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Black Pregnancy Matters: Racial Reproductive Bias in African American Maternal Mortality

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A Capstone Thesis to the Faculty of the College of Arts & Sciences
University of San Francisco

In Partial Fulfillment of the Requirements of the Degree of
MASTER OF ARTS IN URBAN AND PUBLIC AFFAIRS

by

Juhi Kishan Khemani

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Under the guidance and approval of the committee, and approval by all the members, this thesis has been accepted in partial fulfillment of the requirements for the degree.

Approved:

DR. DIANA NEGRÍN _____ Date _____
DR. MARCIANNA NOSEK _____ Date _____

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Abstract

This semester-long research project uncovers how racial biases demonstrated in the reproductive health field, and specifically before, during, and after childbirth, affect the rate of maternal mortality and morbidity for African American mothers in the United States. The rate of maternal mortality for this specific racial group is four times greater as compared to Caucasian women and this discrepancy will be investigated and analyzed throughout this capstone thesis. Interviews were conducted with key figures in the obstetric and gynecological field as well as with Black mothers themselves in an effort to uncover what factors, aside from medical anomalies, are leading to mortality of African American women at much higher rates than other racial groups. Studies suggest that implicit racial bias present between care providers and their patients can lead to solvable yet unaddressed complications which then result in unfavorable outcomes for postpartum Black women. This capstone project will incorporate these research studies and articles into an extensive literature review that include three main frameworks: racial bias, healthcare access and socioeconomic background. Racial bias will be the main framework that informs the other two frames as race in America cannot be separated from economic or healthcare justice. Finally, I offer recommendations that incorporate micro-level guidance and suggestions for interactions between patients and practitioners. I also zoom out on a macro-level and investigate policies that can be implemented on a more widespread scale from midwife and doula protocols to target racial and implicit bias in the larger structure of healthcare.

SECTION I. Introduction

"What we have been doing for decades is putting all of the responsibility on Black mothers."
Raena Granberry, 2019.

Background

Pregnancy is a time of growth and change for women— it is a singular experience for those who chose to have children and is one of the most influential and life-altering experiences an individual can have. However, what should be a time of joy, happiness and new life is being stripped from a significant amount of women. Instead, pregnancy-related complications and lapses in care can lead to detrimental health outcomes and long-lasting negative effects for women —especially Black women. A public health crisis is taking place in the United States: Black women are dying in greater numbers from pregnancy-related complications than women of other races (Flanders-Stepans 2000). To understand why, and more importantly, what can be done to ameliorate this outcome, we must understand on a macro-level the reasons why maternal mortality exists in our country.

In the United States, the maternal mortality rate sits at roughly 24 deaths per 100,000 live births (McCarthy 2019). This is not a low occurrence— in fact, "the U.S. has the worst rate of maternal deaths in the developed world" (Martin and Montagne 2017). While maternal death rates in other countries such as the United Kingdom, Canada, and France continue to decline, mothers in the U.S. today have a greater chance of suffering and dying from a pregnancy-related complications than their mothers and grandmothers—a staggering fact when you compare the advances in medicine and technology over the past three decades (Martin 2017, Rabin 2019). The maternal mortality rate in the United States has more than doubled in the last twenty-five years and when race is factored into this statistics, the percentage of African American women

dying rises three times as compared to Caucasian women (Maternal Mortality UNICEF 2019).[1] Not only is it more risky to have a baby in the U.S. today than it was fifteen years ago, but it has become significantly more fatal for Black women to have children— roughly 3.3 times more fatal than other racial groups (Rabin 2019, Vital Signs Center for Disease Control 2019). On a global scale, these statistics and fatalities are abysmal— for context, the worldwide maternal mortality rate has fallen roughly 2.9% every year in the past seventeen years, an encouraging yet slow step towards the eradication of pregnancy-related death (Maternal Mortality UNICEF 2019). In the United States, the opposite phenomenon has occurred—the maternal mortality rate is increasing—regardless of the scientific strides made in medicine or the increased spending seen in the U.S. healthcare system (Squires 2015). How is it that the United States, a country that boasts the largest per capita spending per citizen for healthcare, has an increasing rate of maternal mortality outcomes for all women and especially Black women?

To fully understand why this alarming statistic affects African American women most, I explore the historical origins of Black maternal mortality as it pertains to the use of Black women's bodies during the Reconstruction era and the present-day ramifications this treatment has had on reproductive healthcare in the 21st century. I acknowledge and examine how generations of enslavement and subjugation have bred explicit racism and bias, which in turn affect the health of African American citizens in the United States today. To narrow my study, I investigate the field of modern obstetrics and gynecology which cannot be divorced from some of the most unsavory, immoral practices that gave birth, literally and figuratively, to this particular field of medicine. The historical practice of using bodies of individuals that were considered "less than" the white majority is not unique nor surprising when examining the

[1] For the purposes of this capstone, the term "African American women" is used interchangeably with "Black women" and will be explained fully within this introduction.

history of the United States— unlawful practices to further scientific medicine or research was common practice centuries ago(Judd 2013). When reproductive medicine was researched and expanded upon, doctors in the United States were known to routinely test their studies and procedures on enslaved African American women with no form of consent (Ibid).

Generations later, the structural inequalities that led to these unconsented, heinous practices, such as sterilization and hysterectomies, and the unconsented use of Black women's bodies still influences certain behaviors and assumptions that permeate the medical, and, more specifically, the reproductive health sphere. Today, this same demographic of African American women is suffering inordinately from mortality after pregnancy; the root of this problem can be traced back to the disproportionate quality of care that enslaved Black women experienced to further the field of gynecology and obstetrics (Judd 2013).

While race remains the central issue that colors the differing maternal mortality rates in the United States, a confluence of other factors, such as access to healthcare, inform these rising statistics among Black women and obfuscates the circumstances that have brought this phenomenon to fruition. Subsequently, the lower quality of healthcare for Black families in the United States and the socioeconomic status of these individuals obscure the largest culprit of Black maternal mortality: inequity and bias based on race. Implicit bias and racial prejudice between physicians and their Black patients is a major cause of increasing mortality rates, but it is harder to discern and address as it exists within preconceived notions and behaviors ingrained into the mindsets of many providers and physicians. As a result of racial bias, physicians often overlook certain patients' complaints or discomfort leading to preventable complications or death (Hoffman et al. 2016). It is difficult to study exactly what leads to varying behaviors and levels of care to different patients as dictated by their race, but the percentage of Black maternal

deaths in the United States points to a problematic and fatal issue within the quality of care throughout and post-pregnancy that must be acknowledged.

The concept of racism and inequitable treatment of marginalized communities is not unique to perinatal and maternal health, nor is it present only in personal interactions. Many different structures and spaces in our current society foster inequalities between people of color and Caucasian people by deemphasizing equity for those that have been undervalued and normalizing advantages for white people. To understand this disparity in healthcare, numerous studies have been done to substantiate the fact that "racial and ethnic minorities" often have less access to healthcare and receive less than adequate preventative care in addition to receiving worse treatment with the care they are able to obtain (Institute of Medicine 2002). Eighteen years ago, a study was completed by the National Academy of Science that brought this issue to the forefront of health policy and specifically stated that even when factors such as income or geographical neighborhood was accounted for, "racial minorities" still had worse access to care and worse health outcomes than their white counterparts (Ibid). There was no ambiguity in their findings— race emerged as one of the most prevalent factors in determining the level and the quality of healthcare people of color in the United States were receiving. The report went on to state the reasons for some of these disparities and spotlighted that prejudicial treatment and "unconscious racial attitudes" was the culprit within healthcare systems (Ibid). It went on to establish that when racial minorities did have health insurance, they were often "lower-end" healthcare plans and the coverage was not as comprehensive as other private insurances (Ibid). Furthermore, disparities linked to the socioeconomic status for people of color, and Black people specifically, have demonstrated that lower income levels can lead to less robust healthcare plans with employment, salary, and insurance tied closely together in the United States (Weller 2019). With less opportunities for gainful employment and less income to spend on higher-end health

insurance plans, African Americans in the United States are once again on the receiving end of prejudice and inequity compounded across multiple structures within the United States. Healthcare and the economy are both major facets of society dedicated to providing for our communities, but we must be aware of the racial divisions that still exist within these structures and the prejudicial inequities they continue to breed.

Justification

This public health issue of African American maternal mortality in the United States constitutes a public policy issue that deserves and, more importantly, demands to be researched and addressed. I have written my capstone through a policy-centered lens: my findings are utilized to create better policies for a specific group of individuals. The public's "affairs" cannot be improved or enhanced without research proposals questioning discrepancies that disproportionately affect certain racial groups and, in this case, Black women.

In this capstone project, I ask why the rates of African American maternal mortality in the United States are far greater than any other racial demographic? I further question how racial biases have led to an increase in African American maternal mortality from pregnancy-related complications in the United States and what can be done to combat these statistics, specifically through a policy lens. How can midwife or doula-centric models be implemented on a widespread scale to help decrease and eventually end these racial biases? This argument is significant because it details not only a problem that affects all women in the United States, with maternal mortality rates reaching higher levels in recent years, but points to a specific group of women that are experiencing the effects of poor obstetric care (Center for Disease Control n.d., accessed October 3, 2019).

This research question guides my investigation throughout my capstone and incorporates data on discrepancies and biases leading to increased maternal mortality in Black women as

compared to women of other races. As many research and news articles have established, racial and implicit biases are harming Black women throughout their pregnancies, even when compared to other women of color such as Latina or Native women, Black women are dying at far greater rates (Roeder 2019).

While this troubling statistic is present throughout the United States, this research question was scaled down to the greater Bay Area so that interviews can be conducted on a more local scale with relative ease (Rabin 2019). Geographically, this research skews towards less evidence of racial bias against African American women— California has experienced a declining maternal mortality rate in the past ten years with this state being lauded as the model the entire country should follow (CA-PAMR 2019). It is important to note that conducting research in California may deliver vastly different results as compared to other states in the US— California is the most populous state in the country and many statewide programs are drafted to incorporate California's forty million residents. By comparison, other states in the US have a significantly smaller population and certain pregnancy-related programs will need to bear this in mind when it comes to issues such as funding or writing legislation. By conducting research in California, larger programs and practices can be retrofitted for smaller populations and applied across the entire nation to lower rates of pregnancy-related death. This difference in California as compared to others states is reconciled after data is collected and research from other states is included and discussed. Nonetheless, the rate of African American maternal mortality in California is still at its highest compared to other racial groups (CA-PAMR 2019). Additionally, other states in the US, particularly in the South, may have more instances of racial discrimination or bias based on these states' troubled history with the enslavement of African Americans and, more recently, the prejudice experienced under the Jim Crow laws up until the mid-1960s. With instances of Confederate flags still waving proudly in Southern States such as South Carolina, it

is not hard to imagine Black women struggling to find equitable pregnancy care in these same states that still respect a flag under which slavery was the norm (Hewitt 2015). This is an example of the differences between states' legislatures that should be taken into account when suggesting policies aimed at tackling racial bias for African Americans— the applicability of such laws in California as compared to, for example, South Carolina, will no doubt be different and met with varying levels of resistance.

As a result of conducting research in California, it was imperative to account for outliers of positive outcomes and factors in the political climate of our state's government, which may account for additional programs or funding in places meant to directly combat African American maternal mortality. Clinics and offices that cater to pregnant Black women are fairly common in the Bay Area. By investigating this research question locally, one-on-one interviews were conducted with patients as well as caregivers during pregnancy.

Through one-on-one interviews, this research question is explored through the lens of Black women's lived experiences and the treatment they received, medical or personal, from conception to postnatal care. From a policy standpoint, it is important to include what practices or changes in protocol these women wish to see in future obstetric experiences such as hospital care through patient follow-up. Additionally, it is crucial to investigate the treatment of pregnant Black women impartially and allow the voices of these Black women to guide and inform the data and conclusions drawn. As a researcher, I allow these women' truths to tell the story of their experience and, I hope, separate out my preconceived notions and beliefs as it pertains to my own research.

Definitions

Racial biases, the frame under which I will be investigating my research question, can be applied across many different types of research studies and projects, and I intend to employ this

definition in the study of reproductive and maternal mortality. I will also define the concept of "racial reproductive bias" — the addition of the word "reproductive" firmly grounds the framework within the topic of prenatal, pregnancy and postpartum health during, and post-pregnancy, and maternal health, both of which will be defined.

Racial reproductive bias is defined as the unequal treatment of an individual based on their race in the arena of reproduction and health. The word "health" could also be substituted in for "reproductive" to widen the sphere of influence to all forms of health versus exclusively reproductive health. Racial health bias is defined as the unequal treatment of an individual (or group of individuals) as it pertains to their health or the care offered in regards to their health and their racialized subjecthood in given place (Rabin 2019). This unequal treatment can stem directly from belonging to a racialized group race (Anachebe & Sutton 2003). Other forms of health bias can stem from socioeconomic status or other sociological factors that breed biases in society (Hostetther and Klein 2018). A different characterization of this occurrence has been named in the research as "ethnic health disparities" and can result from "stereotyping" of certain patients based on practitioners' preconceived notions (Anachebe & Sutton 2003).

Racial reproductive bias applies to unequal treatment based on race in reproductive health and includes general healthcare, doctors' appointments/consultations, availability of care, type of care, behavior during care, gynecological and obstetric care before, during and after pregnancy. While this may seem overzealous in the types of care included in "reproductive care" it is vital to recognize that racial biases start at the inception of health — even before an African American woman gets pregnant or gives birth, systemic factors are working against her because of her race and her gender. It must be noted that the care given to certain individuals in utero can be instrumental in determining their health in adolescence and adulthood (Thornton et al. 2016).

This fact should stress the importance of preventative and early care offered to individuals regardless of race.

The definitions of certain words employed in the rest of this capstone project will also be established when discussing groups of women in the context of pregnancy, maternal, and reproductive care. When examining groups of women that racial bias most affects, the term "Black women" is most often utilized. This term, within the scope of this project, is meant to include Black women who were born in the United States and Black women who have chosen to live in the United States from any other country. In certain texts, the term "non-Hispanic Black women" is presented, and is synonymous with Black women. For the purposes of this capstone, the term "African American women" is also meant to be synonymous with Black women — it is not meant to omit Black women who are not from Africa, but rather include any Black women in the United States. All of these terms are used in conjunction with these women of colors' pregnancy journeys in America.

With these definitions in mind, the literature review included will inform multiple frameworks that interact and inform each other through the lens of African American maternal mortality. Race and socioeconomic factors will characterize the bulk of the literature that is discussed, with economic and healthcare inequalities present as the secondary factors investigated and explored. While significant amounts of research surrounding maternal mortality has been conducted with an entire subsection devoted to Black women's care in obstetrics and gynecology, I will utilize this subsequent literature review to demonstrate that certain lapses in research, particularly work devoted to decreasing the rate of maternal mortality through policy suggestions or widespread federal change, still remain incomplete and insufficient. My conclusion and recommendations section will build upon these gaps ascertained from the literature review and will include my own findings from the one-on-one interviews I conducted.

SECTION II. Theoretical Framework

"I think literature is best when it's voicing what we would prefer not to talk about." Rick Moody, author.

Literature Review

Scholars studying healthcare, social science researchers studying racial inequality, and economic justice warriors have all considered and written extensively on the root causes and potential consequences of maternal mortality amongst Black women in the United States. The intersection of those three subjects—healthcare, racial inequality, and economic justice— all guide this literature review. The impact of racial inequality on maternal mortality is the main issue posed through this capstone project. Moreover, the influence of disparities in healthcare access and socioeconomic status on inequality of care that leads to maternal mortality is recognized and included in this review. By studying this topic and including scholarly works that contend with these three subjects, it is my intention to provide an interdisciplinary perspective with appropriate recommendations that tackle these nuanced issues on multiple levels. To explain further, the relevant literature argues that racial bias and inequity coupled with healthcare access and economic inequality are root causes of racial disparities in maternal mortality. I will demonstrate that while the articles analyzed in this review support the frameworks, they fail to fully appreciate the practicality and implementation of adequate equitable policies. If such policies are appropriately included, they may help Black women throughout their lives starting with their own birth into later life and maternal mortality may be addressed early on. To clarify, most of the subsequent literature contends with the symptoms of maternal mortality and fails to investigate the root disease of the issue—unjust treatment and inadequate support starting before pregnancy. Furthermore, generations of structural inequality weaved into the fabric of our society and our government lends a hand to the treatment that

Black women receive in the United States, one which cannot be fully eradicated without turning inward and examining the ways economic justice, healthcare access and racial equity are accounted for and viewed in our current society.

While it is not possible to clearly separate these three frames when studying the landscape of the literature, the intersectionality of these three frames will be incorporated throughout this review. It is especially prudent to include the meeting of these frameworks because in our society, they are often inextricably tied together— one cannot fully grasp the effects of healthcare inaccessibility without considering the economic ramifications that may have led to this disparity of care. It is similarly difficult to separate socioeconomic status from employment opportunities or level of medical care available from certain employment positions since healthcare and employment often go hand in hand in the United States. Racial bias can permeate every level of these frameworks from jobs to healthcare to opportunities given to an individual and as such, racial bias is the nodal framework from which the other frames are built upon. The level to which these frameworks affect one another cannot be overstated; therefore, the literature included in this review will reflect this convergence.

Racial Bias in the U.S.

Before investigating bias as a framework in the reproductive health sphere, the concept of racial bias and its effects on inequitable treatments for Black people and Black women within the United States must be examined. As outlined by anthropologists Dr. Michael Baran and Dr. James Herron in their course "Race in the Americas," at the Harvard Extension school, both professors begin an investigation of racial bias by first defining the term of racism, stating that "[it is] a lens through which people interpret, naturalize, and reproduce inequality" (Fieseler 2020). While this "lens" can start as an explicit lens that includes overt language of racism and prejudicial behavior, over time these outward classifications of racism can become embedded in

an individual implicitly. Individuals can still perpetuate racial supremacy and discrimination without saying or doing racists things. Instead, this "lens" can become implicit with micro-behaviors and small transgressions against a racial group coloring their every action without conscious knowledge of the racist origins of this behavior. The inequality that is emulated outward under the term of racism is done so through the treatment of people of different races, a concept that was cemented in the psyche of Americans when our country was being formed in the late 18th century (Ibid). From one angle, the United States was preaching "freedom and equality" as grounds for establishing an independent country, but underneath this veneer of fairness and self-governance hides the true foundation of our country's economy— the reliance on slave labor and racial inequality for African Americans that the U.S. depended on to succeed (Ibid). It seemed that notions of equality and individual rights only applied to a small group of people and even in the present day, as we try to move towards equality for all people, the unsavory history of our country's origins casts a shadow on society that we cannot fully escape. This notion of inequality— specifically a group of individuals that society has decided is different and unequal to other individuals— is the exact definition of structural inequality (Amadeo 2019). By preventing certain groups from "structurally" actualizing their rights and freedoms, society is utilizing the commonality within this group— in this case race— as a means for propagating inequality (ibid). I argue that racism and racial bias, as defined by Baran and Herron as the lens to which people reproduce inequality and then employ this inequality to judge others, leads to widespread structural inequality to which certain marginalized groups in the United States are forced to live under. In the case of the United States in the Reconstruction era, to justify the use of enslaved people for our country's economic benefit, Black people were deemed "biologically unequal" and their poor and inhumane treatment was justified through this mindset of superiority all while being cemented into the structures of the U.S. economy from its

inception (Fieseler 2020). The remnants of this characterization would continue to permeate American society for generations to come even when slavery was declared illegal. The concept of racism thrives beyond the legalized tenure of enslaved people.

The connection between present-day Black health and the historical treatment of Black people as "biologically unequal" during Reconstruction has been acknowledged and studied by the academic community, leading to research into the mistreatment of Black women specifically as a historical determinant of the treatment they receive today (Fieseler 2020, Prather et al. 2018, 250). An article published in 2018 by the National Center for Biotechnology Information led to the discovery that many factors contribute to the mortality and failing quality of healthcare for Black women today, including, but not limited to, their legal use as property for medical experimentation and scientific advancement (Prather et al. 2018, Judd 2013). Prather's article illuminates the distinct nature of reproductive health care for Black women as well as the complex factors which contribute to maternal mortality and failing health. Multiple complications compound treating Black women in America, the most nuanced of which is the institutionalized racism that contributes to disparate health outcomes for some races more than others. Laws created during the era of slave labor were not equitable while the mistreatment of African American citizens was commonplace and legal — how can we unearth and expel certain structures and mindsets within our government today when enslaved labor and inequality played a pivotal role in their inception?

This history of medical experimentation and the use of Black women's bodies may have started during the era of slavery, but as recently as the mid 1950s, this practice not only existed, but thrived. In 1951, an African American woman by the name of Henrietta Lacks was diagnosed with cancer and died a painful death nine months later, but today we remember her name because of her undying cell line that continued to multiply decades later. The He-La cell

line was taken from Henrietta's body without her permission and has since been used in a plethora of medical breakthroughs, yet their unlawful obtainment is a stark reminder that the use of African American women in the name of "science" did not die out in the 19th century, but was still taking place as late as 1951 (Grady 2010). The He-La cell line was used towards scientific advancement in vaccines, cancer and even AIDS, but their unauthorized acquisition still casts a shadow on the medical community today (Grady 2010). The precedent set for Henrietta's treatment can be traced back to the doctors during the era of Reconstruction who utilized Black women's bodies without their permission in the name of medicine. In fact, when Henrietta was being treated for cancer, segregation and the lasting effects of slavery were still very much present as she was treated in a Johns Hopkins' hospital labeled "colored," an indication of the times under Jim Crow laws (Grady 2010). These historical practices riddled with inequality and mistreatment cannot be disregarded, as they serve to inform present-day issues of maternal mortality for Black women. This obvious maltreatment and unconsented medical experimentation must be recognized when contending with present-day issues that pervade Black women's everyday experiences including reproductive and maternal health.

The initial categorization of African American people as "biologically inferior" and "unequal" in the United States is one that was and still is not erased easily in present day community, society and even governance. As Baran and Herron point out in Fieseler's article, racial bias and bias overall continue to pervade our society in all avenues which employ forms of judgement on certain individuals. Biases that originated from perceptions on enslaved labor still exist today, regardless of the fact that enslaved labor is outlawed in present-day society (Fieseler 2020). The case of affirmative action is brought to the forefront to demonstrate this relationship between judgement and racial bias. When people are asked to judge on "exclusion" and "inclusion," i.e. who belongs in a certain place and who doesn't, in this case a university of

college, certain preconceived notions cannot be stamped out based on an individual's "lens of interpreting and reproducing inequality" to borrow from the exact definition of racism (Ibid). The lens from which an individual views the world is set in a certain way, and Baran and Herron underline that these "biases explicitly excluded people who were not considered white" — African American individuals fall firmly in this category (Ibid). Baran and Herron continue to argue that because of this institutionalized disadvantage, racial bias must not only be corrected, but the way in which racial bias is embedded in our everyday lives must be recognized and "mitigated" (Ibid). One such solution is the existence of affirmative action in college-level admissions and acceptances. By having a program meant to specifically offset racial disadvantages, while by no means perfect, Baran and Herron suggest that even if biases and judgments cannot be entirely eliminated, certain steps can be taken to reduce the effects and shortcomings of those in powers' inability to separate out their biases. To be clear, Baran and Herron do not suggest that offsetting racial disadvantages is the entire solution to bias in the United States, but they posit that the ultimate solution would be to dismantle racial bias and demonstrate to people that "race is…socially constructed" (Fieseler 2020). Society deemed Black individuals to be "less than" and assigned the concept of racial inferiority to them— this assignment did not have a basis in biology, but rather in the mindsets of those who wished to utilize enslaved labor and needed justification for their actions (Ibid). When asking people to examine the structures of oppression growing from societal mindsets instead of only the symptoms of the issue, both sociologists contend this change in thinking can usher in actionable change, too.

Effects of Racism on African American Women

All African American people can be subjected to this form of racial bias, but to narrow our field of study more, the case of Black women will be emphasized throughout the remainder

of this literature review since maternal mortality exclusively affects women's health. In addition to racial bias affecting Black people on an institutional scale, gender discrimination can also play a significant role in the implicit biases felt by Black women in our country in a variety of institutional spheres. Whether it be the workplace or the doctor's office, Black women can, and often times, are targeted against and subjected to prejudicial beliefs and ideals that lead to discrimination against African American women in society. The ramifications of workplace discrimination for Black women will be explored later in this literature review under the framework of economic injustice leading to healthcare inaccessibility (Yearby 2018). Discrimination in healthcare in the US is the very concept this capstone project aims to investigate as racial and structural bias inordinately affect Black women in this country—maternal mortality affects this group of women more than any other group in this nation (Neighmond 2019). Black women have the unique misfortune of being subjected to both racial bias and gender discrimination in this country, both of which operate concurrently to negatively affect quality of care, employment, and healthcare access for these individuals. The spotlight of this capstone will focus on Black women specifically as they are especially burdened with increased incidence of maternal mortality and my research will unearth the nuanced and widespread forms of bias and discrimination they experience, in a variety of domains, that adversely impacts their perinatal and reproductive healthcare (Rabin 2019).

Race and Reproductive Bias

Through establishing the foundations of racism and racial bias in the United States as well as its application throughout a variety of institutions, we now turn towards race and reproductive bias as the initial "nodal" frame that has informed subsequent research on the topic of African American maternal mortality. This frame could not be separated from most research

observed in the field, as demonstrated by Baron and Herron in their investigation of structural oppression (Fieseler 2020). While numerous articles engage with sociological and economic factors that could be influencing this rising statistics of pregnant Black women's deaths, race must be examined in order to unveil the many deep rooted confounding effects of race in the US on health outcomes. As reported by Rabin's article, maternal death was examined not only in regards to African American women, but expanded to include birth outcomes in women of color overall, including Native American and Asian women (Rabin 2019). The author began by describing associations between race and disparate reproductive healthcare outcomes experienced by women with different ethnic backgrounds. Rabin then segued into specifying that African American women are over three times as likely to die in pregnancy or childbirth as Caucasian women, a statistic confirmed by the Center for Disease Control in a 2019 survey that reported on maternal mortality in the United States between 2011 and 2015 (Petersen EE et al. 2019). Discussing the risks African American women experience when undergoing pregnancy and childbirth, Rabin clarified that conditions such as hypertension or obesity shouldn't be fatal conditions that, for other races of women, are usually not. By including this distinction, Rabin focuses the conversation on why preventable conditions are leading to fatal outcomes for Black women specifically, highlighting the gap that exists, and questions what factors beyond scientific care may be at play (Rabin 2019). For literature surrounding a specific subject to be well-rounded and all encompassing, it must also include the periphery of what central "problem" is being studied. Rabin's article serves as an introductory piece of literature in this review because not only does she scrutinize maternal mortality on the whole, but she also asks the specific questions that this research project wishes to build upon: why are Black women dying more? And what can we do about it? By including a secondary question beyond the initial problem, Rabin is probing into Black maternal health further than naming and recognizing the issue.

Instead, she is inquiring what actionable change can be taken to assist this particular race of women and further narrowing the scope of her article, mirroring the specificity this capstone aims to achieve (Ibid).

Rabin's writing touches on a question that has not only garnered public interest within the United States in the past decades, but it has also caught the eye of governmental public health organizations who recognize that maternal mortality, and especially Black maternal mortality, is a public health crisis. The Center for Disease Control (CDC) launched its own monitoring program entitled the "Pregnancy Mortality Surveillance System" and has been tracking "pregnancy-related" deaths since 1986 (Center for Disease Control, accessed October 3, 2019). The CDC determined through its survey of maternal deaths that "Black non-Hispanic" women are dying at rates of 42.4 deaths per 100,000 live births, as opposed to 13 per 100,000 live births for white women, reaffirming Rabin's claim that Black women are dying more often. The CDC also details this in its surveillance program description, aptly stating that "considerable racial/ethnic disparities exist" and "...more can be done to understand and reduce pregnancy related deaths" that exist from this racial inequality (Center for Disease Control, accessed October 3, 2019, Petersen EE et al. 2019).

Rabin's investigation coupled with the statistics revealed by the CDC offer an entrance point to the body of research conducted on maternal mortality while highlighting the role "racial and ethnic disparities" undoubtedly play in this current public health crisis. While the CDC emphasizes that "non-Hispanic Black women" are more at risk for pregnancy-related deaths, Rabin explored the sources of these deaths, building upon the work done by the CDC and reporting that "despite frequent calls to improve access to medical care for women of color," Black women are still dying more (Petersen EE et al. 2019, Rabin 2019). Further articles in this literature review will explore these "calls to improve access" as well as contend with other

societal and economic factors that undoubtedly affect and compound maternal health for African American women.

To further substantiate this reporting on racial disparities in maternal death as well as build upon the CDC's survey of race and pregnancy-related complications, Flanders-Stepans (2000) provided statistics demonstrating the increase in African American maternal mortality since 1979 and specifically stated this statistic has been getting worse in the past forty years. Furthermore, Flanders-Stepans' points to a potential cause that needs to be investigated to uncover why these deaths are occurring, specifically writing that "health-seeking behavior" and "satisfaction with care" may be part of the reasons for this increasing statistic. More specifically, as explained through this article, the interactions between patient and practitioner can affect the quality of care a patient experiences, suggesting that some forms of bias exist in these interactions and are contributing to maternal death (Flanders-Stepans 2000). Flanders-Stepans' contention that some part of racially disparate maternal death for Black women may be a result of their lack of "satisfaction with care" is echoed later in this paper through my interviews with Black patients and care providers (doulas and midwives) who parallel this belief and provide firsthand experiences of unsatisfactory care they received. The introduction of racial bias through potential sociological or behavioral actions, leading to maternal mortality, is a major portion of my research question. While healthcare access and economic inequalities may lend a hand to Black mothers' increased mortality through lack of resources and unsatisfactory care, the more elusive causes of these deaths may lie in sociological and interpersonal interactions before, during, and after childbirth.

An issue as complex as Black maternal mortality in the United States has no straightforward, simple explanation. To tackle racial bias present in maternal mortality, many different solutions implemented at a variety of levels can and must be emphasized in order to

close the gap in maternal mortality disparities affecting Black women disproportionately. Dána-Ain Davis, a professor of Urban Studies at Queens College City University, understood this plight well, both as a scholar and a Black mother herself. Davis is the author of *Reproductive Injustice: Racism, Pregnancy and Premature Birth* (2019) which details her research into preterm birth and the neonatal intensive care units (NICU) across many states in the U.S. When writing about preterm birth, Davis found that it could not be discussed under the lens of racism and injustice without including the pregnancy of Black women prior to giving birth, stating that "looking at NICUs...also required looking at Black women's birthing experience," (Davis 2019, ix). While Davis' book contends primarily with premature births and increased incidence of such for Black women, Davis herself concedes that "contemporary ideas about reproduction and race have been influenced...during the era of slavery," (Davis 2019, ix). Davis is making the connection between the treatment of Black women in the reproductive arena with the definition of racism provided by Drs. Baron and Herron in Robert Fieseler's article surrounding racial bias, its historical organizations, and its current day implications (Fieseler 2020). While certain ideas about Black people and their inferiority were propagated during the "era of slavery," the ramifications of these notions still influence the "contemporary ideas about…race" which in turn can directly affect the levels of healthcare provided, and in particular, reproductive health (Ibid). Baron and Herron highlight that certain remnants of historical notions can seep down into the structural make-up of many different institutions of modern day society, of which the medical community is not immune (Ibid). Davis echoes this notion by pointing out that these certain "ideas" have a longstanding history embedded in our society's mindset and during the course of her research, she was reminded of this inconvenient truth during her own examination of preterm birth and reproduction.

Davis' research confirms that Black women and Black babies have less successful birth outcomes and higher rates of mortality revealed through in-depth interviews with Black mothers about their medical interactions. Supported by research conducted on "medical racism," the author's discussions with birth advocates on mistreatment due to race highlight the experiences of Black mothers in the NICU as a result of pregnancy complications including premature birth (Davis 2019, 202). Davis describes how Black women are often mistreated or treated with assumptions and biases during their pregnancies as well as during their labor and deliveries, and provided the example of Yvette, a forty year old Black woman who experienced a twin pregnancy and birth in Washington D.C. (Ibid, 91). She relayed how Yvette was met with multiple instances of mistreatment throughout her pregnancy and labor, right up until she gave birth to her twins prematurely at 26 weeks (Ibid). When first meeting with her doctors, Yvette asserted she was a high-risk pregnancy — the data backed up her claim because of her age and the fact she was carrying multiples— but her doctor disagreed and instead accused her of "being a hypochondriac" (Davis 2019, 91). When Yvette was taken to an ER shortly after this incident, she was met with similar treatment with the ER doctors not prioritizing her health because she didn't show enough symptoms, though she points out she was asked more than once if she was on drugs (Ibid). After giving birth to her son and daughter, Yvette noticed the assumptions made about her and her children, noting that though her children were dangerously premature and underdeveloped, nurses and staff kept saying "Black babies are so fit and strong"— an assumption that Yvette believes allowed them to not worry about her children as closely (Ibid, 92). These dangerous racial assumptions allowed nurses and doctors to relax around Yvette's children under the guise that they were "strong" enough to survive simply because of their race instead of being considered "fragile" and in need of constant care, which may have explained why one baby did not survive (Ibid). Yvette's experience is riddled with instances of neglect and

inattention and she felt her race was a contributing factor to this treatment. She candidly states that if she had been "white with blonde hair" her son would still be alive today (Ibid).

The impact of consistent mistreatment is salient and risky— if doctors are not listening to Black women during pregnancy, labor, and delivery, it is not surprising that in complicated births with babies that end up in the NICU, a similar form of behavior and mistreatment would follow suit as seen with Yvette's experiences. Davis investigates this exact claim and concludes the veracity of it. Through multiple interviews with Black women who have had premature babies, difficult births, and been subjected to serious neglect such as being ignored by nurses, Davis finds that pervasive racist behavior and bias is also lending a hand to poorer outcomes for Black babies just as it had with Yvette's baby son (Davis 2019, 92, 202).

Davis also emphasizes in her text the importance of doula and midwife services in the conversation as a solution to bridging the gap between mortality associated with pregnancy and race (2019, 205). The inclusion of alternative birthing plans (i.e. doulas and midwives) promotes more holistic and inclusive care during childbirth and may help pregnant women of color feel more comfortable during this process by the inclusion of extra caregivers to assure the health of these women (Ibid). Davis' inclusion of these remarks and possible solutions in the conclusion of her text parallels the conclusions and comments made by the participants in my own research, detailed in the following sections of this paper. Davis and my participants both emphasize from their own firsthand experience and research that one way to prevent maternal, infant and overall mortality in pregnancy is to "broad[en] prenatal care and birthing options" by encouraging more integrated care and hands-on attention to pregnant women (Ibid). By offering more attention to the needs of Black women and women of color, Davis contends that presenting more "collaborative care" through pregnancy and childbirth will work to negate certain assumptions and cases of mistreatment that could be found in traditional hospital settings (Ibid). By utilizing

"skilled birth workers and advocates," voices of Black women will be heard more, and less instances of prejudice and bias can be present (Ibid). Furthermore, including more than one caregiver as a resource to expectant mothers and encouraging a model that tailors each birth to a pregnant woman's specifications underscores the importance of a woman's choice in her labor and delivery and offers the patient respect and autonomy, the opposite of bias and prejudice. Davis' recommendations borrow from alternative models of care that will be investigated later in this capstone and I will return to her findings when putting forth my own conclusions and recommendations in collaboration with my research.

The power of Davis' text comes from her thorough research and meticulous interviewing over the past five years. Davis' particular use of highlighting Black women's stories throughout her book offers faces and voices of unique journeys compounded by the bleak tales of infant, reproductive and maternal illness. The personification Davis employs in every chapter of her book humanizes the public health crisis which spotlights real women, real babies, and real families suffering and dying at the hand of racial bias in the obstetric and gynecological field. To follow in Davis' footsteps, this next section of the literature review will put forward the stories of two Black women in the past five years who have personally struggled through mistreatment in their pregnancy and whose health has suffered insurmountably as a result.

Kira Johnson, 2016

On April 12th, 2016, Kira Johnson was about to become a mother for the second time. At Cedars-Sinai hospital in Los Angeles, commonly known as a hospital of the stars, Kira was scheduled to have a C-section to give birth to her second child, a baby boy that would later be named Langston. Kira was a healthy, accomplished 39 year old woman and by all accounts, was not concerned about the impending birth of her second son. When Kira and her husband Charles were told she would need to have a C-section, neither were too worried and confident this would

be one of the happiest days of their lives, as detailed by an NBC News article written by Elizabeth Chuck in 2018. Within one day, their dream would turn into a nightmare and Kira would die on a similar operating table to the one she gave birth on just one day before — Kira Johnson was pronounced dead on April 13, 2016, one day after she became a mother for the second time. How could a healthy 39 year-old woman die one day after having a "successful" C-section surgery in the United States? The answer to this tragedy is found in the routine surgery Kira had the day before — Kira's bladder was nicked during this procedure and when Charles brought it to the attention of the nurses, his concern was not taken seriously. Charles recounts that bloodwork was conducted along with the promise of a CT scan, but the blood work wasn't followed up on, a mistake that could have prevented Kira's death as the labs did illuminate abnormalities in her health. The CT scan was never completed and Charles kept asking the doctors to complete the scan as Kira's condition rapidly deteriorated and she "turned pale and began shivering uncontrollably" (Chuck 2018). When Kira was finally taken into surgery, she died almost immediately as a result of blood pooling in her abdomen. Kira's death is not only spotlighted in this literature review because of a preventable complication in her C-section, but also because of the gross mistreatment she and her husband Charles received after and despite the constant requests by Charles to get Kira looked at. The previous literature in this review highlights maternal death for Black women, but Kira's case is particularly devastating to recount: if at any time after her C-section Kira had been looked at or her labs had been read, her death could have been prevented. When Charles retells this tragic story, he says "the staff at Cedars-Sinai told me my wife was not a priority right now," focusing on the same causes of maternal mortality that articles written by Rabin and Flanders-Stepans conclude as well: routine negligence and carelessness are leading to death. Black women are dying more and these deaths,

like Kira's, are preventable if institutions and hospitals would not dismiss Black patients' concerns and complaints after giving birth (Rabin 2018, Flanders-Stepans 2000).

Charles Johnson lost his wife that day in 2016, but has since taken action and has not allowed his wife's death to be in vain. Says Charles, ""Every single woman in this country should have the right to give birth to a healthy baby and live to raise that child. Period" and since then, Charles has turned to activism to draw attention to the circumstances that led to Kira's death so that no other women may suffer a similar fate (Chuck 2018). In addition to suing Cedars-Sinai for gross negligence and the wrongful death of Kira, Charles has also been working to pass legislation to prevent maternal death in the United States and has spoken on behalf of H.R. 1318, a bill that "provides grants to all 50 states to establish state-based maternal mortality review committees to determine why women are dying from pregnancy-related deaths" (King 2019). H.R. 1318 was signed into law in December 2018 and is considered an important forward in the future prevention of maternal mortality in the United States (King 2019). H.R. 1318 is a landmark bill and is the silver lining behind Kira Johnson's death— but for Charles and his family, Kira's death will always be a painful tragedy (King 2019). Charles sums it up best, stating Kira, "challenged him in every aspect of his life" and even in her passing, he was challenged to push for a change so no one else would experience this devastation (Chuck 2018). I would only add that Black women dying should not be the reason we realize Black women shouldn't die— value and importance should always be placed on their lives, just as it should have been placed on Kira Johnson's life in 2016. I include Kira's story in this literature review because not only does it provide a firsthand experience of racial bias endangering the life of a Black woman, but it demonstrates that the complications that Kira endured were not insurmountable or mysterious, but rather very preventable medical issues that could have fixed sooner and saved her life. Charles Johnson knew his wife was in pain and he notified the correct

people to help Kira, but he was told his wife wasn't a priority regardless of the concerning symptoms she was developing. In this particular case, negligence and refusing to take Kira's concerns seriously are what led to her death— this is an example of racial bias's pervasive presence in obstetric care for Black women. The preconceived notions of the staff at Cedars-Sinai prevented Kira from receiving the treatment she should have to save her life, notions that were ingrained into their mindsets regardless of the symptoms Kira displayed and originated from biases which directly influenced the amount of attention Kira was receiving. It is important to note there are two levels of bias working against Black women like Kira: the quality of treatment and interactions these women are receiving from caregivers as well the structurally-cemented beliefs surrounding race that permeate medical and obstetric care. It is one thing to correct types of treatment Black women receive from their nurses and doctors and a whole other undertaking to dismantle the preconceived judgements and notions surround Black women, medical complications and pain that permeate our healthcare system today, as evidenced by Kira's untimely and completely preventable death. Charles Johnson took what happened to Kira and turned this tragedy into legislation to protect other Black women from Kira's fate with a legislative emphasis on reviewing maternal death that affects certain groups disproportionately such as Black women in America (King 2019). If Kira had been white, Charles believes she would still be alive today (Young 2020). He has the research to back up his belief that Kira's race negatively affected her treatment post childbirth with Black women up to 209% more likely to die than white women in respect to maternal mortality (ibid).

Serena Williams

Serena Williams is known worldwide for her Grand Slam titles and in 2017 she earned a new title, one that she considered her most important one: mother. Serena gave birth to her daughter Alexis Olympia Ohanian Jr. on September 1, 2017. Serena was no stranger to hospitals

nor was she unfamiliar with life-threatening conditions: in 2011, she was diagnosed with a pulmonary embolism that almost took her life (Salam 2018). Because of this harrowing chapter, Serena was hyper aware of her health following the birth of her daughter and when she experienced shortness of breath after her delivery, she notified her nurse right away (Salam 2018). Instead of trusting Serena to know her own body, the nurse resisted the self-diagnosis and told Williams she may have gotten confused from the pain medication (Salam 2018). When Serena insisted on a CT scan, the results were concerning: she made multiple clots in her lungs and was immediately put on a heparin IV drip, something she had immediately asked for when she had trouble breathing (Salam 2018). Her immediate concern was not unwarranted: when left without treatment blood clots are often fatal, especially when they are reoccurring in a patient as they were in Serena (Williams 2018). Serena was in a position to advocate for herself — with top notch medical care, childbirth should by no means have been a potentially fatal experience for her. So why weren't Serena's immediate concerns taken seriously? And what if she hadn't insisted on a CT scan, much like Kira Johnson could have used the year prior in Los Angeles?

Serena Williams herself says she is lucky to be alive and considers herself fortunate to even tell her story, but the fact of the matter is she almost died because her initial complaints were dismissed (Williams 2018, Salam 2018). If she had not continued to advocate for herself, her story might have ended far more tragically. Serena was in a position to say what she felt was happening and was able to recognize the signs that eluded her care providers (Salam 2018). She has taken to writing about her experience and lending her voice to the cause of Black maternal and infant mortality within the United States, saying that "who you are or where you are from" should not dictate whether "[you or] your baby dies" (Williams 2018). Serena Williams is included as one of the case studies in this literature review because as a wealthy, accomplished Black woman, she had access to the best insurance and the best care providers, yet she almost

died under similar circumstances as Kira Johnson. Both Charles Johnson and Serena Williams knew something was wrong, but neither were listened to right away (King 2019, Salam 2018). For Charles, the worst case scenario became his reality. When introducing this literature review, I contended that racial bias was the nodal frame informing the other frameworks and the articles introduced in this section. Serena Williams' case is a testament to that fact that when both other frameworks, economic injustice and healthcare inequality, are controlled for— Williams' net worth in 2018 was reported to be $180 million dollars and it would be hard pressed to argue she was economically disadvantaged— racial and implicit bias are still pervasive and can lead to harmful outcomes in pregnancy and childbirth (Cameron 2019). Both Charles Johnson, on behalf of Kira, and Serena Williams have taken these grievous chapters in their lives and turned them into something positive: they have advocated for change and in some cases, passed legislation to combat racial injustice in maternal health.

After a review of the literature that surrounds racial bias as cultivated by structural inequality in maternal mortality, the subsequent literature pivots to the two other secondary frames of my research: healthcare and economic injustice. The articles that relay these two topics are intertwined and instruct each other and will be discussed concurrently. The level of healthcare coverage and type of coverage is correlated with the socioeconomic status of the women who suffer from these negative maternal health outcomes. The National Partnership for Women and Families wrote an article last year entitled "Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities" which specifically handles systemic and healthcare access issues that undoubtedly direct some of the maternal deaths that are observed. The authors dedicate entire sections to the breakdown of healthcare barriers for women of color and the lack of care offered as a result of less resources and financial help given to Black communities and hospitals (Black Women's Maternal Health 2018). NPR

released an article with similar findings this year titled “Why Racial Gaps in Maternal Mortality Persist” that directly points to failures in the healthcare system and shortcomings of providers as a possible reason why more African American women are dying compared to other races (Neighmond 2019). The text goes on to suggest possible ways that hospitals and clinics can reconcile breaks in coverage and assist Black women in feeling more satisfaction with the care they receive (Ibid). The article also investigates racial differences in maternal mortality and acknowledges that widespread systemic change such as new, standardized models of care and communication between doctors and alternative care providers can address these deaths and suggests that implementation needs to occur quickly to stop the increase in this statistic for Black women (Ibid). By prescribing standardized levels of care for all patients and procedures for treating all patients equally, Neighmond suggests that increased oversight and extensive communication throughout hospital systems in the United States creates the “systemic change” we need to negate disparate health outcomes for Black women. This NPR article is irreplaceable in a literature review as it explicitly states that, even when accounting for socioeconomic status or education, these racial disparities “are not ameliorated” and do not disappear. I include Neighmond’s article surrounding race even when shifting to the other frameworks influencing maternal mortality to demonstrate that racial bias in other societal systems is always present and will continue to impact maternal health if these individual frameworks are examined and improved upon independently rather than comprehensively.

Race, and healthcare behavior informed by individuals’ race, remains the consistent sociological factor within multiple pieces of literature and may be the initial inequality that leads to this inconsistency within pregnant Black women in the United States. Clearly, something different is happening to expectant African American mothers that gives them the highest mortality rate within any subgroup of pregnant women. The articles collected within the

framework of "healthcare" all include possible suggestions and solutions in which healthcare inequalities for Black women can be tackled.

Racial and ethnic disparities exist within maternal mortality, but what is being done about it? The previous sources in this literature review contend with the racial gap that exists within maternal mortality. While significant research should continue to be devoted to this topic, after a certain point, research and its findings must be applied to a program or framework to be beneficial. In an effort to understand the reproductive and maternal health landscape for African American women in the U.S.,I discuss articles and programs, envisioned and existing, that are aimed at reducing this racial discrepancy and call for more action beyond "more research, more data collection and more study committees" (Hayes 2019). As of October of 2019, California signed into law Senate Bill 464 entitled the California Dignity in Pregnancy and Childbirth Act, a bill meant to directly target racial bias amongst other factors that lead to increasing rates of maternal mortality (SB 464). The crux of this legislation requires California's collection of maternal death to be more thoroughly catalogued for research purposes in addition to requiring physicians who treat individuals before, during and after pregnancy to undergo mandatory bias training (SB 464). In efforts to prevent mandatory training from lapsing, the bill requires that a "certificate of training completion upon request" be readily available and training must be repeated more frequently, should it be deemed necessary by the facility (SB 464). SB 464 demonstrates that California is taking landmark steps to address maternal mortality and racial biases. More states can and are following suit with powerful legislation, but even with this explicit rhetoric in bias training, mandated training may fall by the wayside. If facilities themselves are judging whether they require more bias training, there is a greater chance they may not recognize the need for more training. When oversight is done by the entity that requires the oversight, an honest appraisal may not be conducted. I recognize California should be

commended for taking the first steps addressing this crisis in a practical way, but SB 464 should be considered an entry point into future legislation across all states and even on a federal level that is more thorough and extensive. By drafting and codifying legislation that is federally applicable, all states will be required to follow the guidelines and rules of a particular bill, standardizing the types of care Black women, and all women receive. It should also be noted that much of SB 464 contends with the healthcare access side of maternal mortality, but other frameworks greatly influence the level of care a Black woman is able to receive, even in California.

This final framework, which could not be completely separated from healthcare access, is economic inequalities and disparities that exist for African American women — and more generally people of color overall. This topic deserves its own extensive research project. The literature utilized here scratches the surface to some of the economic injustices people of color have suffered since the formation of the U.S. The articles discussed in this section deliberately spotlight women of color and African American women. A second National Institute of Health article researched the social determinants of health including socioeconomic status for people of color and found that overall, African Americans are at greater risk for health issues based on their economic status and earning potential, all of which are traced back to racial bias and systematic oppression (Thorton et al. 2016). By incorporating zip code and neighborhood location, all largely affected by economic mobility, this study involved important social determinants and concluded that for those who are "economically disadvantaged" their health is far worse than those who are not (Ibid). The reason for this connection is no big mystery: those who have less income are more likely to skip on routine healthcare appointments and preventative care checks to save money on things such as co-payments, deductibles, and prescriptions that are not life-saving (Ibid). When a woman becomes pregnant, her need for

continued healthcare increases significantly and being "economically disadvantaged"— whether that be possessing a job that does not provide healthcare, being unable to afford healthcare out right, or increased out-of-pocket costs that cannot be covered— leads to less coverage and less quality care even during pregnancy and childbirth. These conclusions tie in closely with maternal mortality— the outcomes experienced in pregnant women's perinatal and reproductive healthcare will be less positive and less healthy as a direct result of decreased oversight and supervision. However, it is important to note that race cannot be fully divided from this category either — people of color and more specifically African Americans are more economically disadvantaged due to systematic and racial oppression tied so deeply into the fabric of our society which in turn influences the type of healthcare they receive. To further expound on this point, Black people in the United States have higher unemployment rates than their white counterparts—5.5% compared to 3.2%—as well as worse access to employment opportunities with "outright discrimination" being an underlying factor (Weller 2019). Beyond programs within the health sphere, legislation should look outward towards pilot programs or initiatives for Black women prior to pregnancy and childbirth such as employment assistance or opportunities for higher education. The source of mistreatment and bias cannot be discussed exhaustively without acknowledging and factoring in the economic inequalities that Black individuals in the United States face every day.

As discussed earlier in this section, Black women are subjugated to racial bias as well as gender discrimination, outlining the intersection of poorer treatment they are likely to experience throughout their life. This same intersection influences their lives in the economic sector as well— not only do Black women experience a gender pay gap, but they are also compounded with a racial pay gap (Frye 2019). To explain this two-tiered level of discrimination further, women in the United States overall are paid less than men in this country and when the race of

these women is factored in, Black women make "61 cents for every dollar earned by white men" in this country (Ibid). The distinction between white women and Black women lies in the treatment both races experienced throughout emancipation and the fight for equal rights: while white women fought to work outside the home, Black women were always expected to work, a notion that stems from Black women's historical presence in our country as exclusively enslaved labor. Because Black women were always expected to work in this country, their presence is less emphasized and as a result, their earnings reflect this habituation. When compared to the overall rate of pay women receive as compared to men in this country, that wage rises to 79 cents— a significant amount greater than the 61 cents for every dollar that Black women make. Because of our fraught history with slavery and the inequalities that affect our society structurally in the 21st century, Black women are often regarded with a different standard than white women— they are perceived as those who do not complete high-paying or important work, as being "lazy" or uninterested in work and, if they do hold positions of power or high-paying jobs, they can be expected to be grateful for whatever amount they are paid since they made it to a certain level (Frye 2019).

All of the preceding biases, from preconceived notions about work ethic to structural inequalities that negatively affect job opportunities, influence Black women in the workforce regardless of the circumstances surrounding their employment and as a result, the gender and racial wage gap come together in an unfortunate partnership to further disadvantage African American women. When tales of women's equality are spread and promoted within the United States, they seldom include the plights that Black women singularly face, nor is their narrative historically considered by the women's equality movement. The arguments surrounding the wage gap for Black women is just another way in which racial and structural inequality exist to disenfranchise this specific group of individuals. With lower salaries and lower paying jobs, the

types of healthcare offered to these same Black women can be lacking, or in some cases, unaffordable and unobtainable (Yearby 2018). An article published by the American Bar Association in 2018 sought to understand the substantial connection between structural racism and healthcare access for minority women including Black women in the United States. This study found that minority women and Black women are more likely to struggle with obtaining healthcare because of "structural racism" in employment and wages— this limited access to care inordinately affected women of color as compared to their Caucasian women counterparts (Ibid). Furthermore, if women of color were able to obtain healthcare, they were more likely to suffer from racial inequality within their healthcare system as well, with the case of worse quality of maternal and infant health for Black women being specifically cited in Yearby's article. Finally, as a result of greater barriers to healthcare access, worse treatment within healthcare, and worse comparable health for Black women and women of color overall, the "biological stresses" of worrying about quality of healthcare led to greater incidences of hypertension for Black women, especially those that were unable to express the harm this disparate treatment was causing them (Ibid). Recurring poor health can, in turn, adversely affect the employment and job security these Black women have, especially if poor health makes these women unable to complete their work and maintain the wages they do have to pay for treatment of their health problems.

When both of these frameworks are combined, this leads to the conclusion that overall, Black Americans, and Black women specifically, do not have access to the same levels of health insurance as their white counterparts. With health benefits and employment tied together securely in the knot that is the privatization of insurance, less employment access and opportunities means less access to healthcare (Weller 2019). Healthcare, employment opportunities, and economic inequalities are deeply intertwined in the well-being of African American citizens in the United States. These injustices include the plight of African American

women and can directly influence their healthcare treatment and experience including the realm of obstetrics and postpartum care. Yearby's research threads the needle from employment discrimination and inequality all the way through worse health outcomes for Black women by connecting the through lines of lower wages and job opportunities to less access to healthcare and quality treatment. It elucidates the tenable connection between the two final frameworks of this literature review— economic injustice and healthcare access— by establishing that both affect each other cyclically and concurrently. Greater instances of economic injustice for Black women lead to worse access to healthcare opportunities and worse healthcare options lead to worse overall health. This can affect the type of employment and job opportunities African American women can obtain in the United States.

Yearby's research also brings to the forefront an entire other facet of health for Black women within the United States — that of "biological stresses" and the combination of racial and gender discriminatory factors that can contribute to lower overall health and increased stress levels for individuals who experience racism and sexism (Yearby 2018). Recent sociological research highlights clear links between the "interconnectedness of inequality" and the "increased risk for poor health" specifically for African American women and other "disadvantaged groups" (Perry et al. 2013). The authors of this sociological study do not mince words when it comes to connecting racism and health, stating that "for African Americans, racism is often a source of chronic strain and psychological distress" (Ibid, 27). To build upon this statement further, the authors of this research contend that by having to deal with adversity in their daily lives much more frequently than their white counterparts, Black individuals take on extra "strain...and distress" simply by combating the micro-aggressions folded into our society on a structural level. The authors maintain a direct link between racial bias experienced by African Americans and their subsequent mental health, bridging the gap between experiencing racism, "daily hassles,"

and stress related to prejudice that can be converted into detrimental psychological conditions including “stress, depression and substance abuse” (Ibid). Furthermore, the authors also turn to the effects of racism on physical health and argue that undue burden from racism on mental health can foray into physical illnesses as well including, but not limited to, “increased risk for hypertension, infectious illnesses, and lifetime history of a range of physical diseases” (Ibid, 27). On their own, these illnesses and conditions are very serious and can lead to a host of other complications in life for individuals. Similar studies echo the long-lasting ramifications of racism on an individual while also investigating the effects of “institutional racism” and look beyond daily interactions, instead focusing on certain structural barriers, economically and otherwise, that contribute to worse health amongst other racial groups in the United States (Karlsen & Nazroo 2002, 624).

When discussing maternal health and racism, the occurrence and increased risk of hypertension reported for Black women is particularly concerning when it comes to labor and childbirth. If racism can cause greater risks of hypertension, and Black women are more likely to experience racism, they are also more likely to experience hypertension, an occurrence that has also been tested amongst pregnant Black women and found to be true (Ghosh et al. 2014). Black women are 1.43 times more likely to enter pregnancy with “chronic hypertension” as compared to their white counterparts and concerningly, greater incidences of “hypertensive disorders... may be related to their higher risk of developing cardiovascular disease later in life” (ibid, 286, 288). Not only are Black women more likely to have hypertension, but they are also at greater risk of developing heart problems later in life of which “social and environmental causes” related to race may explain a convergence, though more research must be done to substantiate this (ibid, 288). Hypertension during childbirth comes with a slew of its own possible complications and can lead to preeclampsia, a sometimes fatal condition that permanently damages organs (Kattah

& Garovic 2013, 229). It can also cause preterm delivery risking the infant's life as well as the need for a C-section, a full abdominal surgery as opposed to natural vaginal birth (ibid 229). If Black women are more likely to have hypertension, there is a greater chance of them experiencing any of the complications that can arise from hypertension, which can in turn lead to labor and delivery risks, some of which can be fatal and lead to increased incidences of maternal death (Ghosh et al. 2014, 286, Kattah & Garovic 2013, 229). This is the crux of racial bias leading to increased health risks and, as a result, less positive outcomes in maternal health and perinatal care. Because of interpersonal and structural racism in society, Black women suffer more from mental and physical health problems that can lead to maternal health complications or death (Perry et al. 2013, 27, Ghosh et al. 2014). The links between racism, health, and structural inequality highlight the intersectionality of disadvantage Black women must contend with on a regular basis, all of which can negatively affect their physical health, employment opportunities, and reproductive and maternal health care.

This survey of literature in the field of African American maternal mortality delves into the main tenets and components that will instruct my own research within this capstone project. Racial bias will be the framework emphasized the most as it in turn impacts all other factors that affect maternal mortality. As a conscientious researcher attempting to investigate maternal death thoroughly in the United States, it is prudent to include all frames that may influence the lens through which research about maternal mortality and racial discrepancies are understood and explained. As the notion of racial bias has distinguished itself as that which operates singularly and permeates all other structures, it must be prioritized when understanding and analyzing my own research and interviews within the context of reproductive and maternal health.

"I fundamentally believe that the people closest to the pain should be closest to the power, driving and informing our policymaking" Congresswoman Ayanna Pressley, 2020.

Research Methods & Scope

In an attempt to understand the research on the theoretical frames that inform the literature review and to provide connections between topics which have yet to be fully actualized by the preceding literature, the aim of my research project is to fill these gaps by conducting one-on-one interviews with actors who are directly involved in eradicating maternal mortality, improving reproductive care, and fulfilling patient services for Black mothers (Galletta & Cross 2012, 55). The range of agents involved include, but was not limited to: midwives, doulas, and their African American patients. The racial identity of the interviewees was critical when testing my methodology and I actively sought out women of color and African American women to interview. To fully research racial bias limiting a specific group of individuals — in this case, Black women— it was imperative my participant pool was primarily made up of this same demographic so they could speak to their firsthand, lived experience. Finally, my methodology includes an analysis of a current policy plan aimed to tackle maternal mortality in the state of New York, with a possibility for expansion into other states in the US. This policy plan is entitled, "*Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities"* and was used as a source to inform my own recommendations for targeting racially-influenced maternal mortality. This plan was published in March 2019 by three community organizations in New York state that all target bias and racism within the maternal and reproductive health sphere. The group that published this initiative is made up of: Ancient Song Doula Services in Brooklyn, New York; Village Birth International in New York, New Jersey and Northern Uganda; and Every Mother Counts, a worldwide non-profit organization. This doula pilot program was announced in 2018 and development was initiated that year to

expand the Medicaid Doula Program. By 2019, the program had been implemented and this report was drafted to catalogue its initial execution in New York State.

Interview Methodology

My research primarily features interviews with African American mothers who spoke to me about their experiences throughout pregnancy as well their responses to the racially-tinged systemic policies found in hospitals or clinics. A few of these same mothers also doubled as doulas and midwives who now work in a practicing role with Black pregnant patients. Through these interviews, I gathered information on the factors which affect the choice these women make in seeking out obstetric and gynecological care during pregnancy and childbirth at a traditional hospital facility versus choosing a more natural and holistic approach such as home birth. This form of methodology, one-on-one interviews, was pivotal in researching viable alternatives to standard obstetric care and negating racial bias. I spoke directly to the advocates who worked with pregnant women and who offered choices that led to more healthy pregnancies. It was imperative to include these voices in the data collected and I was able to make connections in the East Bay through my professors and former mentors that led me to conduct these interviews personally. I interviewed five different women for this research project—three of these women were African American, one woman was African American and multiracial and the final interviewee was a Latina woman. All participants disclosed their race voluntarily.

I conducted fairly casual interviews with my participants and had a set of pre-written questions that differed based upon the profession of the individual I was meeting (Galletta & Cross 2012, 46). Doulas and midwives had similar questions, but midwife-centered questioning contended more with the tenets of a successful birth and focused more on the pathways to a

successful childbirth experience. Questions for doulas tended to lean towards the health of the mother, including the emotional and mental health of the pregnant woman. Midwives have medical training and their profession is more centered on the baby's health, but that is not to suggest they do not treat or work with the pregnant mothers (Interview with Rodriguez February 11, 2020). I wanted to know what models have worked for different healthcare systems in the past and how the inclusion of midwives and doulas could be scaled up and expanded to apply to federal guidelines and policies. Furthermore, I asked caregivers how they think policy can and should be implemented in a practical way to fully address maternal mortality in the United States, specifically how hundreds of hospitals throughout all fifty states may implement a standardized protocol when treating historically underserved patients who have faced discriminatory behavior in the past (Galletta & Cross 2012, 63). Finally, I interviewed patients to get their opinion on what changes must be addressed so that they may feel better supported by practitioners within the healthcare systems in which they seek care. Specifically, I interviewed an African American woman on her choices in perinatal care, as well as some of the doulas who spoke to their experiences before becoming caregivers.

Through one of my interviews, I was invited to observe a doula and midwife support group that met in Oakland, California on a weekly basis. The main purpose of my attendance at this group was to meet other participants who wanted to be interviewed for this project as well as listen to these caregivers' firsthand experiences as it related to pregnancy care and childbirth. The racial background of these participants was varied and I was given the opportunity to ask all

of them if they wished to be interviewed. From my involvement in this meeting, I was able to acquire one more participant for my interviews.

Interview Participants:

Samsarah Morgan, Doula, Former Patient, Founder of the Oakland Better Birth Foundation.

Kiki Jordan, Midwife, Former Patient, The Golden Belly Midwifery.

Patricia Rodriguez, Master of Public Health student, previously worked at the Marin Family Birth Center and member of the SisterWeb Doula Program.

Michelle Dade[2] , Certified Doula, Oakland, CA.

Nabila Lester, An African American Mother.

Plan Analysis

In this section, I examined the initiative "Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities" including the initial research, the targeted demographic of patients, and ultimate recommendations this plan proposed. I analyzed the suggestions this initiative makes regarding the inclusion of doulas and alternative care providers in addition to the traditional obstetric and medical care providers present during pregnancy and childbirth. I also assessed the claims that the incorporation of doulas in pregnancy and childbirth can lead to better outcomes for both mother and infant as well as bridging the gap of cultural differences between providers and their patients leading to safer outcomes and better experiences from patient' points of view. I ended this analysis by inspecting the

[2] This is a pseudonym.

recommendations and implementation possibilities of this plan including the potential transference of protocols to California and other locations in the United States.

Limitations of the Methodology

It should be noted that beyond interviews and an in-depth analysis of a policy initiative aimed at tackling maternal mortality, other forms of methodology and an expansion in the range of the methodology utilized may enrich a research project contending with this topic on a widespread scale. Geographically, all interviews were conducted in a fairly narrow area and all within the state of California. When issuing recommendations and making conclusions based upon the interviews conducted, it is important to recognize that while some recommendations may work on a federal scale, certain states may operate under different guidelines and baselines when facing maternal mortality for African American women. Further research should be encouraged across all fifty states for federal recommendations to be the most feasible, though not to suggest the data accrued in California may not be applicable in a potential federal program. Additionally, if possible to do so in a sensitive way, interviews should be conducted with postpartum African American women who did suffer from post-pregnancy complications, should they feel comfortable speaking about what was undoubtedly a tragic event in their life. The case studies section of this capstone project were meant to shed a light and offer personalized accounts of African American women whose experiences related to pregnancy and postpartum care were not always healthy or positive.

SECTION III. Pregnancy and Racial Bias Data

"Birthing Black women should not have to save their own lives." Timil Jones, 2018.

Interview Analysis

This section of my capstone research focuses on the interviews conducted with midwives, doulas, patients and physicians. Some of these practitioners are African American women themselves who treat Black women before, during and after pregnancy. This section will specifically contain partial transcriptions of the interviews that are conducted. Additionally, data that is pulled from other texts or research articles that is deemed relevant to this project will also be expounded upon. Definitions of certain actors in the obstetric sphere will be provided and background information on participants will be included to better contextualize their relevance and experience that lends credence to their inclusion in the data analysis of this capstone. Their direct interactions with maternal health, and more unfortunately maternal mortality, deem them a prudent inclusion in this section.

Doulas and midwives are being utilized more and more in many women's pregnancy journeys and the inclusion of their voices in this portfolio of interviews felt necessary (Hosseini 2019). For purposes of clarification, midwives and doulas perform some of the same tasks, but midwives have had some form of medical training while doulas concentrate on the holistic health of the mother (Interview with Rodriguez February 11, 2020). In more and more cases, doulas and midwives are relied on through pregnancy in order to make the needs and requests of the mother feel heard and in some cases, this extra attention to detail is leading to better childbirth outcomes for women and women of color (Hosseini 2019). Doulas are encouraged to speak out if they witness or hear any type of mistreatment or if anything gets overlooked, a direct method of correction for any form of bias or influence that may transpire between a physician and patient (Hosseini 2019). Doulas are even able to have direct meetings with physicians and bring up these

corrections directly to providers, with some being "receptive and attempt[ing] to correct the issues" (Hosseini 2019). With an increased emphasis on holistic health and extra support in the form of alternative caregivers, doulas and midwives are becoming more prevalent in maternal health and I prioritized including their voices in my interviews.

The subsequent interviews began with questions regarding a participant's current occupation and place of work within the healthcare structure and then segue into their care of patients. Questions that were posed to these participants included, but are not limited to, questions regarding the demographics of the patients they saw, the types of healthcare coverage these patients had, and their experiences, whether personal or observed, of disparities in quality of healthcare. Follow-up questions included the racial background of specific patients and whether or not participants took part in bias training at their previous or current positions. The interviews culminated in more widespread questions on racial bias and healthcare policy overall with questions inquiring into what participants believe should be implemented or funded on a state or federal scale as well as what current policies in place are considered helpful and successful.

The first doula I interviewed was Samsarah Morgan, the African American executive and founder of the Oakland Better Birth Foundation, a group aimed at lowering the infant and maternal mortality rates in the local community. To better understand Morgan's impetus for starting this foundation and her own healing center, I asked her of her firsthand experiences during her first pregnancy in 1979. Morgan states that when discovering she was pregnant with twins, her journey in finding the right provider had a few false starts: "...I had to fire the first two obstetricians" she candidly shared with me (Interview with Morgan February 4, 2020). When asked to expand on the reasons why, Morgan did not mince words, decidedly stating they were

openly disrespectful to her and checked to see if she was married in the waiting room. When Morgan further detailed she wished to have a natural birth, she stated that the obstetricians looked at her like "[I] was crazy" (Interview with Morgan February 4, 2020). It was this mistreatment and lack of autonomy that led Morgan to want to provide a different, alternative type of support to expectant mothers everywhere. Morgan's experience is not unique — Kiki Jordan, a midwife at the Golden Belly Midwifery in Oakland, echoes Morgan's experiences in her own pregnancy twenty years ago. Recounts Jordan, "the kind of care I was getting was so dismissive...I wanted to offer the polar opposite type of approach" (Interview with Jordan February 7, 2020). When asked to enumerate the behavior she experienced, Jordan sighed a bit and said, "I think information was thrown out at me with the assumption that I just wouldn't be able to understand," her tone suggesting that the preconception of Black women not understanding was one she has encountered more times than she'd like to remember (Interview with Jordan February 7, 2020). She went on to recall that time wasn't taken in her own doctor's appointments to explain certain tests she needed, or how she didn't feel she could ask questions because the doctors knew best — all pervasive, "dismissive" behaviors that Jordan believes Black women have to contend with on a regular basis (Interview with Jordan February 7, 2020). Was this "dismissive" behavior a reflection of lack of time spent on patients or a lack of emphasis on explaining what was happening? Jordan herself recognized the treatment she was receiving at the time was not appropriate, though now she openly calls it something else: implicit bias (Interview with Jordan February 7, 2020). Jordan's physician at the time gave her the distinct impression she wouldn't understand what they were saying, so time was not given to explain the reasoning behind certain tests or express her own impression or ideas. This blatant

mistreatment was partially the impetus for her becoming a midwife in the first place: she wished to give better care than "what [she] received" (Interview with Jordan February 7, 2020).

Both Jordan and Morgan spoke of the inequalities they acutely felt during their own experiences' on the other side of the table, as patients, and highlight these experiences as the impetus to change the level of care offered to their clients. While both these anecdotes may appear to have a silver-lining with both Jordan and Morgan becoming doulas and midwives, respectively, both are examples of failures within the healthcare system with which these women have firsthand experience. To a certain degree, the individual experiencing a pregnancy can make choices for their health, but the onus for a respectful, uplifting interaction with practitioners during a transitional time in the life of a Black women should not fall upon the patient, nor should it require every Black woman to become a doula or a midwife. Jordan sums it best, stating "The responsibility is not Black women's; I don't think it's their responsibility to fix this" (Interview with Jordan February 7, 2020). Both Morgan and Jordan's voices in investigating maternal mortality for Black women should be at the forefront of maternal health advancement, both as women who have experienced stigma or bias in pregnancy and as current actors working with pregnant Black women today.

To demonstrate that times have not changed as much as one would expect, Samsarah Morgan provided another anecdote of an experience from last year, 2019, in which a Black mother was openly disrespected by a white physician. Recalls Morgan, " We had a case...of a woman who was delivering twins at Kaiser. She wants to have a natural birth of her twins...this doctor comes in and just starts yelling at her insisting that she has an epidural because she's prone to having hypertension because she's an African American woman. You're worrying about her being hypertensive [during labor] and yelling at her?" (Interview with Morgan

February 4, 2020). Morgan tells me this story to highlight the blatantly disrespectful treatment that Black women face, even in the most difficult of times. This patient was already going through a stressful time of childbirth and instead of her physician working to ease that, he is adding to it by openly yelling at her in the delivery room for decisions she wished to make about her birth. Furthermore, because she is Black, he makes the assumption that because there is a chance she may have hypertension, not based on her own measurement but because of her race, the physician insists on a different approach to her labor. Even if an epidural does end up being required, the physician's manner of approach to a contraction-experiencing Black woman was not appropriate. Morgan provides this example to me and I glean that it was to demonstrate the sometimes offensive behavior from physicians can occur at the eleventh hour: even in a delivery room right before a birth.

Nabila Lester, an African American mother who gave birth at Highland Hospital in Oakland, has her own share of mistreatment and inappropriate interactions with physicians from when she was pregnant in 2017. Said Lester, "I had a white male doctor say inappropriate things, racist things, ask me if I was sleeping around" (Interview with Lester February 26, 2020). When asked why she felt she was being treated this way, Lester points to the fact these physicians were white and male, not sharing in her own experiences as a Black woman living in the United States today (Lester February 26, 2020). I pressed why this particular obstetrician felt he could treat Lester in such a manner and her answer hit on preconceived notions and biases that accompany some physicians in healthcare today. Said Lester "people treat you as a Black woman, they treat you as if you should be strong and not complain about anything…" another incorrect bias that is leading to the misdiagnosis and fatal mistakes as it did in Serena Williams' case, also in 2017 (Interview with Lester February 26, 2020, Salam 2018). In Williams' case, a nurse suggested that

the pain Williams was experiencing was a result of her being confused, not the multiple, potentially fatal blood clots it turned out to be (Salam 2018). An incorrect claim has been floated before within the medical community that Black people, including Black women, are able to withstand more pain than white people, a misconception that originated from Reconstruction times when enslaved Black people were medically experimented on (Villarosa 2019). Lester is referring to the remnants of that ill-conceived and completely untrue notion— by treating Black women as "strong" and able to withstand more, they can be subjected to poorer treatment under the guise of "strength" (Villarosa 2019).

I followed up Lester's previous experience and asked about her most recent obstetrician, the obstetrician she eventually stayed with, and she had far different things to say: "She [the doctor] was also a Black woman and I'm a Black woman, having a Black doctor had her understand me a lot better than other people, my life, my struggles…" highlighting that Lester felt far more comfortable having someone who looked like her treat her during pregnancy and childbirth, further proof that representation within healthcare not only matters deeply, but can affect the quality of care certain patients receive. Lester went on to emphasize that her obstetrician was Black with four children of her own and that she understood Lester's stress and struggles from having a similar perspective—an understanding that made Lester feel more comfortable and stay with this provider (Interview with Lester February 26, 2020).

Michelle Dade[3], a doula located in the San Francisco Bay Area, also touched on the mistreatment from physicians and the importance of representation in providers, but from a different position in the labor room than Nabila Lester. Dade noted that Black women are more likely to suffer from hypertension, as the physician in Morgan's story had highlighted, but as a

[3] This is a pseudonym.

result, doctors and obstetricians are more focused on this condition, sometimes at the expense of other conditions. (Interview with Dade February 20, 2020). While it is true that Black individuals do suffer from hypertension in higher rates compared to white individuals, the causes for this are not fully known though lifestyle stresses and environmental characteristics may be partially the reason (Fuchs 2011). Stressors in everyday life can lead to higher incidences of blood pressure, but to completely focus on hypertension and not test for other conditions may be a mistake (Interview with Dade February 20, 2020). Dade tells a concerning recollection of an experience with an thirty-six year old African American patient whose blood pressure was tested incorrectly with a blood pressure cuff that was too small— doctors were aware of the miscalculation in the reading, but still labeled this patient as hypertensive because they considered her at-risk based on other factors, her race and age amongst them (Interview with Dade February 20, 2020). Dade informed me that when patients are over 35 years old, they are considered a "geriatric pregnancy" and at greater risk for hypertension and preeclampsia. The doctors knew that this patient's "entire care was based on an incorrect measurement," but continued with the plan of action because the patient was Black and over 35 (Interview with Dade February 20, 2020). Dade tells me this story to highlight that, even when measurements can be within safe zones, preconceived notions about patients change the trajectory of care they receive (Interview with Dade February 20, 2020). When I asked why this made the pregnancy of the patient less safe, Dade made the connection for me: with greater chance of hypertension, C-section can be pushed for by the obstetrician to avoid high blood pressures during delivery (Interview with Dade February 20, 2020). C-sections, abdominal surgeries in themselves, carry higher risks for complications and infections from incisions (Nierenberg 2018). Therefore, labeling a patient as hypertensive even when they are not may lead a physician to advocate for a C-section, which can lead to more complications since surgeries carry more risk in general than normal, vaginal births

(Nierenberg 2018). By considering the patient at greater risk of hypertension and basing this diagnosis on her race and age, these doctors' implicit beliefs despite true measurements stating otherwise led to a higher risk of complications for this patient.

Morgan, Jordan and Dade all have countless examples of interactions between Black women and their physicians that underscore the lack of empathy, miscommunication, or understanding these women endure during a sensitive period in their lives. Morgan explicitly shared that "the darker you are, the more likely you are to have a doctor be disrespectful to you," openly suggesting that there is a blatant difference in how people are treated based on their skin color (Interview with Morgan February 4, 2020). When pressed upon why, Morgan has an equally direct answer: "Racism. White supremacy. The same value is simply not placed on Black babies' [and mama's] lives. We had better mortality numbers under enslavement...because they wanted the product she was carrying" (Interview with Morgan February 4, 2020). By relating maternal survival and capitalism, Morgan has broached an entirely other section of healthcare: healthcare for profit. During Reconstruction times, the survival of Black women and babies was openly championed; to lose a mother and child was to lose a part of the workforce ("What Was It Like to Be n.d., accessed April 2, 2020). With this commercial aspect no longer incentivizing society, the "value" that Morgan mentioned no longer exists. Morgan could have been quoting directly from Dána-Ain Davis's text investigated in the literature review of this project: a direct quote heading the introduction of Davis' book reads "How do you keep the Black female body present and how do you own value for something that society won't give value to?" (Davis 2019, 1, Cocozza 2015). If Morgan were to add her two cents to the above quote, she might add the word "now" to end the quote: that society won't give value to *now*— Morgan's entire hypothesis about Black women dying more sits in the very idea Claudia Rankine poses in Dána-Ain Davis's

book: now that Black women aren't entities to be owned or carriers of a product, how do you make society give them value now? And furthermore, why does society need to be convinced of their value? The answer to the latter question may lie in historical treatment of Black women and the same structural disadvantages and incorrect biases that still exist in our society today— Black women can withstand more so they are given and need less (Villarosa 2019). This dangerous, preconceived notion contributes to the implicit biases Black women are faced with in many different arenas of society —reproductive healthcare is no exception.

Kiki Jordan had a similar answer when posed the same question about Black women's pregnancy and their increased rate of mortality: "[they are] living under the thumb of racism that permeates every single system…" specifically highlighting the hospital systems under which most women give birth (Interview with Jordan February 7, 2020). By touching on hospital systems as less than ideal places for birth, Jordan also recounted to me the correlation between increased incidents of C-section and rates of mortality amongst patients, paralleling an earlier point that Michelle Dade also brought to my attention: C-sections can be more risky for the health of mothers (Interview with Jordan February 7, 2020).

The interviews concluded with questions regarding each participants' thoughts on policy and systematic changes that are, and should, be undertaken. Samsarah Morgan gives credit to those trying to change the norms and help, but pointedly acknowledges "they're working for a system...that is based in racism and capitalism" and until they are willing to attack the institution that is paying their salary, widespread change remains elusive (Interview with Morgan February 4, 2020). Morgan argues in favor of a single payer healthcare system, meant to mimic other countries with far lower infant and maternal mortality rates (Interview with Morgan February 4, 2020). By including this note, Morgan touches on the aspects of healthcare access that also affect

maternal mortality rates— access to care would greatly affect the overall health of any individual, regardless of race, but in this case, Morgan is underlining the fact that certain groups of people have historically worse access to care than others. By contending that single-payer healthcare should be available in the US, Morgan brings in the third theoretical framework included in the literature review of this capstone — maternal mortality of any race cannot be fully separated from the discussions surrounding healthcare in this country. When Michelle Dade is asked her thoughts on policy or positive changes in protocol, her answer is equally as disheartening as Morgan's: while Dade believes that trainings aimed at eradicating racial bias can be helpful, she points out that the "willingness of participants" such as physicians and obstetricians plays a huge role in ushering in change as well as the quality of training and from whose perspective the training is conducted, seemingly highlighting the possible loopholes in protocols and workshops that may still be systematically present (Interview with Dade February 20, 2020). When the onus to change is on the actor that needs to change so prejudice may be stamped out, it becomes more difficult to tell whether implicit bias training is actually successful or whether it is being completed as a requirement to be checked off without any meaningful or lasting improvement.

In an effort to follow Kiki's Jordan's belief that those who are experiencing inequality should be included in the conversation, I asked Nabila Lester what she would like to see change within state and federal protocols and policies when it comes to maternal mortality and racial bias (Interview with Jordan February 7, 2020, Interview with Lester February 26, 2020). Lester paused for a second, then noted it was a good question, one she has clearly thought about previously (Interview with Lester February 26, 2020). Lester continued her thoughts stating, "I think recruiting and supporting Black women doctors— creating schools and providing

scholarship and opportunity for those interested in becoming doctors." Lester may have been sourcing from her own negative experiences with a white male doctor compared to the treatment she later received from a Black woman, tailoring her recommendations to what form of care she preferred (Interview with Lester February 26, 2020). Patricia Rodriguez, the former Chief Operating Officer of the Marin Family Birthing Center, had the same answer when asked what policies she would like to see implemented to tackle maternal mortality for both African American women and women of color: I think there's just more…[to be done]. It should be focused on bringing more providers of color" (Interview with Rodriguez February 11, 2020). When asked to elaborate on what more should be done, Rodriguez touches on the fact that while resources may be available, sometimes pregnant women may not know about them nor may they know to advocate for themselves. Rodriguez contends more advocacy and outreach should be done so that resources can reach those who need them. She also echoes Lester's sentiments that more opportunities for doctors of color should be created (Interview with Rodriguez February 11, 2020). Clearly, offering more opportunities for women of color to be on the other side of the table, as physicians, doctors or leaders in the field, is a priority as evidenced by the answers of more than one participant in my research.

When asked point-blank why African American women are dying from pregnancy at greater rates than other races, Samsarah Morgan points to racism — not just racism within individuals' interactions, but "institutional racism" — racism so firmly embedded in American society that to address these inequalities remains complicated and complex in contemporary healthcare. When asked how Morgan feels these disparities can be addressed, instead of advocating for policy change or governmental assistance, Morgan encourages individual African American young people to be unafraid of pregnancy and maternal risks, and instead forge ahead

in their child-rearing journeys, if that's what they wish (Interview with Morgan February 4, 2020). Instead of approaching this racial disparity from a top-down approach, Morgan speaks directly to her future patients, not so much assigning the responsibility of health on the individual, but recommending these individuals seek out more supportive healthcare including doulas and midwives, as Morgan did herself forty years ago (Interview with Morgan February 4, 2020). This sentiment of agency falling on African American mothers and fathers is not meant to be uncaring, but points to a far more concerning issue: Morgan does not believe that widespread change from organizations or governments will really make a difference because these organizations, in and of themselves, have racial inequalities built so firmly into their fabric, to try and address it would require a dismantling process that would be outright rejected because of the elaborate unraveling that would be required (Interview with Morgan February 4, 2020). And who can blame Samsarah Morgan for thinking so, when this country was founded upon the enslaved labor of her ancestors a mere two hundred and fifty years ago? Morgan doesn't believe that an overhaul of the contemporary systems of society such as healthcare or the economy will be recalibrated and reformed to stamp out discrepancies felt by people of her race— a historical look backwards at the treatment that Black people have experienced in this country, from enslavement to the Jim Crow era to modern-day conflicts and incarceration, demonstrates that her beliefs are not unfounded (Interview with Morgan February 4, 2020).

Samsarah Morgan ends her comments with a more hopeful, albeit foreboding warning, encouraging young African American people to make decisions not out of fear, but out of love— she hopes that the alarming statistics surrounding maternal mortality won't scare off future Black parents (Interview with Morgan February 4, 2020). If parenthood is a journey these individuals wish to undertake, Morgan encourages them to do it regardless of the circumstances and forces

working against them and instead advocates for them to seek out extra support in the form of midwives and doulas. She argues that when young Black individuals make parenting decisions out of fear of mistreatment and mistrust, "institutional racism and white supremacy" wins (Interview with Morgan February 4, 2020). Morgan concludes her interview with the notion that pregnancy and childbirth can be a beautiful thing and when one chooses this path regardless of the external, structural factors working against them, the exercising of their own rights' to parenthood is what can empower them in the face of inequality and racism.

Michelle Dade ends her interview with a more all-encompassing suggestion that she advocates to combat racism: "supporting more Black midwives, Black doulas, doulas of color" will help ease the cultural and racial differences. This allows Black women to "do well" in pregnancy and childbirth, paralleling Nabila Lester's earlier statement that more Black women should be given the opportunity through scholarship and education to lead, to practice, to treat, and work with Black patients (Interview with Lester February 27, 2020, Interview with Dade February 20, 2020, Tweedy 2015, Stallings 2019). Patricia Rodriguez mentions a similar approach when asked the same, final question of her interview regarding combating racism in maternal health and turns to education and awareness. Rodriguez specifies the importance of bringing Black women into the fold and "educat[ing] them" as future patients and future mothers' with alternative options available beyond the traditional routes of care (Interview with Rodriguez February 11, 2020).

Nabila Lester concludes her comments speaking about maternal mortality through a wider lens, bringing in quality of life concerns and economic inequalities that Black individuals contend with every day (Interview with Lester February 27, 2020). Lester concluded her final thoughts saying, "a lot of Black women don't feel supported. High mortality rate of women are a

reflection of the larger issues happening in the Black community" referring to specifically the unequal, largely Black racial makeup of the criminal justice system as well as the "availability of jobs" and "larger systemic issues" associated with the prison-industrial complex (Interview with Lester February 27, 2020). Lester ends her comments with a very sobering reality for Black women and men in the United States: maternal mortality is just the tip of the iceberg when it comes to inequalities that African Americans face every single day. Whether it be greater incidences of incarceration or less opportunities for employment, Black Americans suffer inordinately when compared to Caucasian individuals in the United States (Weller 2019). Lester's comments on "larger systemic issues" mirrors Ruth Gilmore's definition of racism as the practice of placing particular bodies in harm's way —whether it be in a prison cell or a hospital, when Black bodies are not prioritized and exploitation of this group is tolerated, structural inequalities that have led to these decisions are brought to the forefront and underline the disparities for certain races in the systems' we live in (Gilmore 2007). In the system of public health and maternal mortality, Black women are acutely feeling the effects of such inequalities with 3-4 times more incidences of pregnancy-related fatalities as white women— a clear example of a "group-differentiated vulnerability" that Gilmore writes of, with the "group" being Black women and the "vulnerability" being this increased statistic of mortality (Gilmore 2007, Maternal Mortality UNICEF 2019).

Lester's final words are an uncomfortable reminder that to tackle this extensive issue, one must contend with racial barriers implemented at every level against Black individuals. The final section of this capstone project must take this actuality into account when recommending solutions to eliminate the rates of Black maternal mortality completely. Nabila Lester's last sentence in her interview could be the summary behind the motivation for this entire capstone

project: “I want the best for other Black women — I was lucky, but every woman deserves that experience” (Lester February 26, 2020).

The final data I will incorporate into my research is the thorough examination of a community-based model that involves the inclusion of doulas as a measure to target racial disparities in perinatal health. This plan, entitled *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities*, was published in the state of New York in March 2019.

Plan Analysis

"*Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities"*[4]

In this section, I analyze the *Advancing Birth Justice* plan and examine the feasibility of certain recommendations and conclusions from the plan to build upon my own recommendations section of this capstone project. In addition to the inclusion of doulas within pregnancy and childbirth, this plan also encompasses an initiative of reimbursement for doula services to be covered under Medicaid so that it may "address the discrimination and inequities in health care experienced by low-income communities and communities of color" (Bey et al. 2019, 3). In addition to promoting the use of doulas for perinatal care, the program specifically includes their usage in conjunction with lowering the rates of unfavorable outcomes and maternal mortality for communities of color, a key distinction which made this initiative's examination consequential in the data collection stage of my research. In order to prescribe the use of doulas or midwives based upon my participants' interviews, the incorporation of a community-based doula initiative program lends credence to my future recommendations advising doula and midwife services to prevent racial discrepancies in maternal mortality.

While this birth justice plan has been proposed in New York State, the applicability to other states within the US is not far-fetched or out of the realm of possibility. In fact, within the research section of the initiative, the plan itself references a Los Angeles, CA HealthNet Pilot Program that is being implemented currently aimed at "improv[ing] birth outcomes for African American women and infants" (Bey et al. 2019, 23). *Advancing Birth Justice* references this pilot program to demonstrate that across other states, California included, more reimbursements by

4 A copy of the model can be found at: *Advancing Birth Justice*

Medicaid (known as Medi-Cal in California and provided substantially by HealthNet) have been proposed for doula services and community-based training. *Advancing Birth Justice* is utilizing these models to recommend additional funding and reimbursement in New York State as well (Bey et al. 2019, 23). I'm making this connection between this birthing initiative in New York States and its reliance on already existing California programs to demonstrate that when analyzing *Advancing Birth Justice's* recommendations, their transference and applicability to California is not a large leap in logic, but rather a natural, mimicable step. Furthermore, this plan also borrows from legislation and programing assigned within other states such as Massachusetts, Minnesota, and Oregon, building upon what other states have proposed— the next steps could theoretically be federal policy change for doulas services and maternal health outcomes for all races (Ibid).

In an attempt to ground their recommendations in fact and thorough research, *Advancing Birth Justice* (ABJ) provides a detailed explanation for their recommendations regarding doulas services as means to lower maternal mortality rates and provide better care for mothers of all colors (Bey et al. 2019, 6-7). Through their section on the landscape of maternal health, ABJ details the plights of current pregnant mothers of color and the staggering rates of maternal mortality within the U.S. as well as the state of New York (Ibid). An entire section of ABJ's introduction contends specifically with the deaths of Black women with the report stating that the maternal death rate for African American women is three to four times higher than that of white women, highlighting this to be the case country and state-wide (Ibid). ABJ also specifically enumerates that as of 2017, " 68% of women that experienced a pregnancy-related death were enrolled in Medicaid," underlining the reasoning for providing more doula services and coverage within the confines of Medicaid specifically, as this plan later details (Bey at al 2019, 6). For

context purposes, the authors behind ABJ recognize that maternal mortality and pregnancy-related death inordinately affects women of color and specially Black women and through this statistic of Medicaid and pregnancy deaths, ABJ is extrapolating that many of these deaths are most likely women of color or Black women. They are not wrong: the Medicaid Enrollment rate of Black individuals in the state of New York City is roughly 21% and 1.3 million individuals (Medicaid Enrollment by Race/Ethnicity December 2017). Compounded with the fact that Black women in New York State are three to four times more likely to die from pregnancy complications, of the 68% of Medicaid pregnancy-related deaths, roughly one third of these individuals are Black women (Medicaid Enrollment by Race/Ethnicity December 2017). To begin targeting racial disparities, the city of New York recognizes that Black patients, and Black women, make up a significant portion of Medicaid's patient pool— to address the eradication of implicit bias and curb maternal death, this initiative is tackling a population that already has limited resources or income and who are overwhelmingly people of color (Medicaid Enrollment by Race/Ethnicity December 2017).

Advancing Birth Justice recognizes that to eliminate these troubling statistics and promote better pregnancy outcomes, "state agencies must examine health care systems with a race equity lens" and understand specific barriers that are perpetuated against Black women and women of color (Bey at al 2019, 7). The authors of ABJ assert that the Medicaid Doula Pilot Program is meant to fill in the holes of racial health disparities that are currently experienced by communities of color, with a major tenant of this program including specific "feedback from community-based leadership" as a means of including the population at risk in a larger, leadership position (Ibid, 7). The sources behind the assertion that the inclusion of doulas leads to better pregnancy outcomes is supported by the American College of Obstetrics and

Gynecologists (ACOG) who themselves declare that " continuous labor support by a doula is 'one of the most effective tools to improve labor and delivery outcomes'" (Bey et al 2019, 8, American College of Obstetricians and Gynecologists 2014). The potential health benefits of including a doula in traditional obstetric care can lead to a lower likelihood of C-section, (the risks associated with a surgical procedure lead to less positive outcomes), and less usage of pain medication along with a whole host of other healthy birth factors (Ibid, 8). It is important to note that the statistics and conclusions provided by the ACOG are applicable across the United States and not confined to a single state. They are suggesting the use of doulas within pregnancies across the United States would be beneficial in many ways and the studies done by the ACOG were conducted with upwards of 10,000 women as participants over a large geographical spread (American College of Obstetricians and Gynecologists 2014).

With this background research highlighted early on in the model, the final components of *Advancing Birth Justice* detail the recommendations suggested for this community-based doula program. The recommendations section begins with the inclusion of "New York and other states" lending confidence to the fact that beyond the state of New York, these recommendations may still be applied for better birth outcomes and favorable maternal health results throughout the United States (Bey at al 2019, 26). A cornerstone of the plan's conclusions involves the "[collaboration] with...community-based doula programs" suggesting that without the continued support and blessing of already established doula programs, this pilot program within the confines of Medicaid will not be as successful (Ibid, 27). The recommendation goes on to specifically state that the doulas that are used in this program must be "equipped to serve communities of color" spotlighting that race plays a decidedly large role in maternal health and all recommendations should include this fact when shaping their subsequent considerations (Bey

et al 2019, 27). The following recommendation goes on to list exactly how these doulas may better serve these communities, stating that additional frameworks beyond reproductive experience must be incorporated such as "racial equity and cultural humility" (Bey et al 2019, 27). Through this delineation between reproductive training and "cultural humility," the plan advocates beyond good medical training and competent providers, cultural sensitivity to different mothers' backgrounds is also pertinent for a positive experience and greater safety for maternal health. If a laboring mother is from a different country, practices and behaviors that we in the U.S. may deem normal may appear intimidating, inappropriate or offensive to the patient. By including cultural and racial differences in doula-centric training, doulas may better serve their patients and report successful outcomes for these mothers. While this pilot program centers on the addition of doulas to the Medicaid program in New York and other states, I would argue these protocols must go beyond the assisters during labor and include the obstetricians and gynecologists who are treating pregnant patients as well — they too must be aware of racial and cultural differences during labor and childbirth.

The penultimate recommendation prescribed by *Advancing Birth Justice* echoes a suggestion I was exposed to in my own interviews with Nabila Lester and Michelle Dade: ABJ advises that, in order to "improve health equity" and "meet the needs of the intended population" resources must be invested into the training of more doulas of color and sourcing these trainees from the communities of need and communities of color this plan aims to assist in the first place (Bey et al 2019, 26-27). Lester and Dade both urged for a similar course of action with Lester feeling more comfortable when her physician looked like her and advocated for more women of color and Black women to be offered the opportunity to become doctors and midwives (Lester February 26, 2020). Dade also explicitly stated the same thing, contending that more Black

midwives and doulas of color would help ease the cultural and racial differences that are pervading maternal health currently (Dade February 20, 2020). The authors of *Advancing Birth Justice* concur and specifically include a financial stipulation in their recommendation stating that funding must be provided by states in order to "train and certify" these doulas of color to better help underserved populations (Bey et al. 2019, 27). This stipulation is imperative to consider when analyzing the recommendations of this community-based plan because it accounts for the fact that none of these changes will be admissible or applicable if funding is not provided by the state in this Medicaid model— this is an example of funding dedicated to the training and education of individuals from and for communities of color instead of funding for legislation meant to gather data. This recommendation does not state that funding be alloted into research, but rather allocated into action which can be translated into positive change. With more doulas of color trained with the state footing the bill, more Black women and women of color will have better pregnancy experiences and better pregnancy outcomes.

If the previous recommendation advocates for doulas of color from the communities that are underserved, the suggestion immediately following that expands the "community engagement" aspect of this doula program and asserts that in order to improve on health equity for people of color, those same groups must be a part of the conversation of change (Bey et al. 2019, 27). When discussing the final stages of the doula model, implementation and the practical ways this can be done are the final recommendations of *Advancing Birth Justice* and culminates the entire initiative. When proposing steps for how doulas of color can be introduced and utilized within the community, ABJ suggests that the execution of this step should only happen in conjunction with "leadership from within [the] communities of color" in order to establish "equitable models of care" (Bey et al. 2019, 27). In addition to garnering support from within the

community, in order to gain credence amongst the future pregnant client base, the initiative recognizes that in order for this implementation to be fully successful, patients and practitioners must be aware of these doula services so they may ask for them and "active steps to raise awareness" must be undertaken (Bey et al. 2019, 27). While this may sound less important or more trivial than the actual training and incorporation of doulas of color, this recommendation is perhaps the second most important one behind involving communities of color in their own health equity (Bey et al. 2019, 27). For a program or doula-model to be tested for feasibility and accessibility, patients and patients of color must actually utilize this service and the newly trained doulas in order for the program to be considered workable and pursuable. Furthermore, to justify more funding and more monetary resources spent on this doula-program, there must be some quantifiable measure to determine whether their implementation and roll-out of this initiative was done correctly and— perhaps equally important— whether it can be mimicked in other states or within other state-level or federal programs.

This community-based doula program should be commended for their efforts to go beyond funding and research and instead advocate for leadership within the communities of color that have historically been underrepresented and experienced inequality, racial and otherwise, within certain Medicaid structures. The plan openly acknowledges the need for "community participation and engagement," recognizing that without this, doula-implemented portions of this plan may fail or proper reimbursement may not be actualized (Bey et al. 2019, 26). *Advancing Birth Justice* calls for members of the community who can "support" the doula program within Medicaid to be included and utilized properly within the parameters of the initiative so that "racial inequity" may be tackled (Bey et al. 2019, 26). When forming my own recommendations based loosely off this program's advisement as well as my own participants'

firsthand knowledge and experience, I will include requirements of community-based and community-led programs emphasizing the inclusion of Black women and women of color in doula or midwife services and as policy advisers to better address racial disparities that exist within maternal and perinatal health currently.

SECTION IV. Community Analytical Reflection

Through my participation in the Urban and Public Affairs Program at University of San Francisco, I was offered the opportunity to work as a program and policy intern with Breast Cancer Prevention Partners (BCPP), a nonprofit aimed at pushing forward legislation in women's preventative health on a local, state and federal level. I worked at this internship during the Summer of 2019 and was tasked with assignments that varied from collating research from scientific articles and briefs to drafting memos and messaging for outward communications updating the community on the work BCPP was undertaking that particular summer.

My duties as a program and policy intern varied greatly at BCPP— I preferred this as I was able to work concurrently between the communications and policy departments to not only assist with priority legislative work, but then draft updates of said work into discernable and tangible memos that would be published on our website, social media sites, and go out to our nonprofit and business partners. I was also tasked with writing up a blog post for our website that detailed my firsthand experiences as an intern working in the nonprofit sector and what it felt like to be on the ground floor, advocating for legislation that had yet to be signed into law in California.[5]

Additionally, I was often tasked with background research on organizations or individuals who reached out to BCPP hoping to work in conjunction with them and offer support. I pulled together memos for our Program and Policy Director who then reviewed them and offered input on the actors we wished to include in our legislative agenda. Perhaps the most educational experience I had with BCPP were the two lobby days I participated in on behalf of SB 574, safe cosmetics legislation that was being voted on by the California legislature in

[5] The blog post can be found here: Making Change for Safe Cosmetics: Fragrance and Flavor Lobby Day

August of 2019. During these extensive lobby days, groups of advocates were sent to different Assemblymen and State Senators' offices to lobby on behalf of SB 574. This trial by practical experience I garnered during those humid days in our capital in Sacramento were exceedingly relevant—they taught me the skills needed when it comes to discourse between advocates and elected officials, as well as advocates and individuals in commerce related to cosmetics who actively lobbied against SB 574. This form of outreach, in the governmental sector as well as the business sector, is outreach I have since utilized in other internships and jobs I have participated in.

While BCPP's work focused on preventative health, the through lines that connect it with my research project are fairly strong— by applying BCPP's lens of preventative care to the policy and recommendations section of my research concerning maternal mortality, solutions can be brought forward that deal more with the overall public health issue and less with containing the symptoms of the crisis that is Black maternal mortality. Breast Cancer Prevention Partners was my first foray working in the nonprofit world on behalf of women's preventative care and I hope to emulate the work I did there in my future career and priorities.

SECTION V. Conclusions and Recommendations

"I want the best for other Black women — I was lucky, but every woman deserves that experience" - Nabila Lester, 2020.

The preceding data—through interviews, plan analyses, and reviews of the literature—highlight one thing above all else: a complicated, nuanced issue that cannot be solved by a one-size-fits-all approach. To clarify, many forms of recommendations through an interdisciplinary lens at varying levels will be required to fully tackle the issue of maternal mortality and the racial bias component of this subject. A commonality discussed with my interviewees as well as advocated for in the plan analysis of "*Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities"* (*ABJ)* is the inclusion of more Black women in positions of power and leadership. While the specifics of how and where this inclusion should take place varied, the overall message remained the same: when more Black women are put in charge of tackling maternal mortality as it affects their own community and their own lives, more feasible solutions can be implemented to truly reflect how racial bias in Black maternal mortality can be effectively combated.

My interviews with the five women, three African American and two of mixed race, represented five different positions in the field of maternal health and revealed an array of different solutions and recommendations when it comes to solving racial bias as it affects maternal mortality. Many of these solutions overlapped with each other and some echoed the same opinions surrounding representation in reproductive health, while others touched on equally plausible approaches to combating racism, as evidenced from their lived experiences in the medical sphere.

The prevailing sentiments amongst my research participants unanimously circled the concept of increasing educational opportunities for Black women and supporting their presence

as healthcare providers in the reproductive health field. *ABJ* also emphasized including Black women in positions of power in policy and legislation and spotlighting "community-based leadership" to better serve populations at risk (Interview with Lester February 27, 2020, Interview with Rodriguez February 11, 2020, Bey at al 2019, 7).

When asking my interviewees about solutions to racial bias in maternal health on a more micro-level, such as between patient and doctor, I was provided with answers that touched on representation within the obstetric field, specifically by offering more opportunities for Black women as doctors. I cite from my interview with Patricia Rodriguez where she underlines the importance for more "providers of color ", a sentiment that Nabila Lester echoes by stating that more Black women should be given the opportunity to become physicians and obstetricians. By having Black women in the practitioner role, racial bias within one-on-one interactions with patients may significantly decrease with physicians having similar cultural and societal upbringings as the patients they are caring for. With a shared background comes greater understanding and empathy through similar lived experiences. This overall recommendation of increased Black representation is substantiated by the recommendations provided in *ABJ*. One of the final recommendations drafted in this model within the Medicaid program in New York State is the inclusion of training doulas from the communities where they are intending to practice. The model goes on to suggest that when sourcing doulas from the intended communities they aim to practice in, there is a greater chance "health equity" will improve as those from within the community know what best could improve their maternal health rates and standard level of care (Bey et al 2019, 26-27). This mirrors Nabila Lester and Patricia Rodriguez's recommendation as well, albeit with a different form of caregiver: both my interviewees suggest sourcing doctors from the communities they aim to assist, while *ABJ* supports the representation of doulas in a

similar way. My recommendation would be the combination of these suggestions: by having different programs aimed at different positions in caregiving and maternal health such as physicians, obstetricians, and doulas, the maternal well-being of a Black woman will be best served with having more racial representation in her comprehensive perinatal healthcare.

Throughout this project, I asked the question regarding how racial biases have led to an increase in African American maternal mortality and what could be done to combat this mortality crisis through a policy lens. By implementing policies that propagate the education of Black women in the reproductive health field and by carving out programs aimed at offering these same women access to education in the medical field, some forms of racial bias may cease to exist from patient-doctor interactions as a result of increased representation and commonality shared between said doctor and patient. As Nabila Lester, an African American mother who gave birth in Oakland, voiced in her interview, her experiences with a Black obstetrician were far more positive and put her at greater ease than the inappropriate, uneasy interactions she had with her white, male doctor (Interview with Lester February 26, 2020). Lester explicitly felt this way because this Black obstetrician understood her "stresses and struggles"— this recommendation amplifies Lester's experience and calls for more widespread representation for all Black women in the medical field so that this level of commonality can be replicated across all exam rooms.

I parallel Lester's preferences in my recommendation that incorporating providers of color for patients of color eases certain cultural and ethnic barriers that can, in turn, mitigate racial bias and discriminatory treatment in maternal health. This in turn may work towards lowering rates of maternal mortality for women of color and Black women. Offering certain incentive programs such as scholarship opportunities in addition to financial support for

education and medical school for people of color, specifically Black women, can bring this previous recommendation of increased representation in the medical field to fruition.

The inclusion of doulas and midwives as part of the conversation to eliminate maternal mortality for Black women cannot be overemphasized and is mentioned time and time again within my interviews as well as in *ABJ.* In my introduction of this research project, I also posed the question regarding how racial biases can be mitigated from maternal mortality for Black women in the United States and what steps can be taken to combat these elevated death rates for this specific racial group of women through direct action or proposed policies. To echo the recommendations suggested in *ABJ,* Medicaid in New York State is including extra funding in their insurance plans to be used towards doulas and midwives in prenatal care. I recommend other states adopt this legislative goal and include extra funding in their state-provided health insurances for doula and midwives services. This inclusion is substantiated by Sarah Hosseini's article about doulas outlining the importance of extra care providers during pregnancy and labor and explicitly stating that doulas' importance may work to negate racial and implicit bias. The presence of a doula or midwife during a woman's pregnancy and labor offers an extra layer of oversight and support that can be utilized for increased communication, should anything inappropriate or unpleasant transpire between a doctor and a patient. *ABJ* 's research also highlights their suggestion of increased presence of doula services to "improve labor and delivery outcomes" (Bey et al 2019, 8, American College of Obstetricians and Gynecologists 2014, Hosseini 2019). By having an extra caregiver selected by the patient whose sole purpose is the holistic health and wellness of the mother and infant, certain racial biases can be stamped out preemptively by the presence of an advocate on behalf of the mother (Hosseini 2019). Furthermore, in following the recommendations by my interview participants who called for

more representation in healthcare and holistic pregnancy care, I suggest that the doulas and midwives utilized by certain patients reflect these patient's own races and cultures (Interview with Rodriguez February 11, 2020). By having increased representation in the reproductive health sphere, the chances of bias transpiring between client and doula or patient and doctor is greatly reduced and, often times, patients feel more comfortable with caregivers who look like them or who have had a similar journey through life as they have, a notion echoed by Nabila's Lester's own lived experience in her interview (Interview with Lester February 26, 2020). I utilize Nabila Lester's direction and *ABJ's* suggestion stating that to help decrease racial bias, doulas and midwives should be incorporated more regularly into women's perinatal care and covered under state-provided health insurance such as Medicaid. Ideally, this recommendation should be applied across all forms of health insurance, but privatized insurance is more difficult to legislate for than state-sponsored health insurance so Medicaid inclusion of doula services is a strong first step. With Medicaid reimbursements in New York including doulas, it sets a precedent that other states can adopt and implement so increased support and care is offered to women during pregnancy (Hosseini 2019, Bey et al 2019, 8). Furthermore, I would suggest doulas and midwives be re-characterized as essential services instead of elective care providers and their inclusion should be mandated by healthcare legislation.

To take this recommendation of doulas and midwives of color a step further, we must also look beyond doctor-patient representation and establish a framework in which more women of color can be in positions of power to advocate for legislation surrounding equity in healthcare. If this research project were to be expanded, I would recommend interviewing state-level and federal legislators that have already introduced some form of bill or law aimed at tackling racially disparate maternal mortality in the United States. In regards to California legislation, I

reached out to State Senator Holly Mitchell, an African American woman who introduced Senate Bill 464, a bill aimed to reduce implicit bias in pregnancy and childbirth for all women and women of color ("The California Dignity in Pregnancy and Childbirth Act" - SB 464 2020). I was unable to speak with Senator Mitchell, but her legislative voice and the voice of other lawmakers at the state-level is one that should be included in a secondary iteration of this research project. She has already written legislation with three specific policies aimed at negating implicit bias in perinatal care and emphasizes bias training and data collection on Black maternal death so they can be studied and prevented in the future (Ibid). Furthermore, as a woman of color authoring this bill, her representation of the Black community and Black women's health echoes my recommendation that more women of color should be the driving force for legislative change that directly affects their own communities and families. While Senator Mitchell's recommendations include implicit bias training to be mandated in clinics and hospitals that provide perinatal care, none of my interviewee's strongly supported bias training and instead believed that by attending to racial bias on a larger scale would tackle this issue further. Instead of focusing on correcting individual practitioners' prejudices and biases, the participants in this research project stressed the importance of targeting racial bias on a more macro level through more representation of their own race in the medical field. By bringing in more providers of color and more Black women into the fold as doctors and nurses of reproductive health, certain biases would not be present because specific cultural and ethnic barriers would not exist as a result of the provider and patient being of the same race. This is not to say I do not recommend implicit bias training, but that I recognize the shortcomings of training aimed at dismantling deeply-ingrained racial and structural prejudice. Implicit bias training should not be a once a year occurrence, but rather a daily process of examining one's choices and learning from past unfair

judgments and mistakes. This is much harder to mandate and inspect over time as much of it depends on personal growth and sociological, behavioral changes within an individual and in this case, a doctor or practitioner. Regardless, some forms of bias training in reproductive and maternal health should be present and scrutinized often for quality control by the same people of color that it is trying to help.

The issue of Black maternal mortality is multifaceted and can be tackled on many different levels — at the most intimate level, interactions between patients and doctors can be addressed and improved upon through forms of training and bias reduction. The next step up is the incorporation of more doctors and obstetricians of color, including African American women, who should be championed and incentivized to become doctors and ease cultural and ethnic differences that may arise in their respective fields. Parallel to this level of representation, the training and involvement of doulas and midwives of color may work in tandem with Black doctors to fully serve the needs of patients of color in reproductive and overall medical care. Finally, the broader recommendation to lessen maternal death is representation on all fronts and at all levels. For example, the addition of more Black leaders who legislate and prioritize their own underserved and underrepresented communities across many facets of present-day society is paramount to discernable, equitable change. This does not have to be solely in healthcare, but can reach beyond this system and include representation in the business sector, the economy, and higher levels of elected offices. An important tenant to recognize when approaching this problem is that intervention and eradication can be formulated and applied at every level in different systems from interpersonal interactions to representation over entire communities and states.

Beyond greater representation in policy makers and legislating implicit bias training, a second inclusion in this capstone research could have been an interview with an obstetrician or

gynecologist who works with women of color and could offer insight into how they approach perinatal care as it pertains to Black women. A physician in this body of data would have been a valuable addition as doctor/patient interaction is a major component of this capstone and bias training would be completed by a physician as well. The opinions and beliefs of doctors who provide reproductive care should also be included in the array of participants' voices provided in the data section of this research. I would suggest including the voices of Black doctors as well since they may be able to speak from their dual positions as practitioners and people of color who have experienced bias in some way. The views of Black women doctors should also be accentuated in a group of research interviews since they can speak to the unique intersection of racial and gender discrimination they may have faced through their own lives and educational journeys in becoming physicians.

The culmination of all these recommendations, I hope, will offer a roadmap so that maternal mortality rooted in racial bias can be tackled at every level, from inside the examination room all the way to the state and federal capital, where legislation can be ratified and implemented for the benefit and health of Black women. To address racial prejudice through one approach, increased representation of women of color in the health community and in elected offices can help ease the sharp inequality that Black women face, specifically within the reproductive care they receive. By including doctors who look like their patients and following new laws written by women of color, we can hope to ease the disparate maternal healthcare Black women receive in this country and lower the rates of mortality that pervade this community. We can work towards this goal by fostering an environment in which Black women feel empowered to ask questions and express their concerns and their pain by including and supporting advocates such as doulas and midwives within the structure of their obstetric care.

The task of dismantling the structural inequalities that produce implicit biases in healthcare infrastructure requires more than individual changes from doctors and communities—rather, it involves an overhaul of the entire system and a progressive mindset from those who were involved in maintaining these inequitable foundations in the past. By including the voices and opinions of the communities who have suffered from these inequities the most, as well as their hand in the framing and creation of solutions, we can begin to pull apart the prejudicial imbalances that have controlled our communities, our healthcare system, and our governments. This task is not insurmountable, but will require the assistance of those in power now, as well as a concerted effort to bring women, and women of color, to the center of this same power and potential. Proposed legislation tackling prejudice can then become codified into law and racial inequality can begin to unravel from the structures of present-day society. This is not a choice between whether we want to change or not, but rather a choice between doing all we can to save Black women's lives or not. We have to prioritize their well-being and take action so that those who have suffered in the past because of their race will not suffer now for the same reason.

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