people is a disturbing and unsurprising reality.

Black Women's bodies have been vehicles under social control by medical institutions, subjected to the surveillance of the state and federal governments for centuries. Both institutions have affirmed their *authority* in deciding who is and isn't a "legitimate mother," and more specifically who is legally allowed to make choices regarding herself as well as her children (Craven, 2010, p. 80). Black women, and other women of color, have been subjected to having their reproductive lives monitored, controlled, and structured to different extents by laws and policies intended to define the nonwhite status of themselves as well as their children (i.e. Bureau of Vital Statistics) (Solinger, 2005, p. 24). Black women and mothers have been the targets of this control at the intersection of race, class, and gender, demonized as "unfit" parents, hypersexualized, and dehumanized rhetorically by politicians and physicians alike and further portrayed in the media as the "welfare mother." I have hoped to construct in this portion of my research, an understanding of the ways in which the current healthcare system, and the policies related to women's bodies and reproduction, developed without accounting for the well-being and protection of choice for all mothers, specifically serving to ostracize poor women and women of color. Policies supported by physicians and politicians, such as the elimination of midwives, the promotion of negative eugenics, and the funding for mass sterilizations, each had the objective of promoting social and political initiatives serving to benefit persons in power, and to further uphold

White supremacy. With systems that exist on foundations that worked to exclude poor women and women of color from receiving adequate, non-discriminatory, and equal maternal and infant health care, without facing the risk of coercion or being subject to biases promoted against their ability to make decisions about their own bodies or children, the current trends of mass racial disparities in maternal and birth outcomes are reflected in this history that can not be unwritten, but must instead be retaught and acknowledged.

Final Literature Review: The Present Day Maternal Care Crisis in The United States

The rates of maternal and infant mortality in Southern Black communities that public health officials sought to curb in the late 19th century and throughout the 20th century, were never properly addressed via implemented methods, such as the elimination of midwives, the introduction of birth control and sterilization, the requirement of prenatal care, or the shift to hospital births. Largely ignored in each of these efforts were the implications of race and socioeconomic class, as those who were in charge sought to uphold the class distinctions serving to perpetuate White supremacy. Black mothers in Virginia, as well as throughout the South were historically stripped of their pillar of maternal health care, and further discriminated against and rhetorically scapegoated for the threat that their reproductive capacity posed in producing offspring deemed "unfit" and detrimental to society. By racistly charging the "excessive fertility of irresponsible females who persisted in having unwanted babies that cost the taxpayers too much," the detrimental impacts of poverty, that are often linked to race and class disparities, such as neighborhood and resource inequality, and the lack of access to quality health care, were severely overlooked (Ross & Solinger, 2017, p. 40). Today these same social ills exist, and continue to remain unaddressed. Black mothers are suffering disproportionately from inequalities in medical care, inequalities that are rooted in a history of racism and exclusion.

The ongoing maternal care crisis in the United States today is a threat to all mothers, yet Black mothers are disproportionately affected across all levels of maternal care. Annually in the United States, approximately 700 women die of complications that

are related to pregnancy and childbirth, and 50,000 women experience maternal morbidity as a result of labor and delivery (Maternity Care Desert Report, 2020). For over 60 years, Black mothers in the United States have been 3-4 times more likely to experience a maternal death in comparison to White mothers (Every Mother Counts, 2018). To put this statistic into perspective, a Black woman is 243 percent more likely to die from pregnancy or childbirth related causes (Montagne, 2017). Black mothers in the United States die at rates similar to those of women in lower income countries such as Brazil and Mexico, while the mortality rate for White mothers more closely resembles rates in more affluent European nations such as the United Kingdom and France (Roeder, 2019). High blood pressure and cardiovascular disease alone are two of the leading causes of maternal death, according to the Centers for Disease Control and Prevention, however hypertensive disorders, such as pre-eclampsia, have increased by 72 percent since 1993 (Villarosa, 2018). Pre-eclampsia and eclampsia (seizures that develop post pre-eclampsia) are 60% more severe, and common in Black women (Fingar et al., 2017). In a research study conducted by Tucker et al., the prevalence of pregnancy related mortality from 5 conditions (preeclampsia/eclampsia, postpartum hemorrhage, placenta previa or placental abruption) was analyzed between Black and White mothers to determine whether the difference in prevalence of the 5 complications could explain the disproportionate risk of maternal morbidity for Black mothers compared with White mothers. The study concluded that Black women did not have a higher prevalence of the 5 conditions; however Black women with these conditions were 2 to 3 times more likely to die from them than were White women, clearly

indicating the presence of the inequalities in care provided to Black women in comparison to White women (Tucker et al., 2007).

As argued by Dána-Ain Davis in her book chapter *Pregnancy and Prematurity in the Afterlife of Slavery*, the "suboptimal care that some Black women receive [today] may result from the legacy of the racist treatment during the antebellum period and in the afterlife of slavery (Davis, 2003, p. 89)." From researching and learning about the history of gynecology, the medicalization of birth, the development of infant and maternal care in the South, and the overall history of the exploitation, experimentation, and coercion faced by Black women, the linkage between this past and the disparities that exist for Black mothers today is hard to deny. Health Care in the United States is a system that developed based on a framework that excluded Black people from receiving equitable care and partaking in medical progress, and it has continued to exist as a system failing those it was not created to include. As documented in the article "Systemic Racism and U.S. Health Care" published in the Social Science and Medicine Journal, authors Joe Feagin and Sinobia Bennefield compiled decades of empirical research on the racial dimensions of the U.S. health care and public health institutions to illustrate the reality of the systemic racism that exists in healthcare and public health institutions today (Feagin & Bennefield, 2014). Feagin and Bennefield demonstrate that the culmination of generations of White imposed racism in health care, public health, employment, housing, and education, have greatly led to contemporary racial inequalities in health (Feagin & Bennefield, 2014).

Through the public health initiatives aimed at addressing Black maternal and infant health, such as the Sheppard Towner Act, or Planned Parenthood's the 'Negro

Project,' Black scholars have brought to light the ways in which these programs sought to perpetuate control over Black reproductive bodies as seen appropriate in the context of a sexist and racist society. This was achieved by limiting Black fertility through sterilization, policies, and practices, as well as through the rhetorical scapegoating of Black mothers and midwives as unfit, incapable, and ultimately at fault for poor maternal and birth outcomes. These programs failed Black mothers because they were not created with the intent of ever truly helping Black mothers, and the effects of the origins of these frameworks are glaring today. Dorothy Roberts emphasizes that there are "two primary inadequate analyses of racial disparities in health: equating race with socioeconomic status or equating race with genetics (Roberts, 2012 cited in Sigurdson et al., 2018)." Disparate care reflects the failure of the system, as health disparities for Black people transcend socioeconomic lines. To subscribe to the narrative that race, class, and genetics, are linked to a predisposition to poor health is to endorse the mindset that eugenicists promoted in the 20th century in order to justify the coercion and medical mistreatment of Black women and men through mass sterilizations.

Today, birth is unquestionably medicalized and perceived in the United States as a medical emergency instead of as a natural event. In the United States, 98.4% of mothers give birth in hospitals, .99% of mothers give birth at home, and .52% of mothers give birth in freestanding birth centers (MacDorman & Declercq, 2019). Medicalization of birth was historically promoted as necessary in order to achieve both better maternal and birth outcomes, however the movement towards physician-assisted hospital births excluded Black mothers, due to barriers such as segregation, transportation, and cost. In terms of pregnancy outcome, although infant mortality rates

have declined overall in the United States since the 19th century, the disparity between Black and White infant deaths today is actually greater than it was under antebellum slavery (Owens & Fett, 2019). Birth and maternal outcomes for Black mothers and their infants did not improve during the movement to hospital births in the 20th century, and the disparities in care have only remained and increased in the 21st century.

Not only are the majority of mothers giving birth in hospitals, but also the majority of hospital births are attended by physicians, with only 8.7 percent of births attended by certified nurse midwives (CNMS) or certified midwives (CMS) (MacDorman and Declercq, 2019). These statistics reflect the historical removal of midwives, and the impact that the restrictions placed on midwife-assisted births in the 19th and 20th century has on birthing options today. By relying on Fraser's book *African American Midwifery in the South*, I was able to develop an understanding of the medicalization of birth as a result of greed and exclusion, and less with the intent of improving birth outcomes for all mothers. With the medicalization of birth came the loss of birthing knowledge held by all lay African American midwives who had been assisting births for centuries, based on a model that focused on listening and catering to the well-being and comfort of mothers and their children. While hospitals today are desegregated, present day barriers exist preventing equitable maternal care for Black mothers and their infants, contributing to the continuation of historically ill-addressed racial disparities in maternal and infant care.

Changing Social Climate: New Civil Rights Movement

2020 has been the year of an awakening to the systemic racism that infiltrates and shapes the institutions in our country. After the murder of George Floyd, over 4,700

demonstrations ensued, with millions of participants, making these recent protests the largest mass protest movement in the country's history (Burch et al., 2021). Systemic racism in the United States has begun to gain larger public recognition, though there remains a long way to go in order to work towards a future for this country separate from the racist framework of the past. Not only has the media's focus on police brutality and the disparate deaths of Black people at the hands of police served to readjust the focus on the disparities faced by Black people in the United States, but the disproportionate impact of the COVID-19 Pandemic on Black people has drawn the attention to the inequities that have long gone unaddressed in the United State's health care system (COVID-19 Racial and Ethnic Health Disparities, 2020). Black people have suffered disproportionately from COVID-19 cases, hospitalizations, and deaths, and may face increased barriers to access testing (Pham et al., 2020; Corallo et al., 2020). People of color are also facing significant economic impacts due to the pandemic, reporting higher levels of not being able to afford food, housing, utilities and health care expenses due to COVID-19 (Pham et al., 2020; Corallo et al., 2020). As of 2020, The CDC has officially declared racism as a public health threat, and the CDC has acknowledged that racism deprives the "nation and the scientific and medical community of the full breadth of talent, expertise, and perspectives" that are necessary in order to "best address racial and ethnic health disparities (Racism and Health, 2020)."

America's Black maternal care crisis is finally becoming recognized in mainstream media, and targeted by new policies, with the Biden-Harris Administration championing legislature seeking to address the crisis. The majority of the pertinent

research articles that I relied on for this section of my thesis were published within the past 2-3 years. Data suggests that many factors, including the "higher prevalence of comorbidities and pregnancy complications, lower socioeconomic status, and less access to prenatal care" all contribute to but do not fully explain the elevated racial disparities in severe maternal morbidity and mortality for minority women (Howell, 2018). The maternal mortality crisis for Black mothers is one that exists due to a culmination of systemic structural failures, and it cannot be fixed without addressing every contributing layer. Progress, however, is not achieved all at once, but by first acknowledging the disease that is systemic racism, small and promising steps are being made in the right direction.

Structural Inequality contributing to Health Disparities

Maternity Care Deserts

Today, more than 2.2 million women of reproductive age live in maternity care deserts, classified as counties that do not have hospitals that provide obstetric care, birth centers, obstetricians, or certified nurse midwives (CNMs) (Maternity Care Desert Report, 2020). While the focus of maternity care deserts is often in rural areas, this is a phenomenon that occurs in urban areas as well, further disrupting continuity of care and creating barriers, such as transportation, to accessing prenatal and obstetric services to women residing in both rural and urban counties (Maternity Care Desert Report, 2020). The results of a nationwide county-level examination of data on maternal health services provided by local departments displayed that only 42% of examined

departments provided for prenatal services, with an observed net decrease of 33% in prenatal care services offered between the years of 1993 to 2005 (Gadson et al., 2017).

The closing of maternity care units in cities can further contribute to the exacerbation of racial disparities in communities (Maternity Care Desert Report, 2020). When hospitals close in urban areas, the remaining birth care facilities experience large surges in patient volume, placing additional pressure on an already stressed care setting (Lorch et al., 2014). The lack of proximity to a hospital impedes women's ability of choice in terms of the setting of their birth, and whether they want their birth to be assisted by a physician, midwife, or doula (Taylor et al., 2019). In 2004, 45% of rural counties had no hospitals with obstetric services, by 2014 this figure had increased to 54%, a decline that was associated the greatest with predominantly Black counties, in states with the strictest eligibility rules for Medicaid (Gallardo & Martin, 2017; Hung et al., 2017). Women living in these counties, with few hospitals providing obstetric care, few obstetrician-gynecologists, and a high proportion of women without health insurance, may suffer from limited access to appropriate, affordable, and timely prenatal, and postpartum care (Maternity Care Deserts, 2018).

Today rural areas have higher rates of chronic conditions that make pregnancy more challenging and higher rates of maternal and infant deaths, with rural Black communities in the southeast experiencing some of the poorest birth outcomes in comparison to the rest of the country (Gallardo & Martin, 2017). In a research study conducted by the University of Minnesota, obstetric services in 1,984 of the rural countries in America over a 10-year period were examined and found that hospitals are more likely to shut down their obstetric units in communities that have more Black

residents (Gallardo & Martin, 2017). In the past, few physicians wanted to practice in rural areas amongst populations unable to pay for their medical services, yet these same physicians proceeded to advocate for the phasing out of the lay African American midwife who provided services to poor rural women. In the early 20th century, Black people made up the majority of the rural population, living in conditions that were detrimental to their health (Smith, 1995, p. 88) Today, Black people make up 20% of all rural Americans, despite an association of "rural" with White farming communities (Gallardo & Martin, 2017). At the moment, given that access to hospitals offering obstetric services is still impeded greatly, significantly in mostly Black communities, and in states that have the strictest eligibility rules for Medicaid, it is almost like looking at a snapshot of the past.

Rural populations today are still facing the transportation barriers to available obstetrical and prenatal care, just as transportation acted as an obstacle to mothers seeking to use newly implemented health clinic services in the rural early 20th century South (Fraser, 1998, p. 34). Just as the discriminatory practices of segregation in the Jim Crow era South affected the health of Black Americans both in rural and urban areas, today the ramifications of this history play into the racial health disparities that are observed for people of color, who are more likely to experience lower quality of care and less likely to receive routine medical procedures even when controlling for insurance status, income, age, and severity of conditions (Taylor et al., 2020; Nelson et al., 2002). The Institute of Medicine released a report: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, stating that based on extensive research, even when access to healthcare is equivalent, racial and ethnic

minorities still experience a lower quality of health services due to differences at a care provider level (Nelson et al., 2002).

Product of Segregation: "Black-Serving" Hospitals

Seventy-four percent of Black women give birth at hospitals serving predominantly Black populations (Howell et al., 2016). The hospitals where Black mothers give birth are often the products of historical segregation, and are lower in quality than those where White mothers deliver, with higher severe maternal mortality rates (Howell et al., 2017; Creanga et al., 2014; Howell, 2016). The implications of structural racism results in inequalities in treatment, resources, and opportunities, which can be seen today in the geographical segregation of many American cities, that has persisted despite an increasing racial and ethnic population, leading to the continued "segregation" of hospitals by use (Williams & Emamdjomeh, 2018). Black women are more likely to live in segregated neighborhoods and the hospitals within these neighborhoods tend to be lower in quality, particularly in maternity care (Taylor et al., 2019). Specifically in urban settings, women of color have been shown to receive lower quality obstetric care while they are also more likely to deliver in a lower quality hospital (Taylor et al., 2019). Three out of four Black women give birth at low-quality hospitals, in which the risk of poor maternal and birth outcomes are the highest (Taylor et al., 2019). These hospitals are sometimes referred to as "Black-serving" hospitals (Waldman, 2017). Black-serving hospitals have higher rates of maternal complications, and have been found to have considerably higher rates of puerperal infection, obstetric embolism, and in-hospital mortality rates in comparison to either White or Hispanic-serving hospitals (Creanga et al., 2014). Dorothy Roberts emphasizes in her journal

article *Debating the cause of health disparities: Implications for bioethics and racial equality,* that the "geography of healthcare" stands as "evidence of racism", given that the government has "developed inadequate and inferior healthcare resources where Black people are concentrated (Roberts, 1997, p. 333)." Today, critically ill Black individuals are disproportionately cared for in Black-serving hospitals, which have shown significantly less improvement in comparison to non-minority-serving hospitals over the past 10 years (Danziger et al., 2020).

Racial Disparities in Infant Care

The United States' overall infant mortality rate is 71% higher than the comparable country average, such as in the United Kingdom and France, and the Black infant mortality rate in the United States is 110% higher than comparable country average, with a mortality rate for Black infants that is twice that of infants born to White mothers (Kamal et al., 2019; Villarosa, 2018). There has been clinically and statistically significant racial and ethnic variation found in the quality of care provided within and between neonatal intensive care units (NICUs) in the United States (Profit et al., 2017). NICUs are staffed and equipped in order to provide care to premature babies (born before 37 weeks of gestation), and newborn babies that are critically ill. Very low birth weight (VLBW) infants are treated in NICUs, so that they may be closely monitored and provided with immediate necessary care. Black mothers are up to 50% more likely to give birth prematurely in comparison to White mothers, and are 3 times more likely to have a low-birth weight baby (Low birth weight babies, 2017; Martin et al., 2019; Ratnasir et al., 2018). VLBW accounts for more than half of all neonatal deaths and 63% of the Black-White gap in infant mortality in the United States (Iyasu et

al., 1992). Black and Hispanic infants have been observed to receive inferior care in NICUs, and are more likely to receive care from poor quality NICUs (Profit et al., 2017; Howell et al., 2008; Morales et al., 2005).

Nurses are the primary care providers in NICUs, monitoring high-risk infants 24 hours a day, with each nurse averaging two or three infants at a time (Lake et al., 2015). VLBW infants born in high-Black concentration ("Black-serving") hospitals have higher rates of infection and nurse understaffing, attributing to higher 'risk-adjusted' VLBW infant mortality rates (Lake et al., 2015; Morales et al., 2005). A research study conducted by Lake et al. found that Black-serving hospitals have lower quality of care as measured by two nurse-sensitive quality standards in NICUs: infection and discharge home on breast milk (proven to strengthen infant's immune systems and enhance infant growth and health trajectories) (Lake et al., 2015). In conclusion, Lake et al. found that improvements in nursing resources in Black-serving hospitals improve outcomes for seven out of ten Black VLBW infants born in the United States (Lake et al., 2015). In another study conducted by Profit et al., hospital records for 18,616 VLBW infants in California were assessed to examine the effect of the quality of NICU care provided to VLBW infants on the persistence of racial and ethnic disparity in birth outcomes. In this study, Black infants were found to be born at significantly lower gestational ages, and Black and Hispanic infants were less likely to receive certain treatments in a timely manner, or any human breast milk after being discharged from the NICU (Profit et al., 2017) Additionally, both Black and Hispanic babies were found to be more likely to acquire a health-care associated infection (Profit et al., 2017).

Distrust of Health Care professionals

Implicit Biases Held by Health Care Professionals

When analyzing a history, where Black women and mothers have been subjected to reproductive abuse through coercive sterilizations and perpetrated as being under the control of the government, these findings on the current abuses that Black woman and mothers face can be seen as a devastating result of a history that has remained largely unaddressed and suppressed. In a study conducted by Vedam et al., a cross-sectional survey was used to assess the prevalence of mistreatment by race, socio-demographics, mode of birth, place of birth, and context of care, and concluded that mistreatment during birth is experienced more frequently by women of color, in hospitals, among those with social, economic, or health challenges (Vedem et al., 2019). This study surveyed a diverse group of 2,700 women who had recently given birth and found that the most common types of mistreatment reported during childbirth were as follows: being shouted at or scolded by a healthcare provider, health care providers ignoring women or refusing their request for help, and violations of privacy, such as being uncovered or having people in the delivery room without consent (Vedem et al., 2019; Measuring Mistreatment, 2019). This study further found that 17.3 percent of surveyed women reported one or more types of mistreatment, and that the percentages were higher for women of color (Measuring Mistreatment, 2019). In regards to mothers with low socioeconomic status, 27.2 percent of women of color reported mistreatment in comparison to 18.7 percent of White women (Measuring Mistreatment, 2019). Cases of mistreatment were linked to instances of unexpected interventions and situations in

which the families and providers had differences of opinion (Measuring Mistreatment, 2019).

Research has demonstrated that fifty percent of all providers practicing obstetrics and gynecology admit to having some bias (Maternity Care Desert, 2020; Cornwall, 2016). This statistic may arguably reflect the history of physicians in these fields dominating the birthing sphere during a time period of overt political and social segregation, further serving to structurally incorporate beliefs regarding which mothers are or are not worthy of respect in terms of race. Across all medical practices, Black Americans are systematically undertreated for pain in comparison to White Americans (Hoffman et al., 2016). Black patients are less likely to be given pain medication than White patients, and are significantly less likely than White patients to receive painkillers for extremity fractures in emergency rooms (Todd et al., 2000). In a study conducted by Hoffman et al. White laypeople, medical students, and residents, were found to hold false beliefs about biological differences between Black people and White people. This study demonstrated that that these beliefs predict racial bias in pain perception and treatment recommendation accuracy (Hoffman et al., 2016). The study took place at the University of Virginia in 2016, and sought to understand why Black patients receive inadequate treatment for pain, both in comparison to White patients and relative to World Health Organization guidelines (Villarosa, 2018; Hoffman et al., 2016). The study found that many White medical students falsely believed that Black people have less-sensitive nerve endings than White people, that Black people's blood coagulates faster, and that Black people have thicker skin than White people (Villarosa, 2018; Hoffman et al., 2016). Researchers in this study blamed the deeply ingrained

unconscious stereotypes about people of color instead of individual prejudice, stating that physicians struggle to empathize with patients who have different lived experiences from their own (Villarosa, 2018; Hoffman et al., 2016). The racist assumption and belief that Black people do not feel pain is an idea that has long survived the time period of antebellum slavery, as prescribed to and promulgated by 19th century physicians such J. Marion Sims, and has infiltrated medical institutions and contributed to biases that medical professional's have with or without knowing of their origin.

Poor Relationships with Medical Professionals

In the report *Battling over birth: Black women & the maternal health care crisis in California*, the Black Women Birthing Justice (BWBJ) researchers geared their research efforts towards focusing on Black women's birthing experiences and stories instead of relying on data from birth certificates or medical records (Oparah et al., 2018). Through this qualitative research method, the report sought to fill in the gaps in public health and medical literature that tends to focus more so on the poor outcomes for Black women and their babies, instead of seeking to situate Black women's experiences and stories by a means of action to improve the health outcomes among Black women in health care systems. The BWBJ researchers recorded narratives and collected questionnaires from 100 Black women who had given birth in California with a child aged 5 or younger (Oparah et al., 2018). Medical practitioners, birthworkers, advocates, and experts were consulted as well. The major findings in this research project included the discovery of many human rights violations and several accounts of inadequate care experienced by Black women. These findings included but were not limited to the discovery of practices and attitudes that led to conflict between medical

staff and Black pregnant women, considerable barriers to accessing prenatal, doula, or midwifery care, and unnecessary and unwanted medical interventions faced by Black women (Oparah et al., 2018).

In a section of the report titled “Relationships with Maternal Health Care Providers", Oparah et al. outlined characteristics of both positive and negative relationships with health care providers as described by Black mothers. The study determined that relationships between pregnant Black mothers and their health care providers were often a source of stress and anger (Oparah et al., 2018, p. 56). Most participants in the study described these relationships as “stressful,” and “coercive”, and further expressed concern that medical staff ignored their values and beliefs by excluding them from decision making (Oparah et al., 2018, p. 57). Positive relationships were defined as those in which providers and caregivers paid “attention to the pregnant individuals’ emotional and psychological needs, respected the pregnant individuals’ values, beliefs, and choices (such as respecting the mother’s birth plan), and competency and effectiveness (Oparah et al., 2018, p. 57).” Negative relationships were defined as those that existed between medical staff and the study’s participants that were “characterized by conflict, coercion, and stereotyping (Oparah et al., 2018, p. 62).” Black mothers have been stereotyped and exploited through the dog whistle “welfare queen,” which has interconnected the image of Black women with poverty and laziness following suit from the older racist narrative pushed by eugenicists that genetics and race are intertwined, placing Black people as biologically inferior. These racist ideologies have contributed to biases held by healthcare workers and their perceptions

of Black mothers as having a higher pain tolerance, and not being "fit" to be mothers, nor qualified to interpret their own bodies and health danger-signs.

In 2018, New York Times journalist Linda Villarosa published the story "Why America's Black Mothers and Babies are in a Life-or-Death Crisis," centered on the personal experience of a pregnant Black mother, Simone Landrum. Landrum was experiencing crippling headaches, "shocking" pain, and swelling that forced her to quit her job. Her doctor prescribed her Tylenol, and when her symptoms persisted, he suggested for her to up her Tylenol dosage. Landrum's physical symptoms and pain intensified, and her high-blood pressure readings were ignored and left unexplained in terms of the potential detrimental risk factors of high-blood pressure that are associated with pregnancy (such as pre-eclampsia) (Villarosa, 2018). Landrum's untreated and ignored physiological condition and high blood pressure later resulted in her placenta separating from her uterine wall, nearly taking her life, and tragically taking the life of her baby girl (Villarosa, 2018). Landrum's story, and many others like it, exist in multitudes across our country today, afflicting Black mothers of every socioeconomic status, and background. World-renowned tennis champion, Serena Williams, experienced the dismissal of her symptoms of a pulmonary embolism, nearly costing her life, and Beyoncé has publicly discussed her experience of preeclampsia with the birth of her twins. The dismissal of Black mothers' pain as well as their voiced concerns about their bodies and symptoms is a form of medical mistreatment informed by physician bias, that transcends socioeconomic lines and status, placing all Black mothers and their children at risk of losing their lives.

Oparah et al. identified four sets of practices and attitudes that led to conflicts between health care providers and pregnant Black mothers which are listed as the "refusal to listen to women's wisdom about their bodies; not respecting women's boundaries or bodily autonomy, stereotyping based on race, class, age, and marital status; and suppressing advocacy and self-advocacy (Oparah et al., 2018, p. 62)." While 31 percent of participants attended by a physician/nurse team reported feeling disempowered or very disempowered, only 8 percent of participants attended by a physician/midwife team felt the same way, and 0 percent of those attended by a midwife/doula team reported feeling at all disempowered (Oparah et al., 2018, p. 70). In more than 200 stories collected from Black mothers by Propublica and NPR, the feeling of being devalued and disrespected by medical providers remained a constant theme (Montagne, 2017). A common occurrence in these stories was interactions with medical providers who equated being Black with being poor, uneducated, noncompliant, and unworthy (Montagne, 2017). One mother stated, "the nursing culture is White, middle-class and female, so it's largely built around that identity. Anything that doesn't fit that identity is suspect (Montagne, 2017)." Not only are Black mothers subject to discrimination on the account of implicit biases held against them by their health care providers, Black mothers are still being blamed for their poor maternal and birth outcomes.

The USA Today article "Hospitals blame moms when childbirth goes wrong. Secret data suggests it's not that simple", covers the investigation of a Hospital where many mothers have lost their lives, or have become victims of severe morbidity on the account of delayed care, misdiagnoses, and a failure to follow safety measures (Kelly et

al., 2020). In response, the "Black-serving" hospital blamed the "life-style diseases, the high cost of health care, delaying or non-compliance with medical treatment, limited care coordination, poor health, high rates of poverty and high rates of morbidity," for their high rates of morbidity and mortality, instead of evaluating their care practices (Kelly et al., 2020). The founding co-director for the Black Mamas Matter Alliance, a Black-women led advocacy group, Elizabeth Dawes Gay asserts that "(hospitals) also have to be willing to change, to look at their practices, their policies, their providers and ask" Where are we failing women? (Kelly et al., 2020)." Blaming mothers, especially Black mothers, for their health and birth outcomes, has been a trend in medical history dating back to when J. Marion Sims blamed enslaved women for their living conditions that predisposed them to infection following childbirth. It is a lazy prescription, provided by physicians who refuse to take accountability for their contributions to a broken system that has not been built to serve all mothers equally. When physicians are not aware of their implicit biases, or their historical origins, when treating women of color, they are not able to provide equitable care. Black mothers have voiced their experiences of discrimination and ignored pain when receiving obstetrical care. They should not have to completely bear the weight of advocating for themselves to an institution of people who have not tried to educate themselves on the history of the mistreatment and abuse of Black people's bodies in our country.

Public Health Threat: Racism causing Adverse Health Effects for Black Mothers

The idea of "stress," in terms of "overwork and anxiety," has long been postulated to be a predisposing factor to infant and maternal mortality, an idea

hypothesized early on by Frances Bradley, a physician who spearheaded the Children's Bureau's rural public health service in 1924 (Fraser, 1998, p. 130). Dorothy Roberts reflects on the story published in the Boston Globe in 1972 that documented White doctors treating Black women "callously" further adding to their anguish and stress, while pressuring them into signing consent forms for experimental sterilization procedures (whilst forging medical records to reflect a different surgery instead of the performed *unnecessary* hysterectomy) (Roberts, 1997, p. 91). This form of deceitful coercion, for "training purposes" at Boston City Hospital, is a *recent* history that has been replicated to some extent across the country, from New York City to Los Angeles, and has served to further heighten the mistrust that Black people have for their White physicians, further increasing stress in a setting *intended* to provide treatment and care (Roberts, 1997, p. 91). Racism has officially become, in the 21st century, more of an accepted and explored cause for racial disparities in health in terms of the physiological impact of racism as a stressor. Racism is a chronic stressor that has been proven to directly affect the health of pregnant women and their children (Mustillo et al., 2004).

As analyzed by Dorothy Roberts in her journal article *Debating the cause of health disparities: Implications for bioethics and racial equality*, current research has identified chronic exposure to stress, segregation in unhealthy neighborhoods, and the transmission of harms from one generation to the next through the "fetal environment" as the main forms of racial discrimination that contribute to the adverse health effects experienced by Black people today (Roberts, 2012, p. 334). As racism plays into poverty, unemployment, and other social factors that increase the experience of stress,

these are additional layers that must be addressed hand in hand with health care reform in order to effectively work towards eliminating current disparities.

Exposure to discrimination across Black women's life spans has been identified as having the effect of "weathering," serving to increase their allostatic load and physiologically compromising their health and pregnancies (Backes et al., 2020, Lu & Halfon, 2003). Allostatic load is the cumulative long-term effect of continued exposure to chronic stress on the body. In an investigation completed by the New York Times, thousands of documented cases of pregnant women suffering from miscarriages and premature labor following the denial of accommodations in the workplace, specifically in positions requiring manual labor, have been documented in public records (Taylor et al., 2019). Black women have been disproportionately affected by this type of discrimination, due to biases held by employers fed by the racist stereotypes that Black women have a higher tolerance for pain and a higher capacity for physical labor (Taylor et al., 2019). As encompassed in the Reproductive Justice Framework, no pregnant individual should be forced to decide between their livelihood and a healthy pregnancy (Taylor et al., 2019; Ross & Solinger, 2017, p. 9). Paradoxically, pregnancy outcomes worsen with increasing class status and education for women of color as upward mobility is associated with increased exposure to acute and chronic discrimination (Riggan et al., 2020). The long-term physiological toll of racism predisposes Black women to having a higher risk for a range of medical conditions that put their lives, as well as the lives of their infants, at risk. These conditions include preeclampsia (pregnancy-related high blood pressure), eclampsia (a complication of preeclampsia

characterized by seizures), embolisms (blood clots) and mental health conditions (Taylor et al., 2019).

An association has been made between Black women's exposure to chronic stress from intrapersonal racism and an increase in risk for hypertension, which is detrimental to infants' birth weight (Stancil et al., 2000). Increased stress levels lead to a constriction of blood flow to the placenta, limiting fetal growth, and increasing the risk of premature delivery (When the Bough Breaks, 2008). Additionally, certain stress hormones can trigger labor at high concentrations, or lead to serious inflammation inside the uterus that could lead to premature labor (When the Bough Breaks, 2008). The lifelong accumulated experiences of racial discrimination constitute an independent risk factor for preterm delivery and VLBW risk (Collins, 2004). In a disturbing assessment, the 2008 documentary "When the Bough Breaks" presents data displaying when African women immigrate to the U.S. it takes only one generation before their daughters are at risk of having premature babies at a significantly higher rate and with poorer birth outcomes, indicating that the "social milieu that [Black] women living in the United States" experience causes the disparities in birth outcomes that are so prominent today (When the Bough Breaks, 2008).

A major source of stress reported by women of color is the interactions that they have with the health care system and medical personnel (Riggan et al., 2020). In a journal review titled "Acknowledging and addressing allostatic load in pregnancy care," Riggan et al. systematically reviewed a plethora of current research studies and compiled the data findings showing that today "Black women are more likely to have an inappropriate hysterectomy for uterine fibroids," more likely to report that their

providers “frequently used language or tone that suggest a devaluation of Black reproduction”, and to be seen by providers that were “less likely to comply with birth plans or solicit consent to initiate cesarean births (Riggan et al., 2020).” The findings of this study glaringly display the direct impact that systemic racism in the obstetric field has on Black mothers, as their treatment today directly mirrors their treatment in the past, at the hands of a segregated system that developed by devaluing Black mothers and their fertility and by suppressing their voices and further providing them with wholly inequitable care. While sterilization laws have been abolished, Black women remain more likely to receive unnecessary hysterectomies, rendering them sterile, for a diagnosis that has other options (uterine fibroids). Between the years 2006 and 2010, the Center for Investigative Reporting reported that 148 pregnant women were sterilized following birth while incarcerated in two California prisons (Jindia, 2020). The majority of these women were Black and Latina, and the staff targeted women found *likely* to be incarcerated again (Jindia, 2020). During the CIR investigation, it was found that California used state funds to surpass the federal law prohibiting the use of federal funds to pay for sterilization procedures, to pay doctors $150,000 to sterilize women, an amount that represented, as one doctor put it, “what you would save on welfare (Jindia, 2020).”

Additionally, the present day rhetoric utilized by hospital staff, and care providers, devaluing Black women’s reproduction, originates from rhetoric utilized by eugenicists that sought to suppress Black fertility. This same rhetoric was utilized by racist politicians and physicians to promote the belief that the fertility of Black people was escalating welfare costs, overcrowding urban schools, and increasing rates of

crime, in order to gain support and promote welfare policy that incentivized government funded sterilizations of the scapegoated "welfare queen," an undeniably racialized dog whistle, intended to be associated with Black women and mothers (Roberts, 1997, p. 111). The image of the 'welfare queen' has survived the end of sterilization policies, and remains an integral component of appealing to a White electorate in order to maintain political and economic power (Ross & Solinger, 2017, p. 46). Language and tone suggesting the devaluation of Black reproduction is a product of systemic racism in maternal care that, left unaddressed and misunderstood by healthcare professionals, will continue to exist just as it has survived from the 20th century to today, and continue to contribute to the disparities in the quality of care for Black mothers and their infants.

Sigurdson et al. conducted a qualitative study of minority family and clinician accounts in order to assess disparities in NICU care, and further identified three types of suboptimal care faced by minority families - neglectful care, judgmental care, and systemic barriers to care (Sigurdson et al., 2018). In this study, 26% of accounts described or referenced NICU staff overtly or subtly judging families "moral status," circumstances, or behaviors based on their race/ethnicity, socioeconomic status, or history of drug use (Singurdson et al., 2018). Other narrative accounts detailed the NICU staff using "offensive language reflecting racially or otherwise biased attitudes," through "mak[ing] fun of Black sounding names," and describing single Black mothers as having "made her bed" and using the racially charged term "baby daddy" in reference to fathers of the Black infants (Sigurdson et al., 2018).

Interviewed families expressed that "biased attitudes and offensive language" resulted in them spending less time with their babies in the NICU or engaging less

frequently with NICU clinicians given a "lack of trust and rapport" with clinicians (Sigurdson et al., 2018). Several other accounts noted that Black families were assumed to be "violent, difficult, or at fault for their life circumstances (Sigurdson et al., 2018)." Just as the families interviewed for Sigurdson et al.'s study were deterred from interacting with NICU clinicians due to outward forms of discrimination and bias, experiences of racism and bias held by health care providers has also been associated with a delay in prenatal care (Gadson et al., 2017).

In the responses to the 2013 Listening to Mothers III survey, a national survey of women's maternity experiences in the United States revealed that 40% of participants reported communication issues in prenatal care, and 24% perceived discrimination during birth hospitalization (Gadson et al., 2017). Black or Hispanic race/ethnicity was correlated with nearly three times higher odds of discrimination on the basis of race, language, or culture, with uninsured women facing nearly twice the odds of experiencing perceived discrimination on the account of race-based and insurance-based discrimination (Gadson et al., 2017). Hypertension and diabetes were also associated with higher odds of experiencing perceived discrimination in prenatal or obstetric care, with Black and Hispanic Women suffering from these medical conditions at disproportionately higher rates in comparison to White women (Anttanasio & Kozhimannil, 2016; Gadson et al., 2017; Tanaka et al., 2007; Tucker et al., 2007).

Disparities in Mental Health Care

Black women are half as likely to receive mental health treatment and counseling as White women (Taylor et al.. 2019). Maternal depression has been linked to risk factors for maternal mortality and morbidity, including hypertension,

preeclampsia, and gestational diabetes (Talyor et al., 2019). Mood disorders such as maternal depression are common amongst new mothers, particularly women of color, who have faced multiple stressors over their lifetime, including racism (Taylor et al., 2019). Black mothers and Hispanic mothers who experience maternal depression have higher rates of adverse health outcomes in comparison to White mothers (Taylor et al., 2019; Taylor & Gamble, 2017). While Black mothers experience disparate health effects in comparison to their White counterparts from poor mental health, women of color are least likely to have access to mental health care during pregnancy or during the postpartum period (Taylor et al., 2019; Taylor & Gamble, 2017). Barriers to accessing mental health care for women of color include affordability (such as limited in-network providers), availability of culturally sensitive care, and geographic disparities in access to mental health services (Taylor et al., 2019). Multiple studies have concurred that Black people in the United States have the highest rate of morbidity and mortality as a result of living in poverty and from encountering stress, sexism, and racism in interactions within health care systems (Basu, 2009, Steven-Watkins et al. 2014). Further, it has been concluded in multiple studies that Black women experience more physiological and psychological stress and poor health status than do women from all other racial groups (Gibbons et al., 2014; Jagannathan et al., 2010; Maddox, 2013). This finding can be further attributed to women of color experiencing the combined impact of gender discrimination as well as sexism, sexual harassment, and race related discrimination, leading to Black women experiencing the highest documented allostatic load scores ("wear and tear on the body") (Riggan et al., 2020).

Disparate Impacts Related to the Lack of Representation of Black Health Care Workers

Black Health Care Workers: An Absence in Representation Due to a History of Exclusion

The implications of Black health care workers being historically excluded from the field of obstetrics, and legally banned from practicing traditional lay midwifery, are apparent in the lack of representation of Black health care workers in the field today. By forcing lay African American Midwives out of the healthcare sphere, the roles that they filled failed to be replaced with an easily accessible or considerate alternative for the women they served in the 20th century and the effects of phasing out the midwife are still largely apparent today (Fraser, 1998, p. 51). The personal narratives and history of African American midwives, as well as the records of their practices, in Virginia, and throughout the vernacular South have been largely unaccounted for, leaving large gaps in history, and contributing to the irreplaceable loss of natural birthing knowledge in the Black community.

Currently, less than 10% of births in the United States are attended by midwives, compared to other affluent countries, such as Great Britain, where midwives attend more than half of all births (Martin, 2018). In fact, in most other countries midwives largely outnumber obstetrician-gynecologists (OB-GYNS), compared to in the United States where OB-GYNS are overrepresented relative to midwives, with an overall shortage in maternity care providers relative to births (Tikkanen, 2020). Additionally, 45.6% of the people who use midwives in the United-States identify as non-White, whereas only 12% of all practicing midwives identify as non-White (Kennedy et al.,

2006). Midwives of color represent only 5-6% of the American College of Nurse Midwives (ACNM), compared to 3% in 1981 (ACNM's Outstanding 2018 Award Winners, 2018). For a 2014 dissertation by Keisha L. Goode at NYU, 22 Black midwives were interviewed about their experiences in the field. All echoed sentiments of feeling silenced, unheard, and disrespected (Mulder, 2018). In a similar vein, six midwives of the Midwives Alliance of North America 2012 Women of Color Section resigned due to experiences of institutional racism (Goode, 2014). Today, only 5% of practicing physicians in the United States are Black (AAMC). And only 2% of physicians are Black female identifying (Roy, 2020).

Historically, as I have learned through my research discussed in previous sections, Black female-identifying health care workers, particularly Black nurses and Black lay midwives, were phased out and prevented from practice. The ramifications of this are clear in the lack of representation of practicing Black female physicians, nurses, and midwives today, further exemplifying the ways that the health care system is not capable of serving the people that it wasn't built to include. A 2014 research study conducted by Xue and Brewer examining the racial and ethnic diversity profile of the nurse workforce by geographic region revealed that in general, states with the highest proportion of Black and Hispanic people also had the greatest underrepresentation of these respective groups in the state's nurse workforce (Xue & Brewer, 2014). Further, Xue and Brewer determined that the top 10 states (Mississippi, District of Columbia, Louisiana, South Carolina, Maryland, Delaware, Virginia, Alabama, North Carolina, and Tennessee) with the largest gap in "Black nurse representation" were in the South (Xue & Brewer, 2014). In the early 20th century, in Southern States with a majority

Black population, Black nurses faced great opposition to being hired for positions in public health departments, and while I can not comment completely on correlation, I want to make a point, and argue, that the trends that are observable today in the underrepresentation of Black nurses have probable origin once contextualized in history.

Donald Alcendor, a professor at a historically Black Medical college stated "There simply are not enough doctors who look like the patients in the underserved communities. And this systemic distrust [these] communities have for the medical system is something that is long-standing and has at least a chance of being overcome with Black doctors' presence to create a better patient-doctor relationship (Bunn, 2020)." The 2020 research study “physician-patient racial concordance and disparities in birthing mortality for newborns" conducted by Greenwood et al. found that the newborn-physician racial concordance is associated with a significant improvement in mortality for Black infants when analyzing 1.8 million hospital births in Florida between 1992 and 2015 (Greenwood et al., 2020). In other words, the study found that Black newborns are more likely to survive if they are cared for by Black doctors, but are three times more likely to die when looked over by White doctors (Greenwood et al., 2020). In a CNN article showcasing this study with the alarming headline “Black Newborns More Likely to Die When Looked After by White Doctors,” the study’s key findings are suggested to reflect that Black physicians outperform their White colleagues when caring for Black newborns (Picheta, 2020). While the researchers do not draw conclusions to the existence of the trend, they do believe that these results should provide “warrant for hospitals and other care organizations to invest in efforts to

reduce such biases and explore their connection to institutional racism (Greenwood et al., 2020)."

Midwives are seen by some providers and legislators as crucial factors in extending and increasing access to obstetric providers in underserved communities and in addressing the existing inequities in birth outcomes (Masters, 2021). The Lancet Series on Midwifery completed a series of four papers assessing systematic reviews on women's views, experiences, effective practices, and maternal and newborn care providers, to identify the impact of midwifery care on the quality of care provided to childbearing women and children. The project's researchers concluded that educated, trained, licensed, and regulated midwives led to better maternal health outcomes (Renfrew et al., 2014). The Lancet Series on Midwifery further concluded "national investment in midwives and in their work environment, regulation, and management, is crucial to the achievement of national and international goals and targets in reproductive, maternal, newborn, and child health (Hoope-Bender P et al., 2014)."

Black mothers are 40% more likely to undergo a cesarean section (C-section), a birthing intervention that is associated with higher rates of both maternal mortality and severe maternal morbidity (Villarosa, 2018). C-sections put women more at risk for premature births, increased neonatal intensive care admissions, infections and blood clots (Ross & Solinger, 2017, p. 190). Additionally, the rate of sudden infant death syndrome (SIDS), one of the leading causes of infant mortality in the United States, is nearly double as high for Black infants in comparison to that of White infants (Taylor et al., 2019). Breastfeeding has been linked to reducing the risk for SIDS, as well as for other infections and chronic conditions suffered by infants (Taylor et al., 2019). Large

disparities exist in breastfeeding rates between Black and White infants, which can be attributed to Black women's earlier returns to work and a lack of access to breastfeeding support and information from professional health care providers (Anstey et al., 2017). The CDC conducted a study revealing that hospitals serving areas with higher percentages of Black residents were less likely to provide new mothers with adequate breastfeeding information or support (Lind et al., 2014).

In a study completed by Vedam et al., "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes," the integration of midwives by state density for all 50 states was utilized in order to assess the correlation between increased or decreased integration and maternal and infant outcomes by state. In conclusion the study determined that states that have a higher density and integration of practicing midwives in their health care systems have associated higher rates of spontaneous vaginal births and lower rates of obstetric interventions (Vedam et al., 2018). These findings are especially significant when considering the increased costs that are associated with cesarean sections, and preterm births, and the ability that midwives have in potentially providing *safer* births, with less medical interventions, for a *lower* cost (Vedam et al., 2018). Additionally, in states where midwives of all types (i.e. CNMS and CPMS) are regulated and integrated into health care systems in both home and hospital births, the best outcomes for mothers and their babies were observed with lower rates of preterm births, low birth weight infants, and neonatal deaths (Vedam et al., 2018). This study additionally concluded that in communities where access to any maternity provider is limited, midwifery care has the potential to serve as an important part of the solution, as increased reliance on midwives has been researched to have the

ability to "reduce the costly overuse of obstetric interventions, reduce rates of preterm birth and neonatal loss, and improve breastfeeding and vaginal birth rates, thereby helping to address serious maternal-newborn health deficits in the United States (Vedam et al., 2018)."

Vedam et al.'s study additionally analyzed disparities in neonatal mortality by race, and found that there was a correlation between a lower rate of race-specific neonatal mortality in states where midwives were more highly integrated (Vedam et al., 2018). When completing race-specific analysis of birth outcomes, the researchers in this study determined that in most states where Black women gave birth, they did not have access to midwives who were well integrated into the system and additionally reported the highest rates of neonatal mortality (Vedem et al., 2018). This study additionally found that there was a correlation between a lower rate of race-specific neonatal mortality in states where midwives were more highly integrated (Vedam et al., 2018). When completing race-specific analysis of birth outcomes, the researchers in this study determined that in most states where Black mothers gave birth, they did not have access to midwives who were well integrated into the system and additionally reported the highest rates of neonatal mortality (Vedem et al., 2018).

Global health experts recommend increasing midwifery services in order to improve maternal and newborn outcomes and reduce rates of unnecessary interventions (Vedam et al., 2018). It has been estimated that up to 50 percent of all maternal deaths are preventable, given focused improvements specifically at the provider level (Howell & Zeitlin, 2017). Skilled midwives are capable of assisting mothers to assess their birth site options and to aid them in finding appropriate resources, however a midwives'

abilities are limited by legislation that restricts the midwife's practice in many parts of the United States (Vedam et al., 2018). Cost is another major barrier for poor people in accessing in-home midwife-assisted hospital births given that Medicaid only covers home births in a select number of states (Scheier, 2020). Bureaucratic requirements and restrictions similarly repress midwives' ability to practice, such as those that initially pushed midwives out of legal practice, making it difficult for most midwives to accept Medicaid (Scheier, 2020). Today a quarter of the United States does not offer midwife licenses, making the practice of home birth illegal (Sheier, 2020).

Hannah Yoder and Lynda R. Hardy conducted a systematic review on Black women's experiences with prenatal care, including analysis of the role of midwives in providing prenatal care for Black women, in order to further understand Black women's views of midwifery to further curate and propose prenatal care options that may serve to facilitate improved outcomes for Black women and their children (Yoder & Hardy, 2018). In the year 2014, the percentage of Black women who used midwives only made up 12 percent of the total number of CNM/ CM-attended live births in the United States (Yoder & Hardy, 2018). As of 2018, the percentage of Black women using midwives decreased to 8.4% (Maternity Care Desert, 2020). Yoder and Hardy concluded that midwifery has the potential to be a good method of care to offer Black women, however there is not enough research currently available on Black women's opinions or desirability for this health care option (Yoder & Hardy, 2018). Through Yoder and Hardy's collective examination of existing literature, they further concluded that midwifery offers the ability to address the lower prenatal care rates that Black women experience, as it is favorably looked upon, connected to good maternal and birth

outcomes, and serves to better accommodate Black women's qualitatively assessed desires for prenatal care, described as providing for an "attentive health care provider, continuity of care," and being "woman empowering (Yoder & Hardy, 2018)." Black women receiving prenatal care by midwives were less likely to deliver preterm or have a C-section, and received more encouragement to engage in healthy behaviors during their pregnancies, have increased breastfeeding rates, and observe more adequate weight gain for infants (Yoder & Hardy, 2018). Mothers who have reported receiving 'sufficient' health behavior advice during prenatal care are at a lower risk of delivering a low birth weight infant, while mothers who received 'insufficient' health behavior advice have been found to be at higher risk of delivering low birth weight infants (Lu et al., 2010; Kogan et al., 1994). Black mothers were found to be significantly less likely than White mothers to be informed by prenatal healthcare providers on advice relating to health behaviors during their pregnancy, specifically in regards to smoking cessation and alcohol use (Kogan et al., 1994).

Barriers to Adequate Prenatal and Postpartum Maternal Care

Prenatal Care

Prenatal care is associated with an absence of high-risk pregnancy for Black and White mothers, as well as with a reduced risk for preterm birth (Vintzileos et al., 2002). Barriers to prenatal care include but are not limited to access to health insurance and relationships with medical practitioners, amongst other socioeconomic factors. Through the qualitative approach of group discussion amongst Black women who either did or did not receive early prenatal care in the first trimester, Daniels et al. determined

that factors that inhibit low-income Black women from seeking prenatal care include unsatisfying clinical experiences, lack of specific social support, clinical staff insensitivity, and stress. While Daniel's research focused on low income Black women, in a study conducted by Williams et al. it was concluded that at equal levels of socioeconomic status, insurance coverage, and healthcare access, Black Americans receive lower quality medical care than White Americans (Williams et al., 2009). Socioeconomic status has been found to only account for 21.4 % of the racial gap in low birth weight and 19% in preterm birth (Lhila & Long, 2011). Black mothers with a college education are at a 60 percent greater risk for a maternal death than a White or Hispanic mother with less than a high school education (Declercq and Zephyrin, 2020). Oparah et al. differentiates between the barriers that prevent Black women from receiving adequate health care by prescribing lack of health insurance as a barrier to "accessing" prenatal care and poor relationships with medical practitioners as a "significant barrier to persisting with prenatal care (Oparah et al., 2018)." As of 2020, 77.3 percent of White women and 81.1 percent of Asian women entered prenatal care in the first trimester in comparison to only 66.6 percent of Black women and 72.3 percent of Hispanic women (Backes et al., 2020). While 95 percent of Black women access prenatal care at some point in their pregnancy, Black women who receive prenatal care still experience a disproportionate rate of poor birth outcomes such as preterm birth and low birth weight indicating differences attributed to the quality of prenatal care (Lu et al., 2010). Black mothers disproportionately receive inadequate prenatal care in comparison to their non-White counter parts as demonstrated by research conducted by Creanga et al., Gadson et al., and Daniels et al.

Health Insurance

The Affordable Care Act (ACA) served to expand access to health insurance to 7.7 million previously uninsured women in the United State (HHS, 2015). Access to health insurance is critical in order to provide more women with the prenatal and postnatal care needed to identify health risks, prevent future birthing complications, and potentially lower the incidence of preterm births and infants born with VLBW (Taylor et al. 2019). The ACA worked to expand "presumptive eligibility," which allowed women to access care in a more timely manner as needed (Taylor et al., 2019). While the ACA expanded Medicaid eligibility, following a Supreme Court ruling, provisions made by the ACA, including Medicaid expansion, were made optional for state governments (Taylor et al., 2019). To date, only 38 states and the District of Columbia have adopted this Medicaid expansion, with 12 states, mostly clustered in the vernacular South, having not adopted Medicaid expansion (KFF, 2021). For states that adopted Medicaid expansion, those who qualify for Medicaid are entitled to coverage of 10 essential health benefits, including contraception, maternity care, newborn care, and pediatric services as well as for maternity benefits such as prenatal visits, screenings, and breastfeeding supports, which are required to be provided with no cost sharing (Taylor et al., 2019).

In research conducted by Oparah et al., 9% of the 100 Black mothers who participated in their qualitative study *Battling over birth* reported that they did not have health insurance that covered their prenatal care and childbirth, with 2% of the women reporting that their health coverage was inadequate or terminated during their pregnancy (Oparah et al., 29). Evidence shows that people with health insurance are

more likely to receive routine check ups in comparison to those without, allowing for preventative care, routing screenings and management of chronic conditions (National Partnership for Women and Families, 2019). Black women have higher rates of multiple preventable diseases and chronic health conditions, including diabetes, hypertension, and cardiovascular disease compared to White women (National Partnership for Women and Families, 2019). The American Journal of Public Health presented research that displays that states that have adopted the expansion of Medicaid saw infant mortality rates decline, with the greatest decline among Black infants (Taylor et al., 2019). Data released by the U.S. The Census Bureau shows that despite health insurance gains for women since the ACA, pervasive coverage disparities remain for Black women (National Partnership for Women and Families, 2019). Asian and White women are more likely than Black, Hispanic, American Indian and Alaska Native (AIAN) women to have private insurance to cover their births (Backes et al., 2020). Not only do people of color have more limited access to private insurance but people of color also have lower incomes in comparison to their White counterparts (Pham, 2020). Women of color are more likely to be covered by Medicaid, which covers almost half of all births in the United States, thus this program is seen as essential to addressing racial disparities in maternal and infant mortality (Taylor et al., 2019).

In a study conducted by Taylor et al. assessing the data of 9,613 women with deliveries at 6 hospitals in North Carolina, women with Medicaid or no insurance at delivery were found to be less likely to use preventative care and more likely to use emergency care (ED) in comparison to women with commercial insurance, with Black women using ED at a much higher rate for pregnancy visits (Taylor et al., 2020).

Additionally, Taylor et al. asserted that as assessed by previous research, women with Medicaid were more likely to enter prenatal care late (Taylor et al., 2020). Clapp et al. analyzed self-reported insurance status claims in relation to the initiation of prenatal care and birth outcomes and found that out of 181,675 women interviewed from 32 states that women who were uninsured prior to conception had a 20% higher risk of preterm birth than insured women (Clapp et al., 2019). While women covered by private insurance may have additional options, they are still constrained by the types of providers reimbursed by their plans and if their care is financed by their type of coverage (Backes et al., 2020).

If a state has expanded Medicaid, women with low incomes may have access to coverage before and after their pregnancies, however if a woman relies on pregnancy-related Medicaid, she is not able to receive coverage until after she is pregnant, and may experience a delay in access to services if her state does not follow presumptive eligibility, and run the risk of losing her coverage 2 months postpartum (Backes et al., 2020). Medicaid and other forms of insurance reimburse hospitals at higher levels for cesareans, providing incentives for more intervention, whereas the lowest-reimbursed providers are those outside of the hospital such as birth settings attended by midwives (Backes et al., 2020).

In the fact sheet "Black Women Experience Pervasive Disparities in Access to Health Insurance," constructed by the National Partnership for Women and Families, Black women of reproductive age (15-44) are shown to face the biggest coverage disparity (National Partnership for Women and Families, 2019). Black women in the South have the lowest rates of health insurance coverage amongst all Black women,

with sixteen percent of Black women in the South lacking health insurance (National Partnership for Women and Families, 2019). Black women overall are more likely to be uninsured outside of pregnancy, when Medicaid kicks in, and are more likely to start prenatal care later and to lose coverage in the postpartum period (Montagne, 2017). More specifically, younger women, less educated women, those with unplanned pregnancies, the uninsured, and those living in deprived neighborhoods have been found to be more likely to receive inadequate prenatal care and experience adverse outcomes, highlighting the classist system that impedes quality of care for all (Gadson, 2017).

More than half of pregnancy-related deaths occur during the postpartum period, 12% of which happen six-weeks after postpartum (Petersen et al., 2019). As previously mentioned, Black women have higher rates of C-section and are more than twice as likely to be admitted to the hospital in the month following this surgery (Montagne, 2017). Black women are also twice as likely to suffer from postpartum depression, which contributes to poor outcomes, while simultaneously remaining less likely to receive mental health treatment (Kozhimannil et al., 2011). Black women are more likely than White women to hold low-wage jobs that do not provide their employees with health benefits (Taylor et al., 2019). More than 3.3 million Black women (1 in 4 nationally) are covered by Medicaid, which helps Black women with low incomes access essential maternal health services, hence Medicaid policy largely influences the access and availability of crucial health care for many Black women during and after their pregnancy (National Partnership for Women and Families, 2019). While half of uninsured women were able to obtain Medicaid coverage within a month of delivery, 55

percent of women with this coverage lost insurance in six months following delivery, with the majority of these women suffering from loss of insurance serving as the sole caregiver in their homes, low income mothers, and residing in the Southern United States, a region where most states have yet to expand Medicaid (Daw et al., 2017).

The Black Maternal Health Caucus, launched by Congresswomen Alma Adams and Lauren Underwood in 2019, is one of the largest bipartisan caucus in congress, created with the intent of elevating the Black maternal health crisis in Congress and advancing policy solutions intended to improve maternal outcomes and disparities. In June 25, 2020 the Black Maternal Health Caucus introduced the *Patient protection and affordable care enhancement act*, which includes policies to incentivize states to expand Medicaid and to require that states extend Medicaid coverage to new mothers for 1 year postpartum (Black Maternal Health Caucus, 2020). Although a large portion of maternal deaths occur postpartum, the United States is the only developed country that does not guarantee access to provider home visits or paid parental leave in the postpartum period, with covered visits varying by state Medicaid program and by individual insurer (Tikkanen et al., 2020). Severe bleeding, high blood pressure, and infection are the most common contributors to maternal deaths within the first week postpartum, and cardiomyopathy is the leading cause of later deaths (Declercq & Zephyrin, 2020).

Reproductive Justice and Birth Justice

In Loretta J. Ross and Rickie Solinger's book *Reproductive justice: An introduction*, Reproductive Justice is defined as a political movement and a

contemporary framework for social activism, and for thinking about the experience of reproduction (Ross & Solinger, 2017, p. 9). Loretta J. Ross, coauthor of *Reproductive justice: An introduction*, is an activist and advocate for Reproductive Justice, and a cofounder of the organization Sistersong. Sistersong is a Southern based, national membership organization, that aims to continue to expand a network of individuals and organizations with the intention of improving institutional policies and systems that affect the reproductive lives of marginalized communities (Sistersong, n.d.). SisterSong Women of Color Reproductive Justice Collective was formed in 1997 by 16 organizations of women of color coming together all seeking to represent themselves and their communities and to advance the perspectives and needs of women of color (Sistersong, n.d.). At the basis of Reproductive Justice is the claim that "all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences," a goal that depends on access to "specific, community-based resources including high-quality health care, housing and education, a living wage, a healthy environment, and a safety net for times when these resources fail (Ross & Solinger, 2017, p. 9)."

As argued by Reproductive Justice activists, the "needs and the voices of poor women, disabled women, women of color, immigrant women, and other vulnerable individuals must be at the center of debates about reproduction (Ross & Solinger, 2017, p. 190)." Each of these populations of women can trace their reproductive capacity back to the eugenics movement's ideology that only "fit people have the right to reproduce" and that non-White women's bodies are inherently "pathological (Ross & Solinger, 2017, p. 190)." Reproductive Justice activists firmly uphold that women should have

the right to determine their own birth plans, use midwives and doulas if they desire, and have the ability to choose to have home births or use freestanding birthing centers (Ross & Solinger, 2017, p. 188). This movement is articulated and led by women of color, and incorporates a human rights and social justice framework to raise awareness of the intersectionality of women's identities and struggles against sexism, racism, homophobia, and economic marginalization (Summary of birthing reproductive justice, n.d.).

Birth Justice is a part of the Reproductive Justice Framework (Voices for birth justice, n.d.). The SisterSong Women of Color Reproductive Justice Collective formed the SisterSong Birth Justice Team in Fall of 2019, in response to high maternal mortality rates impacting the Southern United States (Sistersong, n.d.). Birth Justice, as defined by the Black Women Birthing Justice (BWBJ), aims to dismantle inequalities of race, class, gender, and sexuality that contribute to negative birth experiences, especially for women of color, low income women, survivors of violence, immigrant women, queer and transfolks, and women in the Global South (What is birth justice, n.d.). Black Women Birthing Justice states on their website that Birth Justice exists when "women and transfolks are empowered during pregnancy, labor, childbirth and postpartum to make healthy decisions for themselves and their babies." The Birth Justice movement emerged to address the contemporary inequities that surround Black reproduction as connected to the long history of trauma and reproductive oppression that Black communities and other underserved groups have experienced (Voices for birth justice, n.d.).

The Birth Justice movement challenges systems of oppression, specifically racism and sexism in reproductive care, and advocates for culturally-appropriate and person centered care (Voices for birth justice, n.d.). Birth Justice further supports increased access to breastfeeding support and traditional birth-workers, such as midwives and doulas (Voices for birth justice, n.d.). Activists and advocates for Birth Justice act to educate the community, and challenge abuses by medical personnel and the overuse of medical interventions (What is birth justice, n.d.). Since its creation the Birth Justice Team has created community-programming groups such as Mama Talk, Labor Intensive Trainings, and the Birth Justice Care Fund (Sistersong, n.d.). The Birth Justice campaign centers its campaign upon elevating the voices of Black mothers, and other mothers of color, by creating a space for them to share their stories to raise awareness for "birth justice" in order to work towards advocating for changes in policies to combat the birth disparities conceived from racist systems (Voices for birth justice project, n.d.). The goals of the Black Women Birthing Justice Collective are to educate, to document birth stories, and to raise awareness about birthing alternatives for Black women (Oparah et al., 2018).

Cultural Humility

The Cultural Humility Model is one that incorporates training health care professionals to be understanding, affirming of, and sensitive to cultural differences, and has been identified as being critical to combating racism and unequal treatment in the United States healthcare system (Taylor et al., 2019). It has been proposed to be implemented in educational programs and licensing for staff, and to become a part of ongoing training in health care settings as a requirement for maintaining licensure

(Taylor et al., 2019). The cultural humility model is a promising approach to improving interactions and relationships between Black mothers and other mothers of color and physicians by alleviating contributing factors such as implicit biases that impact the quality of care received by Black mothers (Taylor et al., 2019). As discussed in the report Battling over Birth, Oparah et al. explains that in the current healthcare system there exists a context where behaviors and choices are shaped by a Euro-American worldview, where Black women are "vulnerable to judgment, shaming and coercion" by well-meaning medical professionals that are unaware of their implicit biases (Oparah et al., 2018, p. 34). Oparah et al. found through their qualitative process of listening to the birth stories of 100 Black women that the lack of cultural humility represented a barrier to Black mothers both accessing and persisting with prenatal care (Oparah et al., 2018, p. 30).

Cultural humility involves an "ongoing" lifelong commitment to self-evaluation and self-critique," combined with a willingness to learn and listen to others; it further allows persons to recognize their own cultural biases (such as ingrained stereotypes) and to realize that they do not know everything about a given culture (Stewart, 2019). In the webinar "Cultural Humility and Black Maternal Health in Historical Context," presented by the co-founder of the Cultural Humility Model, Dr. Jann Murrary-Garcia, she discusses the importance of Cultural Humility in "Readdressing Power imbalances" across all institutions (Cultural humility webinar, 2020). In the maternal care system, power imbalances exist in Black mother's interactions with OB-GYNS, nurses, and other health practitioners that ignore Black women's requests for pain management or "talk down" to them during pre- and postnatal care (Taylor et al., 2019). In a more

specific example provided by Dr. Stewart, she discussed an experience in which one of her Black patients had first been seen by a doctor who blamed the patient's diet of "fried foods" for her heart disease, without knowing, or caring to look beyond their bias to learn that the Black patient was a practicing vegetarian whose condition was more likely related to her family history (Stewart, 2019). By applying a cultural humility framework and focusing on the question proposed by Dr. Garcia "How are you going to make it so Black women can teach you about what's going on in their bodies, their families, their extended families?," health care providers and health care staff are forced to face their implicit biases, unlearn stereotypes, and work towards providing their Black patients with more equitable and less stressful care.

The Cultural Humility model allows for the grounds to address these power imbalances, and allows Black mothers to become prioritized in having their own decision-making power in terms of treatment plans, or birth plans, which segues into improving the provision of holistic care to patients (Taylor et al., 2019). Holistic care is care that is based on a mutual understanding of a patient's physical, physiological, emotional and spiritual dimensions, that additionally emphasizes a relationship between health care personnel and patient allowing for negotiation of healthcare that leads to recovery (Jasemi et al., 2017). A proposal by the Black Mamas Matter Alliance, *Advancing holistic maternal care for Black women through policy*, directly states that

> "In order to effectively provide care to Black women, we must establish systems of care that are equitable and culturally relevant by acknowledging the value of traditional birthing practices and addressing racism, discrimination, and bias and, thus, dismantling existing systems of care that have created and perpetuated inequities in health care service and delivery and ultimately resulted in grave disparities in health outcomes (Black Mamas Matter Alliance, 2018)."

Cultural humility training has been proposed by the Black Women Birthing Justice collective, as a means to improve relationships between staff and pregnant individuals, and for aiding in offering a true holistic framework of care for Black mothers, serving to "reduc[e] hierarchy," "empower pregnant individuals to take control of their health care," "emphasiz[e] relationship building," and provide for overall "more in depth care (Oparah et al., 2018, p. 191)."

Assessment and Acknowledgement of Successful Programs

Commonsense Childbirth: The JJ Way Care Model

Commonsense Childbirth is a non-profit midwifery-led practice in Orlando Florida that was founded in 1998 by Jennie Joseph, a British trained midwife (National Partnership, 2020). Upon moving to the United States, Joseph was shocked at the controversy centered around midwifery care, stating in an interview

> "The culture shock that I experienced was that as a Black woman of West Indian descent; I assumed that I was culturally aware and able to manage assimilation into the American experience. I knew about the differences amongst races and I knew about racism, having experienced it myself...I felt alienated and marginalized as a professionally trained hospital-based midwife. I felt marginalized as a midwife who believed in empowerment for women and independence... I was marginalized from a place of being a Black woman with an English accent (Hahn, 2014)."

As a patient in the United States, Joseph had been encouraged by her OB-GYN to have an unnecessary hysterectomy for her endometriosis, and she was unnecessarily sterilized for a disease that has other treatments. In reflecting on this experience Joseph states that she was unaware of the "racial connotation of hysterectomy in the United States," at the time (Hahn, 2014). In an effort to decrease barriers to women of color, and low-income women, for accessing and receiving quality prenatal care; Joseph

opened up her own midwifery practice to provide women of all races safe, holistic, patient-centered care.

Commonsense Childbirth started as a home birth practice that has today transformed into a community-based maternity medical home (Tackling Maternal Health Disparities, 2019). Commonsense Childbirth provides midwifery care, social service navigation, doula attendance at birth when available, childbirth education, lactation consultations, as well as standard prenatal care and postpartum care (Tackling Maternal Health Disparities, 2019). Commonsense Childbirth's care model is that of the JJ Way (Tackling Maternal Health Disparities, 2019). Jennie Joseph, designed the JJ way, a holistic model of prenatal care, in order to address and reduce adverse maternal and newborn health outcomes (The JJ Way, 2014). The JJ Way is a patient-centered model that focuses on developing relationships with parents, addressing unmet needs and barriers to care, while additionally providing education and psychosocial support for at risk moms in an affordable and effective way (Novoa, 2020; The JJ Way, 2014). The JJ way is implemented through 'The Birth Place' Birthing Center and the Easy Access Clinic (Joseph, 2019). The 'Birth Place' birthing center in Orlando provides prenatal and postnatal care, birth services and support, educational and social support services to women, regardless of their delivery site, practitioner, citizenship, insurance status, or ability to pay for services (Joseph, 2019). While The Birth Place is a freestanding birthing center, the Easy Access Clinic provides care for women who choose in-hospital births (Joseph, 2019). At The Birth Place clients are covered by private insurance, Medicaid, or they have the ability to pay out of pocket; additionally the Easy Access Clinic provides aid to clients experiencing financial barriers to

maternal health care (Tackling Maternal Health Disparities, 2019). Primarily women of color and/or low-income women are the main clients at the Commonsense Childbirth's Easy Access Clinic (National Partnership, Tackling Maternal Health Disparities). In an effort to reach the most high risk and disadvantaged women living in areas lacking resources and support, Commonsense Childbirth offers services in readily accessible sites such as community centers or neighborhood resource centers called "Perinatal Safe Spots (Tackling Maternal Health Disparities, 2019)." Many of Commonsense Childbirth's clients are uninsured when they first come to the clinic, but Commonsense Childbirth helps them to enroll in Medicaid, which covers prenatal, childbirth, and postpartum care in Florida (Tackling Maternal Health Disparities, 2019).

A goal of the JJ Way is to work towards eliminating racial and class disparities in prenatal health and to improve birth outcomes for all infants through a midwifery-based model that was "culturally relevant and accessible to women of color and low-income women (Association of Maternal and Child Health Programs, 2009)." Commonsense Childbirth clients have often experienced marginalization and negative experiences in other healthcare encounters; Commonsense Childbirth aims to provide clients with care defined by respect, choice and access, in order to provide an atmosphere for women to be "heard, listened to and valued (Tackling Maternal Health Disparities, 2019)." At the time that the JJ way was being evaluated as an emerging practice, 18.5% of Black infants in Florida were preterm compared to 13.7% of all infants, and 13.6% of Black infants in Florida were low birth-weight compared to 8.7% of all infants (Association of Maternal and Child Health Programs, 2009). In 2007, the Health Council of East Central Florida analyzed the birth-outcomes for 100 low-income

JJ Way patients, and found that 4.8% of babies were low-birth weight, and 4.7% were preterm, while the Orange County-wide rate was 9.1% for babies born with a low-birth weight and 15.4% born preterm in years 2005-2007 (Association of Maternal and Child Health Programs, 2009). The key components of the JJ way as listed on the Commonsense Childbirth website are: prenatal bonding through respect, support, education, encouragement, and empowerment, as well as Freedom of Choice, allowing women to choose where to give birth, whether it be at home, or in a hospital (Commonsense Childbirth, n.d.). By informing expectant mothers and their families on their birthing options and by reaffirming their agency and choices as respected, mothers are more likely to continue with and seek continuity of maternal care at the Commonsense Childbirth clinic (Novoa, 2020).

The JJ Way provides 100% access, no woman who enters the clinic is turned away, even during the 3rd trimester when women seeking prenatal care for the first time are likely to be refused by other healthcare practitioners (Joseph, 2019). Funding for the JJ Way is provided through contracts secured by Florida's Medicaid managed care organizations, as well as through funds raised through Commonsense Childbirth (Novoa, 2020). Commonsense Childbirth Staff work to identify structural barriers to expectant mothers seeking and continuing with care, such as the lack of health insurance, and offer individually crafted solutions to aid mothers in overcoming these barriers (Novoa, 2020). If clients are unable to afford provided prenatal and postpartum services, Commonsense Childbirth works to offer these services at a lower rate, on a payment plan, or free of charge (Tackling Maternal Health Disparities, 2019). This payment policy has shaped the program's reputation in the community as being known

for serving all families, whether they are able to pay or not, making it easier for women to seek out services (Novoa, 2020). Providing services to all families regardless of their ability to pay, paired with the program's active effort to raise community awareness via outreach, encourages and aids families to overcome the structural barriers of service costs, and fear of care due to inability to pay (Novoa, 2020).

Birth outcomes for Black mothers and their children who receive care through Commonsense Childbirth are statistically better than those of both Orange County and Florida State averages (Tackling Maternal Health Disparities, 2019). The preterm birth rate for Black Women who were cared for through the JJ way was 8.6%, while state and county rates are at 13%. Additionally, this model obtained better low birth weight rate outcomes for Black women at 8.6% in comparison to the state and county average of 13.1%. (Tackling Maternal Health Disparities, 2019). Black women in the program have experienced less morbidity even through pregnancies presenting with chronic medical conditions (Joseph, 2019). For a population of women who experience on average a 13-20% prematurity rate, Commonsense Childbirth has succeeded in maintaining a less than 5% prematurity rate since 2006 (Joseph, 2019). Moreover, the cesarean rate of Commonsense Childbirth's clients is 8% in comparison to 30-50% rates measured from local hospitals (Tackling Maternal Health Disparities, 2019).

Mamatoto Village

Based in Washington D.C., Mamatoto Village is a nonprofit organization that works to provide community support as well as health care services to women of color and their families through advocating and supporting healthy pregnancy, childbirth, and postpartum experiences (Taylor et al., 2019). More specifically, Mamatoto Village is a

community-based organization that provides maternity support to Black and low income women in Washington D.C. (Tackling Maternal Health Disparities, 2019). Mamatoto is Swahili for "the connection between mother and baby," a bond that the team of trained professionals at Mamatoto Village are dedicated to strengthening (Tackling Maternal Health Disparities, 2019). A belief of Mamatoto Village is that women are strengthened by other women within their communities, and the organization works towards empowering women of color to become "maternal health care providers, training community birth workers, perinatal community health and family support workers, and lactation specialists (Taylor et al., 2019)." Mamatoto Village is dedicated to working towards Reproductive Justice, and is striving to combat health disparities for mothers, babies, and their families that are a result of barriers to accessing and receiving equitable care in terms of accessing information and tools necessary to preserve their lives and the lives of their children, and thus violating their human rights to "health and self-preservation according to one's own will (Mamatoto Village, n.d.)." Mamatoto Village works to combat racial disparities in maternal and infant health by providing both holistic and culturally competent services to women and their families (Taylor et al., 2019). Mamatoto Village's motto is "healthy mamas, healthy babies, healthy communities (Tackling Maternal Health Disparities, 2019)" Every year Mamatoto Village provides services to about 400 women and their families, with clients that are primarily "Black women and/ or low-income women, that are extremely high risk, financially insecure, lack safe or affordable housing, or reliable transportation (Tackling Maternal Health Disparities, 2019)." Mamatoto Village receives reimbursement through Medicaid managed care organizations that provide

adequate funding to cover maternity support for their clients and to pay their employees salary (Tackling Maternal Health Disparities, 2019). In a 2017 review of women who received care through Mamatoto Village, 74% had vaginal births, 89% were able to breastfeed, 92% attended their six week postpartum follow up appointment, and out of all of the births there were zero infant or maternal losses (Taylor et al., 2019; Chalhoub & Rimar, 2018).

Loving Steps Foundation: Norfolk

The Virginia Department of Health has collaborated with Eastern Virginia Medical School (EVMS) to implement Virginia's Healthy Start Program, called Loving Steps, in Norfolk (Loving Steps Brochure, N.D.). Healthy Start is a national project that was developed in order to improve the health of mothers and babies. The Healthy Start program was created in 1991, and today there are 101 Healthy Start Projects in 34 states, Washington D.C., and Puerto Rico (Healthy Start, 2016). Healthy Start is federally funded and offers education, promotes positive birth outcomes, and was designed to protect the health and well being of all mothers and children (Healthy Start, 2012). Healthy Start is focused on fulfilling the needs and serving women who are considered the most at risk for infant mortality, low birth weight, and racial disparities in birth and maternal outcomes (Healthy Start, 2012). There are 96 of these programs in place throughout the United States, serving populations of women who reside within the program's targeted area (Healthy Start, 2012). Loving Steps is Virginia's Healthy Start program, and is currently implemented in three areas in Virginia that were selected due to high infant mortality rates and significant perinatal health disparities (Communities family home visiting, n.d.). The

three communities are Westmoreland County, a rural community in the Northern Neck region of Virginia, Petersburg, a small urban community in central Virginia, and Norfolk, a large urban community in the tidewater region of Virginia (Communities family home visiting, n.d.). Across these three Virginia Healthy Start Communities, the non-Hispanic Black infant mortality rate is nearly three times the non-Hispanic White infant mortality rate. The goal of the Loving Steps program in Norfolk, as administered by the Eastern Virginia Medical School, is to improve access to care and provide support to mothers and babies in the City of Norfolk (When childbirth is deadly, 2018). The Loving Steps Foundation is a Healthy-Start home-visit program that is staffed by community health workers (When childbirth is deadly, 2018). Loving Steps services include prenatal and postpartum education, health risk assessment and referrals, infant developmental screenings, screens for depression, domestic violence, and substance abuse, and support groups (ABBA List, n.d.). Home-visits serve the purpose of answering questions, providing support and mentorship through pregnancy and after delivery until the infant is two years old (ABBA List, n.d.). Transportation to essential appointments is additionally available if needed, as well as explanations of the directions provided by health care providers, self care, infant care, nutrition, breastfeeding support, and prenatal and postnatal care (ABBA List, n.d.). Loving Steps provides their services free of charge to those who qualify for the program; pregnant women of any age living in Norfolk in their first trimester of pregnancy with unmet needs, infants from birth to two years of age residing in Norfolk, high risk infants living in Norfolk, and pregnant women with medical and or nutritional needs and risks (ABBA List, n.d.). The Loving Steps Program states that their purpose is to work

towards eliminating significant disparities in perinatal health experienced by Black women and their families (Virginia Healthy Start Initiative, n.d.). I was not able to find any sources outlining any quantifiable statistics reflecting the success or failure of this program.

Reflection

My Initial Inspiration: Norfolk, Virginia

When I started this project, my goals, as I listed in my thesis prospectus, were to either propose amendments to existing interventions, or to draft entirely new policies, or a new plan of reform. Through my research, and through discussions with my primary thesis advisor, it became more apparent during my reading, learning, and writing process, that it is absolutely not my place, as a White woman, to propose any type of "solution" addressing the racial disparities in maternal care. As a Human Physiology student, this thesis allowed me to learn of a history that I was never completely exposed to through either the Clark Honors College curriculum, nor that of my major. While my undergraduate studies have checked all of the boxes in regards to fulfilling prerequisites for medical school and for pursuing my dreams of becoming a practicing physician, my thesis project filled a gap in my pursuit of knowledge in shaping myself into a better ally. Growing up in a city that mirrors national trends, in pervasive and apparent racial disparities, I have found myself wanting to educate myself and understand the origin and history of these existing disparities. I have been able to visually observe inequities in the Norfolk Public school system, in sports facilities and programs and crumbling school buildings, and most blatantly in the neighborhoods that fall within different school districts. I recognized that while my public school and the others in its system were referred to as "dangerous," and "ghetto," that those using this rhetoric were both knowingly, and unknowingly, utilizing racially coded language to

link the quality of these schools with their population of majority poor kids from underserved neighborhoods.

Norfolk bears the unhealed scars of a history of racist segregation policies that have failed to be fully addressed and additionally perpetuated into the present day, through de facto segregated school systems and neighborhoods. Following World War II, Norfolk Redevelopment and Housing Authority (NRHA) jump-started urban renewal programs to replace inner-city slums with public housing (Urban Renewal Center, 2019). During this process, federal government policy required that all public housing for Black people be built in already Black majority neighborhoods that were struggling economically, and would only continue to get poorer (Urban Renewal Center, 2019)." As Black families were barred from receiving insurance loans through the practice of redlining in addition to slum clearance projects, impoverished Black people were concentrated into the St. Paul's Area, resulting in school segregation (Fella, 2020). Following the Supreme Court Decision in Brown vs. Board of education, slums continued to be torn down, however public housing was no longer being built, instead these slums were paved over with industrial parks and schools to act as "buffer zones," designed to keep neighborhoods segregated, and thus schools segregated (Urban Renewal Center, 2019).

As of 2021, the Norfolk Public school system has only been desegregated for 62 years (Gregory, 2021). Following the Supreme Court ruling in Brown vs. The Board of Education, Virginia enacted its "Plan of Massive Resistance," and closed its schools for a year instead of integrating their school systems (Gregory, 2021). Norfolk closed 6 of their schools, including my middle and high school and my sister's high school (Fella,

2020). In the 1980s, ten years after Norfolk announced the end of official school segregation, the city ended its mandatory desegregation programs, becoming the "first in the country to be released from federal orders to desegregate (Gregory, 2021)." Norfolk was also the first city to be relieved of the requirement of "bussing", or the movement of students out of their respective school districts in order to integrate schools, by arguing that segregation was "over" and students deserved to attend neighborhood schools (Murphy & Gregory, 2021). However, neighborhoods were still segregated, which led to schools becoming resegregated (Murphy & Gregory, 2021).

Discriminatory housing policies are still seen in Norfolk today, while Norfolk is a minority city, more than half of all those living below the poverty line are Black (Urban Renewal Center, 2019). Norfolk's eviction rates are among the highest in the nation, standing as evidence of marked rental instability that disproportionately impacts Black people and other minorities (Urban Renewal Center, 2019). Today, in Tidewater Park, where public housing was initially built, the Norfolk public schools located here remain de facto segregated, and the neighborhood is in the top 10 percent for incarceration rates in the country (Urban Renewal Center, 2019). Gentrification continues to act to reconcentrate poverty, and displace Black people in Norfolk, as Norfolk has recently approved the demolition of St. Pauls public housing, with a plan of knocking down 618 homes, and only planning to replace 220 units for families who want to return to the area (Melby, 2020). This project will displace thousands of residents, mostly Black, and mostly poor, including about 2,200 children (Gregory, 2021; Melby, 2020). By rebuilding and reinvesting in this area located downtown, the

city of Norfolk will be able to increase this area's property values and reap large economic benefits (URC, What is Gentrification).

As analyzed by Murphy & Gregory in the project "Dividing Lines: How Norfolk remains deeply segregated, in 8 maps," when looking at a map displaying Norfolk's racial divisions, and comparing it to maps showing poverty, education, and health, it is difficult to tell the maps apart (Murphy & Gregory, 2021). The same neighborhoods that were redlined in 1940, remain predominantly Black neighborhoods today (Murphy & Gregory, 2021). In these historically redlined Black neighborhoods, residents are far more likely to drop out of high school and to never go to college (Murphy & Gregory, 2021). Residential segregation was advanced in Norfolk in part by the effort to maintain the segregation of schools, a method that proved efficient until the federal government forced integration (Murphy & Gregory, 2021). Today in Norfolk, Black neighborhoods are poorer than White ones, with higher rates of poverty, lower household incomes, and lower home values (Murphy & Gregory, 2021). The neighborhoods in Norfolk with the lowest life expectancy, and the highest rates of diabetes, asthma, and coronary artery disease, along with the worst access to medical care, are the city's poor Black neighborhoods (Murphy & Gregory, 2021).

Norfolk maintains segregated schools to this day, as many students are zoned to attend schools in their neighborhoods, which are the legacies of intentional segregation to limit school integration, neighborhoods that "still bear the scars of disinvestment and thwarted opportunity (Gregory, 2021)." In fact, some public schools in Norfolk are the most segregated in the entire state of Virginia (Gregory, 2021). Schools, like health care systems, reflect the lasting consequences of segregated housing policies (Fella, 2020).

While the city of Norfolk's population is split evenly between White and Black residents, the public school system is just under 60% Black and about 20% White, with some schools more than 95% Black (Murphy & Gregory, 2021). Norfolk's predominantly Black schools are in predominantly Black neighborhoods, which have some of the highest poverty rates in the country (Fella, 2020). Today, Booker T. Washington Highschool, located in the St. Paul's region, has over 750 Black students, and 60 White students, with a graduation rate 13% below the state average, and 25% of student's have been recorded as 'chronically absent (Fella, 2020)'. In comparison, Maury High school, where 855 students are Black, and 560 are White, Maury's graduation rate is only 6 percent below the state average (Fella, 2020). Following in suit of trends in health outcomes for Black Mothers and their children, school segregation, in Norfolk and elsewhere is worsening (Gregory, 2021). In the State of Virginia alone, Black students and other minority students are more likely now, in comparison to 15 years ago, to attend majority non-White schools, that in turn tend to have higher rates of poverty, with fewer resources and fewer course offerings (Gregory, 2021). White students in Virginia are 2.1 times more likely to be enrolled in advanced classes, while Black students are 3.7 times more likely to be suspended compared to White students (Fella, 2020).

Norfolk's infant mortality rate (6.7), while on the decline, is higher than both the US (5.9) and Virginia (5.6) value (value measured by deaths/ 1,000 live births) (Community Indicators Dashboard, 2018). However, by breaking down infant morality rate by race, the Black infant mortality rate is 10.8 (61.19% higher than the overall rate), and White infant mortality rate is 3.9 (41.79 % lower than overall rate)

(Community Indicators Dashboard, 2018). In an article published in the Virginia Pilot, author Elizabeth Simpson concluded, “Why Hampton Roads has a higher-than-average infant mortality rate is not clearly known, but a number of factors could be at play. Rates have historically been higher among Black people and low-income populations, and the percentage of residents who are Black or poor is higher in Hampton Roads than in the state as a whole.” This year, the Virginia Department of Health’s Office reported that the maternal mortality rate for Black women is over two times as high as White women in Virginia, as well as nationally (Northam introduces maternal health strategic plan, 2021). Nationwide, Black women are 243 percent more likely to die from pregnancy or childbirth-related causes in comparison to White Women (When childbirth is deadly, 2018). According to the Virginia Department of Public Health, in Virginia, Black women are 300 percent more likely to die in childbirth than White women (When Childbirth is deadly, 2018). Virginia's governor announced a goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025. This proposal entailed a $22 million dollar budget to expand Medicare coverage for new moms, increase home health visits, and to explore Medicaid reimbursement for doula service (Governor Northam, 2019). Part of Northam’s proposal included a 10 stop listening tour across Virginia in order to receive input from mothers, medical professionals, doctors and community advocates (Governor Northam, 2019). However none of these 10 stops included Norfolk, nor Virginia Beach, despite the fact that both of these cities were the only Virginia cities to make the March of Dimes’ 2020 list of the 100 cities with the greatest number of live births in 2018 (March of Dimes report card, 2020). For preterm birth rate by city, Virginia Beach received a D+ (preterm birth

rate of 10.4 to 10.7%) grade while Norfolk received a F (a preterm birth rate greater than or equal to 11.5%) in comparison to the United States grade of a C- (preterm birth rate of 10.1 to 10.3%) (March of Dimes report card, 2020), in Virginia, preterm birth rate is 54% higher amongst Black women than all other women (March of Dimes report card, 2020).

The history, and present state, of the City of Norfolk is similar to many other areas throughout the United States and exemplifies how multidimensional the effects of systemic racism truly are. The racial disparities in the care currently provided and accessible to Black mothers, as well as in the experienced maternal, and birth outcomes for Black mothers are interrelated to the inequities that exist between and within neighborhoods and school systems. Black-serving hospitals that provide lower quality of care have been found to be understaffed, and suffer from overall worse health outcomes for their patients, are a symptom of neighborhood inequality. Poor school systems, another symptom of neighborhood inequality, such as Booker T. Washington, are a prime example of the nonexistence of equal opportunity. Equal educational systems, with equal resources, support, course availability, and college counseling are a requirement in order to ensure all children have the ability to achieve a higher education, and make their way into fields such as the medical field. The inequities in healthcare, school systems, neighborhoods, and opportunity are the legacies of racist segregationist frameworks and policies that continue to contribute to the wide range of disparities faced by Black people living in the United States today. Throughout my thesis, I have focused on learning mainly about the history of maternal care for Black mothers, and I recognize there is more to the narrative then I was able to assess and

learn during my thesis research. There is so much more to learn, and I feel like I have just begun my real journey down the lifelong path of cultural humility. I grew up thinking that my hometown was different, and that my school system was just poor, and that Norfolk was an exception, and I have grown uncomfortably aware that Norfolk is instead the norm.

Allyship

During my thesis research, I focused on reading books, articles, and reports written by Black women, who each put forth immense effort in piecing together a scattered, and forgotten narrative of the erasure of Black birth workers, the mistreatment and abuse of enslaved Black mothers at the hands of White physicians, and of the inequities and discrimination that Black mothers have faced throughout history and continue to face today. With a history of public health interventions created to address infant and maternal mortality rates by White physicians and politicians, that only served to further increase disparities in care for Black mothers and their children, as well as heighten disparate birth outcomes for these women and their children, I believe that it is clear, that the only way for the disparities in care for Black mothers to be alleviated, their voices need to be *elevated* and *listened* to. Several organizations promoting Reproductive Justice and Birth Justice exist today that are founded and led by Black women and other women of color. These organizations include SisterSong, Black Mama's Alliance, Black Women Birthing Justice, and the Black Maternal Health Caucus. Each of these organizations are advocating, and proposing policy and interventions that are written by Black mothers and Black women, having been

influenced by the birth stories, personal experiences and the qualitatively assessed needs of Black mothers, in order to help Black mothers.

As a White woman, my place in advocating and supporting Birth Justice and Reproductive Justice movements for Black Mothers is through the role of allyship. As defined in the Racial Equity Tools Glossary, Anti-racist allies recognize systemic racism, as well as the existence of race-based oppression (Figueroa & Kast, 2021). Nicole Asong Nfonoyim-Hara, the Director of the Diversity Programs at Mayo Clinic, defines allyship as a person of privilege working "in solidarity and partnership with a marginalized group of people to help take down the systems that challenge that group's basic rights, equal access, and ability to thrive in our society (Dickenson, 2021). Sistersong, the largest multi-ethnic Reproductive Justice collective, states that allies in the movement are those who "support women's human right to lead fully self-determined lives (Sistersong, n.d.)." White Allies are able to acknowledge their own privilege and examine how their own life experiences have served to oppress Black, Indigenous, and People of color populations, to further work on taking the necessary steps to actively work against racism in their daily lives (Figueroa & Kast, 2021). Allies do their own research and work to gather their own information on the history and impact that racism and discrimination has on marginalized communities, while dually working towards being anti-racist themselves (Figueroa & Kast, 2021). Ultimately, an ally's purpose is to work towards achieving equity and inclusion, by holding one's self accountable to advancing marginalized people's needs (Pyrrhus & Abulhab, n.d.).

Prior to embarking on my thesis journey, I was familiar with the term ally, and self-identified as an ally who wanted to learn, and know more about the history of oppression that Black people have faced in this country while further working on addressing my own implicit biases that are informed by my upbringing, society, growing up in Norfolk, as well as other lived experiences. It is part of my privilege to be able to learn about racial disparities in maternal care, as these are disparities, and experiences, that I will never completely understand, as I do not, and will never know what it is like to experience racism, discrimination, or to be a victim of bias, because of the color of my skin. Through this project, I have learned of a history that now allows me to continue to observe, listen, and learn about the racial disparities in maternal care in a deeper more analytic sense. As a White woman, it is not the responsibility of Black mothers, Black teachers, or Black health care professionals to inform me, or anyone else, of this cruel history of mistreatment and abuse that so largely contributes to and shapes current racial disparities today. I would argue that every current and aspiring healthcare professional should seek on their own to inform themselves of the history of medical abuse and mistreatment of Black people in America, in order to come face to face with both their conscious and unconscious biases, and to further improve the quality of care that they are providing to their Black patients. While I was familiar with the term ally, I was not aware of the term "Co-conspirator."A Co-conspirator, also known as an accomplice, is someone that actively "makes daily choices and takes steps to eliminate racism," and focuses on "dismantling the structures that oppress the individual or group," with "such work [being] directed by the stakeholders in the marginalized group (Figueroa & Kast, 2021; Pyrrhus & Abulhab, n.d.)."

Following the completion of this thesis project, I would like to continue my personal journey of cultural humility, and transition to become not just an ally, but also a Co-conspirator, by continuing to read works published by Black women, following national and local social media accounts for Birthing Justice and Reproductive Justice organizations, and signing up for newsletters, to listen to and follow the Black leaders spearheading and guiding the movement for Black mothers and their infants to receive equitable care.

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