# Black women's experiences of stereotype-related gendered racism in Health care delivery during pregnancy, Birth and postpartum

by
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## Dedication and Acknowledgements

I am thankful to the strong and brave Black women who told their stories to the primary investigator and to me. I thank them for entrusting us with their heart and believing that we would use them to make care better for the Black women and individuals behind them, and for themselves the next time they become pregnant. I give thanks to my family, Paul and London, who have sacrificed with me in this journey. To my parents, La Shawn and Toi Wells, who said they would be here and always have been. To my mentors/colleagues/co-researchers/ advisors Dr. Monica McLemore, Dr. Molly Altman, Dr. Karen Scott, Dr. Brittany Chambers, who I can't say enough about, who inspire me in their work, and who encourage me to be my best self. To my accountability partners, dear friends and colleagues, Bridget Rochios, Gloria Gonzalez, Florence Chien, Camyl Anderson, Brianna Singleton, Denisse Porter, who have learned alongside me, and who have embraced me. I honor and thank you all.



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## Contributions

Previously published materials have been used to support this thesis. This work is published in Social Science and Medicine and the reference is as follows:

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**Black women's experiences of stereotype-related gendered racism in health care delivery during pregnancy, birth and postpartum**

**Talita Wells Oseguera**

**Abstract**

Societal knowledge and research about health disparities that affect Black women and individuals with the capacity to become pregnant lacks an acknowledgement of the historical and presently occurring effects of individually and structurally mediated racism. While stereotype threat is recognized in the field of social psychology as related to performance-based tasks, it may likely play a role in health care settings between patients and health care providers; what's more, the concept of stereotype-related gendered racism mediates pregnancy-specific stress. This secondary analysis of data from a University of California, San Francisco Preterm Birth Initiative (UCSF PTBi) funded study, sought to center the experiences of Black women and validates both the presence of stereotype-related gendered racism and obstetric violence in the clinical setting and their contribution to outcomes for low-income Black women at risk for preterm birth; the parent study examined the interactions of person of color participants and their health care providers in San Francisco, California during pregnancy, childbirth and the postpartum period. The present analysis exemplifies Black women's lived experiences of stereotype-related gendered racism and that of obstetric racism. This thesis further aims to demonstrate to institutions who train health care providers, particularly those who will care for pregnant people, the harm that stereotype-related gendered racism and obstetric racism being upheld, and even taught, in the institutions can affect patients. This thesis begins to discuss how obstetric racism can be disrupted when training programs especially seek to disrupt, in Davis' (2018) words, the "technological and medicalized dominance and disempowering medicalization of pregnancy, labor, birth" and postpartum care.

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## Introduction

The University of California Preterm Birth Initiative's (PTBi) (www.pretermbirth.ucsf.edu) aim to end preterm birth and it's commitment to research that makes a difference outside of the lab and translates to real life led to, in 2015, a team of nurse scientists to take a community-based participatory informed approach. This intention led to focus groups where persons of color of reproductive age, who were pregnant or had recently experienced a pregnancy and whose pregnancies were at risk for preterm birth were asked to identify questions they wanted researched about pregnancy, childbirth, preterm birth, and preterm babies (Franck et al, 2018), and from there, several of those questions as presented by the community were studied**.** Guided by questions around the type and quality of health care delivery related to a person's race and their health insurance type as well as concerns about the most effective ways to improve patient-provider communication, particularly when patients perceive health care workers to be rude and insensitive, one PTBi postdoctoral fellow sought to ask about experiences of patient-provider interactions during pregnancy, labor and childbirth, and the postpartum period up to one year (Altman et al, 2019). The study's aims included the: exploration of the experiences of patient-provider interactions, identification of any underlying differences within the provider-patient interactions that affect decision-making around future pregnancies, identification of the potential ways for providers to better support women at risk for preterm birth during the preconception and inter-pregnancy periods (Altman et al, 2019). It should be noted that while the term women is used in this thesis- because that is how participants in this study identified- not every person with the capacity to becomes pregnant



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identifies with the term; this thesis means to include trans and gender non-conforming individuals.

## Statement of the problem

Maternal mortality is defined as the death of a person while pregnant through forty-two days of the termination of pregnancy, no matter the pregnancy outcome, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (World Health Organization, 2004); an earlier interpretation of the International Classification of Diseases, through 1998, included deaths occurring up to one year (CDC, 2007). Preterm birth is defined as birth occurring prior to thirty-seven weeks of gestation (Behrman & Butler, 2007). Despite the 1950s United Nations Educational, Scientific and Cultural Organization report asserting that all humans belong to the same species and that “race” is not a biological reality but a myth, the Centers for Disease Control continues to list “Black race” as a risk factor for preterm birth (CDC, 2017). In the United States (U.S.), Black women are at increased risk for both maternal mortality and preterm birth, not because of anything innate to their biology, but because of the cumulative impact of racism they experience over the life-course (Lu & Halfon, 2003). Racism is a system that structures opportunity and assigns value based on the social interpretation of how one looks and unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources (Jones, 2016). According to Critical Race Theory (CRT), the trans-disciplinary, race-equity methodology that originated in legal studies and is grounded in social justice (Ford & Airhihenbuwa, 2010),



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recognizes that the effects of racism cannot be separated from the evaluation of health outcomes.

Critical Race Theory proposes race to have no biological basis, and that race and races are products of social thought and relations; racism is “ordinary, not aberrational… the common way society does business, the common, everyday experience of most people of color in this country” (Delgado & Stefancic, 2017). CRT recognizes that racism is engrained into American society, so much that an individual racist need not exist to note that institutional racism is pervasive in the dominant culture, including the health care system. CRT then, could be applied to conclude that categorically, race should not be considered a risk factor for health outcomes; instead analysis of the effects of racism offers a more meaningful and clear explanation for disparities in health and health care delivery. The experience of race, in the form of racism, has been shown multiple times over, to effect birth outcomes, first by David and Collins (1997), including preterm delivery (Rich-Edwards et al, 2001).

The ordinariness of racism, as descried by CRT, is difficult to address or cure because it often goes unacknowledged, or worse, invalidated. In the healthcare setting where a certain color-blindness, or belief in the irrelevance of racism characterized by the tendency to attribute racial inequities to non-racial factors, ie socio-economic status (SES) (Ford & Airhihenbuwa, 2010) may be in effect, unconscious bias and structural racism are maintained. For patients of color, an existence of race consciousness, the deep awareness of one’s racial position is an added factor; this consciousness may be exacerbated especially when gendered racism, the ongoing unique oppression due to the intersection of race/ethnicity and stereotype threat (Steele, 2010) based on historically-rooted stereotypes about Black and Latina women’s



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sexuality and motherhood (Rosenthal & Lobel, 2018) is at play. Gendered racism, including that which occurs daily throughout one's lifetime, and specifically during pregnancy, influences women's sexual and reproductive health, including placing people at an increased risk for adverse birth outcomes, including preterm birth, low birth weight newborns, morbidity and mortality (Rosenthal and Lobel, 2018; Davis, 2018). Furthermore, pregnancy-specific stress is an outcome known to affect birth outcomes (Lobel et al, 2008; Lobel and Dunkel-Schetter, 2016). Pregnant people experience stress originating from a variety of pregnancy-specific issues, including physical symptoms, parenting concerns, relationship strains, bodily changes and accommodations, anxiety about labor and delivery, and concerns about the baby's health (Lobel et al, 2008). Black women in this study discussed other forms of pregnancy-specific stress related to prenatal care and heath care delivery, fear of forced separation, and discrimination from health care providers based on intersections of their identities, including race, economic status, marital status, and background. Stereotype-related gendered racism is not only associated with greater pregnancy-specific stress, it has role in mediating it (Rosenthal and Lobel, 2018) for Black women.

Davis (2018) introduced the concept of obstetric racism, which rests at the intersection of obstetric violence and medical racism; it is a specific form of gender-based violence experienced by birthing people who are subjected to acts of violence that result in "being subordinated *because* they are obstetric patients". The term recognizes the point where institutional violence and violence towards women meet. Obstetric violence describes health care professionals' participation in dehumanizing treatment and medical abuse, such as reproductive dominance, including birth rape and other physical violations. In countries outside

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of the United States, such acts are considered violations of human rights, however in the United States, they may be seen as the effects of the medicalization and technological shift of birth and healthcare access and a phenomenon experienced by particular women (Davis, 2018). As stated by Davis (2018), the term obstetric violence alone fails to describe how racism is folded in during medical encounters for Black women, those of medical racism. Historically, Black women have been subjected to detrimental medical encounters and deemed as “superbodies” worthy enough for experimentation, but devalued enough to be dehumanized (Cooper Owens, 2017). In addition to physical harm and abuse, Black women are disproportionately made to deal with emotional violence and abuse. Specifically, health care interactions during pregnancy lend themselves to a particular type of pregnancy-related stress (Lobel et al, 2008) that Black women may find the need to protect themselves from. The expectation of attending adequate prenatal care in and of itself is an effect of the paternalistic nature of the health care system. Seeking health care for one’s self is not required, yet it is expected as soon as a person with capacity to become pregnant does so. Cultural Health Capital (CHC), a theoretical framework for understanding how broad social inequalities operate in patient-provider interactions, argues that certain socially-transmitted and differentially distributed skills and resources are critical to the ability to engage and communicate within a clinical setting (Shim, 2010). For example, Shim (2010) proposes that due to the current U.S. health care system’s emphasis on patient initiative, self-knowledge, self-surveillance, and self-management, certain characteristics tend to be rewarded in clinical interactions, including: knowledge of what information is relevant to health care providers; the ability to take an involved attitude toward one’s body and health; the

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ability to communicate social privilege and resources that can act as cues of valuable social and economic status.

This thesis supports current evidence that interactions with health care providers and other points of health care delivery services are a source of such pregnancy-related stress and this particular stress is mediated by stereotype-related gendered racism. I reviewed the data and transcripts with specific attention to themes influenced by the Revised Prenatal Distress Questionnaire (Lobel et al, 2008) and pervasive, stereotypical archetypes identified by Davis (2019). This analysis also begins to explore the ways in which Black women, whether consciously or subconsciously, attempt to reconcile or mitigate the stereotype-related gendered racism.

I've experienced first-hand the injustice that persons of color, namely Black people, face within the healthcare system. In my positionality as a nurse-midwife trainee, I am particularly obligated to address these injustices. I believe the state of maternal health in the United States, my involvement in community-based research, and the training I have so far received both holds me to a particular accountability and equips me. Midwifery, as a practice, can be a solution. I hope studies such as this one can influence the midwifery field as well as the way people are trained as midwives.

**Research questions**

Despite research and findings related to stereotype threat in the academic and higher education setting, the inquiry into the ways in which gendered racism and obstetric racism occurs in health care delivery is novel. Based on the narratives, I argue in this secondary analysis that reproductive health care practices, procedures, and structural polices that



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participants described exemplified stereotype-related gendered racism and obstetric racism. I aimed to ask to following: 1. What are the ways Black women in San Francisco experience stereotype-related gendered racism and obstetric racism? 2. What are the intersectional archetypes most at play for Black women (in this study) seeking reproductive health care? 3. What strategies, if any, are Black women employing in an attempt to mitigate obstetric and stereotype-related gendered racism? Further, I am interested in exploring what solutions in terms of the midwifery profession and nurse midwifery training, can be applied as informed by Black women.

## Methods

### Design

This thesis is a secondary, post-hoc analysis of qualitative data from the larger PTBi-funded study on patient-provider interactions where the original exploratory descriptive study used a constructivist grounded theory approach for semi-structured interviews with participants up to one year post-partum, who during their pregnancies were at risk for preterm birth. The current analysis will use it as its data source.

### Parent study

Data for the parent study were collected between September 2015 and December 2017 using constructivist grounded theory methodologies described by Charmaz, Schatzman, and Clarke (Schatzman, 1991; Clarke, 2003; Charmaz, 2014). With constructivist grounded theory, the researcher does not act simply as an objective observer, but rather an active partner in the interaction, where both subjectivity and involvement exist. Conducting research in this way requires continued reflexivity and interrogation of researchers' positionality to reveal and



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account for the multiple ways in which acquired knowledge and assumptions inform the research process (Charmaz, 2014; Schatzman, 1991; Clarke, 2003). The study's team consisted of researchers with extensive expertise in qualitative research, reproductive health and health care delivery, community-based research, vulnerable populations, and racism and discrimination; four researchers were in clinical practice as nurses or nurse-midwives and two self-identified as women of color. As described by Altman et al (2019), "the study was informed by the following initial assumptions: 1) how patients are treated influences not only their experience but also their outcomes; 2) racism and discrimination exist and are prevalent in health care interactions; 3) people come to their health care encounters with experiences that can either help or hinder their ability to trust the care they receive; and 4) providers have an opportunity to provide care that builds trust and respect with patients and families." These specific baseline assumptions provided a foundation for the initial research question within a social justice context and were continually modified as understanding was deepened through participants' recollection of experiences told in the interviews.

**Sample, recruitment, and setting**

The original study consisted of 22 interviews with self-identified people of color recruited from one community-based organization in San Francisco. There was some snowball effect through existing community networks. Audio-recorded interviews, lasting between 30 and 120 minutes and were professionally transcribed verbatim for analysis. Human subjects approval was obtained for UCSF 317004 under Study Number 15-17548.  Verbal informed consent was obtained for all participants, and data were managed in accordance to the University privacy and security standards. All participants received a $50 gift card for their



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participation in the interviews. The present analysis focused on the sample of 12 interviews in which people self-identified as Black or African American. People who had recently given birth were invited to join the study if they were at least 18 years of age, between 6 weeks and 1 year postpartum, and self-identified as a person of color. After meeting inclusion criteria, participants were invited to engage in an open-ended, semi-structured interview with one of the investigators to discuss personal interactions with health care providers during pregnancy, birth, and postpartum period. All interviews were conducted in a private room at the community-based organization. The principal investigator, a white-identified nurse-midwife and researcher, and a Black-identified student graduate student nurse midwife conducted the interviews. Interview questions served as prompts however, participants were permitted to direct the interviews to topics most important to them, within the scope of the study. Later in the study, theoretical sampling (purposive sampling and/or re-examination of existing data based on ongoing analysis and developing theory or concepts) was performed to saturate concepts of common experience (Schatzman, 1991; Charmaz, 2014).

**Analysis**

Though the original data were collected using constant comparison and grounded theory, transcripts were analyzed secondarily using the process of thematic analysis (Braun & Clarke, 2006) through the steps described below. In brief, thematic analysis consists of a six-phase, theoretically-flexible process and tool used to analyze qualitative data. Thematic analysis, as described by Braun and Clarke (2006), can be a way to both reflect reality and to acknowledge the ways in which individuals make sense of their experiences. While thematic analysis is not bound to any particular theory, Braun and Clarke note the importance of making



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the theoretical position of the analysis clear. In this secondary analysis, I used the theoretical frameworks of critical race theory and cultural health capital exchange as well as the concepts of stereotype threat, stereotype-related gendered racism, and obstetric racism. I began the analysis by first re-familiarizing myself with the data set by re-reading and listening to all transcripts and voice recordings of self-identified Black participants (phase one). I actively engaged with repeated reading in an active way, searching for patterns, meaning, (Braun & Clarke, 2006) and emphasis and began to pull quotes, or extracts, from the interviews. In phase two, *generating for initial codes*, I gave codes to the extractions across the data set, often assigning multiple codes to each extraction. Extractions were kept large and with surrounding data so as to keep context. With a long list of codes identified across the data set, I then began looking for themes, or patterned responses, related to interactions participants had with health care providers, in phase three, *searching for themes*. I considered relationships between the codes and themes and recognized some sub-themes emerging quickly while other codes didn't seem to quite fit with one another. Braun and Clarke (2006) advise to keep all codes and themes in preparation of the next phase, when it could become apparent that themes should be combined, separated, or discarded. Phase four, *reviewing themes,* was a two-step process. First, I reviewed each theme with the accompanying extracts. I drew a thematic map, which aided me to see which themes had many extracts, which had few, and which had only one. In this phase, I re-read the coded extracts by theme to ensure that a coherent pattern was being formed. For the extracts that encompassed multiple codes, I considered with which code the extract might have more meaning. The fourth phase's second step consisted of considering the themes against the data set as a whole to consider the validity of individual themes related to



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the data set and if the themes when considered together, accurately represented the data set in it's entirety. Once I was satisfied with a group of themes, I moved to phase five, defining and naming themes. Because this phase was about defining and refining themes as well as identifying the stories that each told, I chose to consider existing literature in preparation for the final analysis. In this phase, I named working titles based on reviewed literature. In the sixth and final phase of this thematic analysis, *producing the report*, I aimed to choose vivid extracts without unnecessary complexity to ensure the data could be presented as a compelling, coherent, logical, non-repetitive account of the stories the data tells (Braun & Clarke, 2006).

This thesis represents perspectives and experiences as described by 12 self-identified Black participants as well as a consideration of Black women's experiences in the health care system as identified among existing literature.

## Results

The process of thematic analysis applied to this data set revealed the presence of two main themes: stereotype-related gendered racism and pregnancy-specific stress and sub-themes of: intolerance of the expression of Black pain, control of Black bodies and reproduction, incompetence or inability to parent well, fear of separation, experiences of racism.  In support of these themes, I have extracted exemplars from the transcripts that highlight the presence of such themes across participants' experiences of reproductive health care delivery.

### Stereotype-related gendered racism

#### *Black pain and the intolerable expression of it*

While it is known that Black patients' pain, even pediatric patients (Goyal et al, 2015),



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goes overwhelmingly undertreated in the United States, an interesting phenomenon emerged in this study, where it was communicated that health care providers might be intolerant of Black persons' expression of pain. Related to receiving pain medication for labor pain management, Black women described the experience to be violent, whether physically or emotionally:

> *"And then I got to the hospital… I told them I didn't want to have my child under no narcotics, no nothing… There was a reason why I did not want -- you know? I wanted to have a natural childbirth for the first time, you know?... And they decided to strap me down to the bed and stick this huge needle in my neck and I was pretty much just knocked out after that. Yeah. I'm in pain, but I'm not enough pain to where I want you guys to do anything about it… I mean I'm used to dealing with a lot of pain. And they told that if I kept screaming the way that I was screaming and making the noise that I was making that they would have no choice but to -- restrain me and make the situation bearable. And I told them. I kept telling them that I was fine and that I didn't need anything… I don't want anything. I can deal with it. And then four people came in there and held me down, both my arms and then the other ones held my legs down. And she turned my neck and she put it in my neck and I was kind of like dozed off for a second. And I woke up to them saying, "You have to push now. You have to push now." –Ray*

One woman shared that her choices for pain management were not respected when she wanted to "have her [baby] naturally", which for her, meant vaginally with no epidural. More specifically, she described how providers forced her to agree to an epidural she did not want. Denise recalled:

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*"I felt like the epidural was forced on me […] I already asked them not to bring it up, and they kept pushing it on me.  And then they're like, "You know, you should take the epidural because you're in a lot of pain, and if you don't take it, then you're probably going to have to get a C-section [...] I felt like that everybody was like ganging up on me and trying to tell me what to do […] I felt forced. It was really forced because it's just like, you know, you know I don't want a C-section, and so you say, "If you don't get the epidural, then you have to get a C-section." So, it was just like a lose-lose, and I still ended up getting a C-section […] It was just like I got lied to." - Denise*

Women described being disregarded by providers.  Being forced into labor pain management via medication, and any consequences of it, was considered in the best interest of the provider, instead of the patient. Ray, who was forcefully drugged, recalled being very sleepy after the birth and repeatedly fell asleep after the birth. At one point she woke up, asking to see her baby. The nurse's dismissive response caused this participant to further inquire about the baby's status:

*"And the lady [nurse] was telling me that it wasn't an appropriate time, to just go back to sleep, and they'll deal with me later […] And I go, "Is my baby even alive?"  And nobody would tell me anything.  So, I doze back off and then by the next time I woke up they told me that I couldn't get up.  My baby was in the NICU and that I could see him tomorrow. –-Ray*

Across the interviews, when discussing childbirth, people shared that they were either drugged against their will or coerced into agreeing to medications, even while verbally declining



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pharmacological pain management. For each of the participants, it was important to be fully present during their births as well as have their desires listened to and respected.

***Control of Black bodies and reproduction***

Study participants recounted times when the Black woman's bodily autonomy was permissively devalued in the health care setting. Individual Black women may be seen as just another young, poor, uneducated Black girl (Rosenthal and Lobel, 2018) that should be controlled. One participant shared her provider makes it a point at each visit to pressure her into agreeing to an intrauterine device (IUD) to prevent pregnancy:

> *"So, I didn't let her do it [place an IUD] (laughs) and I still won't let her do it. And every time I go she goes, "You ready to get that IUD today?" "Hell no. I'm not getting it." I'll use condoms […] She asks me every single time. And every time I'm like, 'No.' She's like, 'Are you sure?' I'm sure. I'm positive. I'm not getting it. You can ask me a million times. I'll go and learn how to say no in other languages and come back and tell you that shit in (laughs) other languages because I'm not doing it." --Beverly*

While preventing unintended pregnancy, defined as mistimed or unplanned pregnancy (National Center for Health Statistics, 2010), is an established public health goal named in Healthy People 2020 (cdc.gov), aimed at improving pregnancy planning, spacing, and preventing unintended pregnancy, health care providers' potential sense of obligation to lessening the burden on the health care system comes across as hastily controlling Black bodies. Lisa spoke about being pressured to choose a birth control method to, in essence, avoid burdening the public by becoming pregnant again:



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*"They immediately want to put you on birth control. They really pressed the issue to put you on birth control meaning like, 'Okay, you've had this baby. Let's not have another one right away,' kind of thing. Well, say somebody wanted to. I didn't personally, but say somebody wanted to. Why are you pressing? 'Okay, well, you need to get on one of these. You need to get on one of these birth controls immediately', kind of thing. It was almost like, '(claps) Come on now (claps)'. What if I just don't want to use birth control? She [this baby] was planned with precision 'cause my illness -- she was planned. It wasn't just like, 'Oh, you're pregnant,' you know? She's no welfare baby […] Medi-Cal is given to people with low income or, you know, or something like that. So, let's not make any more babies that's kind of, you know, on our dime kind of thing… No more babies on our dime. ' You can have this one. Okay, no more, you know, kind of thing. –Lisa*

Teri also shared about the pressure from health care providers to choose a birth control method while in the hospital and also discussed whose benefit she thought was being considered most important:

*"They wanted to get me on a birth control while I was still in the hospital. It felt like they were trying to temporarily sterilize me, you know, and make sure that they don't have to have another bill or another kid or whatever. But I think it seemed like it was more for them, not really about my needs." –Teri*

The stereotype that Black people can't be trusted to responsibly manage their own fertility and that Black people's reproduction should be limited is clear in these stories. Further, these experiences existed across prenatal, hospital admissions for childbirth, and in the postpartum encounters.



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***Incompetence, irresponsibility, or inability to parent well***

Participants conveyed that judgment was placed on them for becoming pregnant and, or, that their parenting ability was under surveillance. Lisa talked about providers' disapproval of her pregnancy, equating it to being irresponsible:

> *"Because of my illness, those that are uneducated about it -- I almost got a look like, "How dare you?" You know, "How dare you bring a child into this world and under your circumstances and your situation […] She's not suffering from the same illness that I have because I take care of myself. They're [prenatal providers] uneducated about the situation […] Her and her father are ok […] It's just me—that has to deal with it. It is not a death sentence like it used to be[…] It's like, almost like, I'm irresponsible, you know? She was planned with precision 'cause my illness -- she was planned." --Lisa*

Lauryn, who was parenting for the first time, and who birthed a set of twins, discussed being met with providers' "stinky attitudes" and coldness during prenatal care, especially whenever she had many questions. When asked about what led to their behavior and whether she suspected all patients are treated similarly or if it was the provider's personality, she responded:

> "*No. I felt like maybe they treated certain people from a certain background like that, or maybe they, like, read my chart and my background and was, like-- you know, they didn't look at me as being a fit parent."* –Lauryn

Even when their choices and plans around parenthood were given great consideration, participants were subject to judgments around parenting ability, competence, and responsibility.



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**Stereotype-related gendered racism and pregnancy-specific stress**

***Fear of separation***

Some Black women interviewees experienced the threat of forced separation as a pregnancy-related stress. Participants talked about fear of separation based on housing instability:

> *"You know, I feel like they ask you questions repeatedly since -- depending on your living situation. It kind of made me feel like I wouldn't be able to take her out with me because I'm at a shelter." --Denise*

Teri shared that early in her pregnancy, she reached out to providers about getting support with and quitting substance use. She mentioned that her living arrangement was not conducive for abstinence. Though she felt it necessary to disclose this information to seek help, she still had a fear of being reported and subsequently separated from her child:

> "*I got some positive feedback saying that it was good that I was brave enough to be honest about it, you know, soon into my pregnancy. So I felt comfortable talking about it. And I did mention that I had fears of like CPS [Child Protective Services] coming in like right when I deliver, but they were like as long as you're clean and stuff when the baby is born that's the main thing." -Teri*

Later, when Teri was struggling to breastfeed, fears about being separated from her child resurfaced when health care providers recognized that her baby was hungry:

> *"And then it was like, yeah, I just felt really bad when they'd [nurses or pediatricians] say she was hungry -- like I'm starving my kid or something. And the CPS thoughts came up like maybe they're going to see that I'm not fit from the jump, but that's not what happened". -Teri*



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While some Black women were threatened by separation from their infant, others experienced it. During the hospital stay, Lisa woke to her baby no longer being in her postpartum room. The nurses claimed they needed to check the baby's bilirubin, but neither gained consent nor alerted the mother of their intentions. Lisa recalls:

> *"Where's my baby?" They're like, "She's in the nursery because-- you know, whatever". And I'm like, "Well, why didn't anybody wake me up and tell me about this? […] This is my baby. Bring my baby back here," you know? What does she need to go in the nursery for?... "Why can't you do that in here in the room? Why do you have to take her somewhere? [...] I want her in my presence at all times you know what I mean? I carried this baby for nine months. Why are you taking her somewhere else to stick her with something?" –Lisa*

Ray, in the postpartum period at the hospital recalled it seeming as though staff purposefully created a barrier for breastfeeding her child, claiming that she refused to take a drug test. She reported,

> *"They said, "Well, we need you to do a drug test first." And I said, "Okay." Nobody ever came back. And then they told the worker that I refused the test. And I said, "I never refused the test. Why would I refuse the test if I'm trying to breastfeed my child? He's a preemie. I know how important it is for him to have my milk." -Ray*

While Ray's baby was being cared for in the intensive care unit, she pumped breastmilk daily, only to learn that nurses never gave her breastmilk.

Some Black patients experience the health care system as a set-up for failure or entrapment. Slim, who expressed concerning mental health symptoms over the phone to her



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therapist, feared being separated from her baby if she agreed to going to an inpatient psychiatric unit. Mobile mental heath services personnel conveyed that she would be taken to the labor and delivery unit where she would be evaluated. She only agreed because she was told that her daughter would be cared for in the nursery. When she arrived to the hospital, she was instead taken to the psychiatric emergency services (PES) unit and the baby was removed, placed under the care of CPS. Slim shared:

> *"And then so they brought me to the PES, which is not Labor and Delivery and then I was just trapped there. And then I couldn't get out. And then, so they kept saying that they were going to bring me to Labor and Delivery when there was a bed available, and all this stuff. And then that never happened. And I was breastfeeding. Not pumping, just straight breastfeeding. So, the doctors from the Labor and Delivery came with a pump so they could help me pump. This was after like four or five hours of being there and then not being able to see her [the baby]. And then when the doctors went to give her, her milk, the two CPS people had taken her away." -Slim*

The threat of forced separation, beginning as a pregnancy-specific stressor was experienced among participants in this study in a multitude of contexts. In both the inpatient and outpatient settings of the postpartum period, Black women in this study were also not safe from the threat or reality of forced separation.

***Racism in health care delivery and consequences***

Black women in this study identified the often subtle yet impactful ways healthcare providers invoked discrimination, disrespect, and treated them as less-than-human.



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*"I would tell them about my concerns.  And they were just like, oh, okay; yeah, yeah, yeah.  And then sending me off because [they] want to hurry up and get through this appointment.  But the people after me, you know, [they're] nice and sweet to them.  I saw a difference in care. […]  I think race and status.  Her dad didn't go to the shorter appointments with me because they were like 15 minutes and he was coming from a different city.  So, wouldn't that make sense to come -- but he was at all the big, big appointments.  So, I think not seeing -- it felt more like stereotyping.  You know, like another black female without a husband or someone.  It just kind of made me feel that way, like I was just another number, just somebody you just kind of sent along." --Tanya*

*"But they judged me because of my skin tone, my baby daddy's skin tone. –Gia*

Sometimes, the treatment received from providers led individuals to consider disengaging from care:

*"So, do I want to go to the doctor?  No!  It's like every time I have an appointment… Every time they call me they want me to go into an appointment it's like to set me up, or something.  It's like a trap and all I'm doing is minding my business and trying to communicate my symptoms or something.  I can't ask for help and I can't not ask for help because either way they'll catch you.  And then once you're in the system, then you're in it.  And then you can't do anything." –Slim*

At other times, Black women lapsed in their prenatal care as a way to protect themselves from a system that, in many circumstances, perpetuates harm.

*"I felt like -- like, the doctors were, like, against me in some sort of way… I'm like, you're not going to sit there and be rude to me and just, like, make me feel like I don't have a say or a choice in the matter, and you expect me to keep coming here. And those two,*



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*three months where I went without care was, like, really scary to me, but at the same time it was scarier to think about going into these facilities, as weird as it sounds… Especially, like, people who come from trauma backgrounds. Like, they will, freaking, like, leave and not come back if they feel unsafe." – Lauryn*

For participants, experiences of racism and discrimination were varied from blatant acts to covert micro-aggressions. These occurred across time from prenatal care appointments, to the hospital admission, to postpartum, both in and outpatient, and among all provider types.

***Mitigating stereotype-related gendered racism***

While Black women may perceive lack of control over others' perception of them, especially those in power (ie health care providers), they may still attempt to mitigate being judged, and then treated, by stereotypes. Mitigation can take various forms. In the current study, it meant Black women sometimes chose to disengage in care when they felt unsafe, consciously altered the way they presented themselves in hopes of being treated better as a way to receive standard care, or as a means to avoid unintended consequences created by the health care system. Harry discussed a palpable change of shift in the way providers interacted with her once she mentioned being educated, for example, having attended undergraduate studies at a respected university versus when providers may have thought her to be, in her words, "a crazy Black woman".

*"And I've noticed the difference […] It's like I'm not just another like whatever patient, you know, another random person to just push along, you know? I have something there that they feel is valuable enough for me to be especially respected I suppose as opposed to others, yeah". -Harry*

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When asked specifically about what makes people more comfortable when they find out that a Black woman is educated, Harry replied,

> *"[…] I think that potentially it's probably like they would consider me more tame in a lot of ways than their general understanding of like some stereotypes about black women. Or maybe even that I may understand where they're coming from more because they have education. Or maybe just that -- I don't know. Maybe they feel like they don't have to talk down if they think that I can understand them I guess." Harry, 12*

These kinds of cognitive, attitudinal, and behavioral resources can be deployed by patients and, depending upon providers' variable responses to them, may result in more attentive and satisfying engagements with health professionals (Shim, 2010). Harry reflected,

> *"But I think an interesting thing is, though, that I always received a different response once people realized that I went to UC Berkeley. Like somehow it comes up and then they treat me differently, which is really interesting because it feels unfair because what if I hadn't, you know?" -Harry*

Even though it was uncomfortable to do so, Harry decided after all to expose her education privilege in order to get quality care, which she calls "the height of care" because of fear—fear that her baby may be in danger. She said,

> *"I think I struggle with this because I feel really uncomfortable with it. But sometimes I'm just like, "[self, Name], don't. Like, don't mention that. Like, just be treated like everyone else, you know?" But a part of me-- like when it's something like the care of my child-- and I'm like in this scary situation, I'm like maybe no… Like, I want like the height of care right now because I'm in this scary situation and, you know, my baby is*



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*small and they want me to induce early.  And I don't know what that means because what if I'm not as far along as they think I am and they're really inducing me at 33 weeks and I'm not really 36 weeks and I'm just like scared?  So, it's like, yeah, by the way, like I'm educated.  Like let's use that privilege right now because I'm scared". -Harry*

Other participants named the need to go against their own ways of coping and instead complying with providers' recommendations, even when complying might result in a dangerous situation. Slim, who was managing an abusive relationship shared:

*If we don't go to our appointments then they come looking for us.  So, now I'm forced to be in this relationship with the providers.  Now the providers are making things more worse for me than I was on my own […] And I've tried to tell them the whole safety -- how I've been trying to get away from him and all this kind of stuff.  The doctors said that they didn't agree." –Slim*

Black participants in this study similarly named the ways in which they put effort into mitigating stereotype-related gendered racism, even without knowledge of the concept, at various turns in pregnancy, birth, and postpartum, it was direly necessary for Black women to make adjustments in order to ensure the safety of themselves and their children.

**Discussion**

For the purposes of qualitative analysis of these data, I draw from Davis' methods that are informed by feminist ethnography and thematic analysis. In her work (2018), Black women's experience and recollection of health care encounters across pregnancy, labor, childbirth, and postpartum can be a central place that reveals the merger of obstetric racism and medical violence; it is at the intersection between the two, that Black women and their



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infants are placed at risk.  The phenomenon Davis asserts is validated by Black women in this study as they recalled encounters where they were neglected, dismissed or disrespected; there was an initiation and/or exacerbation of pain and discomfort; there was medical abuse or coercion to accept tests, procedures, or medications; or there were violations of respect of persons by performing tests, exams, and/or procedures without consent.

Black women in this study were subjected to the common assumptions and stereotypes that are assigned to Black women and mothers. The idea that Black people do not experience pain is a long-held belief originating from the influences of early white “scientists”, such as Carl Linneaus, who created theories to justify, legitimize, and perpetuate a social order that oppressed non-white individuals; scientific racism is a tradition in which science has been used to prove not only the existence of race, but social hierarchies (Castagna & Sefa, 2000). Since American culture cannot conceive of Black reproductive liberty, reproduction by Black women has been both discouraged and devalued (Roberts, 1997).  Furthermore, one effect of stereotype-related gendered racism is the girth of assumptions made about Black mothers, including the stereotype of a presumed incompetence of minoritized groups (Gutierrezy Muhs et al, 2012) may also lead providers toward a sense of obligation to monitor and control Black women’s parenting capacity.

Black women’s experiences of stereotype-related gendered racism, and the distress that comes with it, may be exacerbated in particular time frames, specifically during pregnancy when stereotypes about one’s identity may be more significant (Rosenthal and Lobel, 2018). The physical stressors and emotional distress that individuals face during pregnancy contribute to discomfort and exhaustion as well as to the physical and mental health for the pregnant



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person as well as to the health and development of their children (Ibrahim and Lobel, 2016). Experience of racism as a pregnancy-specific stressor comes from these experiences showing up in the health care setting. It is well- known in the literature (Children's Bureau, 2016) and through county-specific statistics that Black children today are disproportionately separated from their families via Child Protective Services (CPS). Given this, and the historical context from which it comes from-- where enslaved children were routinely separated from their enslaved mothers when there was a profit to be made during chattel slavery (Davis, 1981) forced separation is a valid threat for pregnant Black women. Women of color report stressful interactions with all levels of health care providers throughout their prenatal care and birth experiences (McLemore et al, 2017; Vedam et al, 2019). This secondary analysis is another exemplar of these experiences.

**Limitations**

Because study participants were recruited from one community organization, it is likely that results from this study are relevant to a particular geographic location and income level, but not others. Additionally, because some participants in this study participated in a research prioritization process among peers in multiple focus group sessions, this study's design may have lent itself to a sort of social desirability bias, where participants may have reported experiences they deemed as especially acceptable to the interviewers; it is possible that some experiences were not disclosed. This analysis is also limited in that it is unable to encompass the complexity and entirety of the African Diaspora. Black people are a rich, diverse, non-homogenous people and there are aspects, and likely themes, that specifically were not captured. As a secondary analysis of an existing data set, I was unable to more deeply



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interrogate these themes and findings in a constant comparison, as the study had already completed when I began familiarizing myself with the data with the thesis in mind. Still, it is significant that the parent study is saturated with themes connected to the stereotype- related gendered racism and obstetric violence placed on the Black woman along specific points on the reproductive health continuum as they relate to pregnancy; this paper is one of the first explorations of how stereotype-related gendered racism and obstetric racism are experienced and exemplified by Black women and individuals across a specific timeframe on the reproductive health continuum. Despite these limitations, the experiences of these participants are insightful and lend greatly to improving the health care experiences for Black women and individuals during pregnancy, birth and the postpartum period.

## Implications

As this analysis demonstrates not only do racial disparities in health outcomes exist, so do racial disparities in the quality of health care received, where racism is a key factor (Smedley, et al, 2009), where structurally embedded racism can prevent medical professionals from listening to their patients (Tello, 2017, Burgess et al, 2010) regardless of the provider's race; it's in the institution. Based on cultural health capital (CHC), race concordant patient-provider interactions, may require less need for intentional practices to ensure quality care; this may influence who Black women prefer as health care providers when given the choice. Race concordant care provides an opportunity for the perception that the provider likely has similar life experiences, which may bring a certain level of comfort to patients. While research has shown the importance of building a workforce that racially reflects the communities it serves by providing patients with opportunities to receive race concordant care (Serbin & Donnelley,



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2015), the need for race concordant care is not yet included in patient-centered care models (Santana et al, 2017). Similarly, graduate degree programs training future advanced practice clinicians, such as nurse midwives, neither explicitly recruit future midwives of color, nor do they intentionally create learning environments that are equitable and driven by social justice. It is time to replace white supremacy and patriarchy with a new care model (Black Mamas Matter Alliance, 2018). It is time for midwifery training programs to take explicit action to challenge structural inequities (Karani et al, 2017), improve the diversity of the profession, to implement educational environments where existing barriers to the obtainment of midwifery education that occur at the individual and institutional levels are eliminated while practices of inclusivity in education and midwifery care can be realized for marginalized communities. There is a role for training programs' specific and demonstrated commitment to a reproductive justice (Ross et al, 2017) framework that doesn't perpetuate obstetric racism and obstetric violence even though these are long-held tenets of clinician training (Roberts, 1997; Cooper Owens, 2017).



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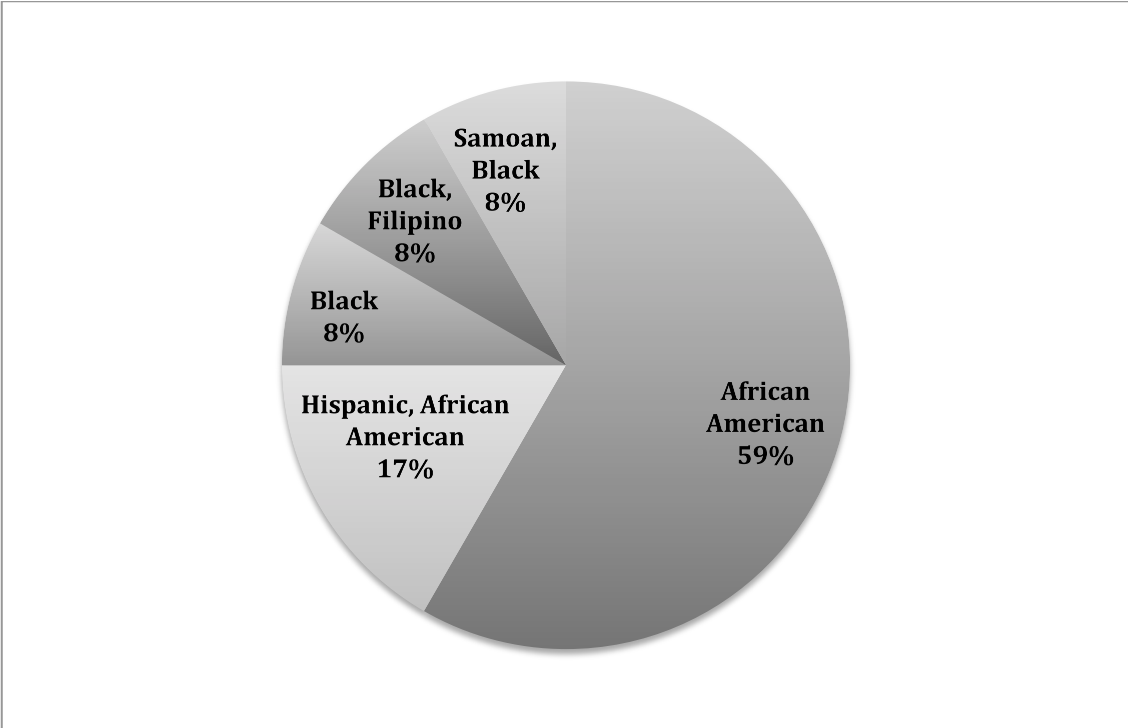


Figure 1. Demographics: race/ethnicity by participants' self-identification

Figure 2: Hospitals in San Francisco, CA where Black women in this study received care in pregnancy, childbirth, and postpartum; self-report



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## References

Abdou, C.M., Fingerhut, A.D., Jackson, J.S. & Wheaton, F. (2016). Healthcare Stereotype Threat in Older Adults in the Health and Retirement Study. American Journal of Preventative Medicine. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4755717/pdf/nihms756065.pdf.

Alhusen, J. L., Bower, K. M., Epstein, E., & Sharps, P. (2016). Racial discrimination and adverse birth outcomes: An integrative review. *Journal of Midwifery & Women's Health, 61*(6), 707-720. 10.1111/jmwh.12490 Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12490/abstract

Altman, M.R., Oseguera, T., McLemore, M.R., Kantrowitz-Gordon, I., Franck, L.S., Lyndon, A. Information and Power: Women of color's experiences interacting with health care providers in pregnancy, birth. Social Science and Medicine. https://doi.org/10.1016/j.socscimed.2019.112491

Behrman, R. & Butler, A. (2007). Preterm birth: causes, consequences, and prevention. Washington, D.C.: National Academies Press.

Black Mamas Matter Alliance, 2018. Black Paper: Setting the Standard for Holistic Care of and for Black Women. http://black_mamasmatter.org/wp-content/uploads/2018/04/BMMA_Black_Paper_April-2018.pdf

Braun, V and Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology. Available from: http://dx.doi.org/10.1191/1478088706qp063oa



المنارة للاستشارات
www.manaraa.com

Burgess, D.J., Warren, J., Phelan, S., Dovidio, J., van Ryn, M. (2010). Stereotype Threat and Health Disparities: What Medical Educators and Future Physicians Need to Know. *Journal of General Internal Medicine*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847106/

Castagna M, Sefa D. (2000). An Historical Overview of the Application of the Race Concept in Social Practice. Anti-Racist Feminism: Critical Race and Gender Studies Halifax. Nova Scotia: Fernwood; 2000. pp. 19–37.

Centers for Disease Control and Prevention. (2007). Vital and Health Statistics: Maternal Mortality and Related Concepts. Retrieved from https://www.cdc.gov/nchs/data/series/sr_03/sr03_033.pdf

Centers for Disease Control and Prevention. (2017). Reproductive Health: Pregnancy Mortality Surveillance System. CDC Website. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

Charmaz. K. (2104). Constructing Grounded Theory, 6th Edition. London: Sage

Child Welfare Information Gateway. (2016). Racial disproportionality and disparity in child welfare. Children's Bureau: Issue Brief November 2016. Retrieved from https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/

Clarke, A.E. (2003). Situational analyses: grounded theory mapping after the postmodern turn. Symb. Interact., 26 (4) (2003), pp 553-576

Cooper Owens, D. (2017). Medical Bondage: Race, Gender, and the Origins of American Gynecology. Athens, GA: The University of Georgia Press

المنارة للاستشارات



www.manaraa.com

David, R. J., & Collins, J. W. (1997). Differing birth weight among infants of U.S.-born blacks, African-born blacks, and U.S.-born whites. *The New England Journal of Medicine, 337*(17), 1209-1214. 10.1056/NEJM199710233371706 Retrieved from http://content.nejm.org/cgi/content/abstract/337/17/1209

Davis, A. (1981). Women, Race, and Class. Pp. 4. Random House: New York. Retrieved from https://legalform.files.wordpress.com/2017/08/davis-women-race-class.pdf

Davis, D.A. (2019). Racism and reproductive justice: black mothers, premature birth, and the NICU. Anthropologies of American Medicine: Culture, Power, and Practice. New York , NY: New York University Press

Davis, D.A. (2018). Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing. *Medical Anthropology*. Hppts://doi.org/10.1080/01459740.2018.1549389

enters for Disease Control and Prevention. (2017). Preterm Birth Infographic. CDC Website. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm

Delgado, R. & Stefancic, J. (2017). Critical Race Theory (Third Edition): An Introduction. New York, NY: NYU Press E-book.

Ford, C. L., & Airhihenbuwa, C. O. (2010a). Critical race theory, race equity, and public health: Toward antiracism praxis. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837428/

Franck, L. Franck, L.S., McLemore, M.R., Cooper, N., De Castro, B., Gordon, A.Y., Williams, S., Rand, L. (2018). A novel method for involving women of color at high risk for preterm birth in research priority setting. J. Vis. Exp.(131). Retrieved from



المنارة للاستشارات
www.manaraa.com

https://doi.org/10.3791/56220.

Goyal, M., Kupperman, N., Cleary, S.D., Teach, S.J., Chamberlain, J.M. (2015). Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatrics*. Retrieved from https://jamanetwork.com/journals/jamapediatrics/fullarticle/2441797

Hoffman, K.M., Trawalter, S., Axt, J.R., & Oliver, M.N. (2016) Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proceedings of the National Academy of Sciences of the United States of America. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/

Ibrahim, S. M. and Lobel, M. (2016) Conceptualization, measurement, and pregnancy-specific stress: review of research using Prenatal Distress Questionnaire. Journal of Behavioral Medicine. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/31183596

Jones, C.P. (2017). Achieving Health Equity: tools for a national campaign against racism [Powerpoint slides]. Retrieved from https://www.bms.com/assets/bms/us/en-us/pdf/grantee-summit-2017/keynote-i-health-equity-definition.pdf

Karani, R., Varpio, L., May, W., Horsley, T., Chenault, J., Hughes Miller, K., O'Brien, B. (2017). Commentary: Racism and bias in health professions education: how educators, faculty developers, and Researchers can cake a difference. *Academic Medicine.* Retrieved from https://wp.uthscsa.edu/diversity/wp-content/uploads/sites/80/2018/10/Commentary___Racism_and_Bias_in_Health_Professions.2-1.pdf



المنارة للاستشارات
www.manaraa.com

Lobel, M., Cannella, D.L., Graham, J.E., DeVincent, C., Schneider, J., Meyer, B.A. (2008). Pregnancy-Specific Stress, Prenatal Health Behaviors, and Birth Outcomes . Retrieved from https://pdfs.semanticscholar.org/30e2/85b22f8a22f573c79f848358cd3ceb8c0ead.pdf

Lobel, M., & Dunkel Schetter, C. (2016). Pregnancy and prenatal stress. In H. S. Friedman (Ed.), Encyclopedia of mental health (2nd ed., pp. 318–329). Waltham, MA: Academic Press.

Lu, M. & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life-course perspective. *Maternal and Child Health Journal, 7*(1), 13-30. 1022537516969 Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12710797

McLemore, M.R., Altman, M.R., Cooper, N., William, S., Williams, S., Rand, L. (2018). Health care experiences for of pregnant and postpartum women of color at risk for preterm birth. *Social Science and Medicine*. Retrieved from https://doi.org/10.1016/j.socscimed.2018.02.013

Oparah, C., Arega, H., Hudson., D., Jones, L., Oseguera, T. (2018). Battling Over Birth: Black Women and the Maternal Health Care Crisis. Amarillo, TX: Praeclarus.

Prather C, Fuller TR, Jeffries WL 4th, Marshall KJ, Howell AV, Belyue-Umole A, King W. (2013). The Impact of Racism on the Sexual and Reproductive Health of African American Women. Journal of Women's Health. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939479/



المنارة للاستشارات
www.manaraa.com

Roberts, Dorothy E.. (1997) *Killing the black body :race, reproduction, and the meaning of liberty.* New York, NY: Pantheon Books.

Rosenthal, L., Lobel, M. (2018). Gendered racism and the sexual and reproductive health of Black and Latina women. *Ethnicity and Health*. Retrieved from https://doi.org/10.1080/13557858.2018.1439896

Rosenthal, L., Lobel, M. (2016). Stereotypes of black American women related to sexuality and motherhood. *Psychology of Women Quarterly*. Retrieved from https://doi.org/10.1177/0361684315627459.

Ross, L., Roberts, L., Derkas, E., Peoples, W., Bridgewater Toure, P., Roberts, D. (2017). Radical Reproductive Justice: Foundation, Theory, Practice, Critique. Feminist Press: New York

Salm Ward, T.C., Mazul ,M., Ngui, E.M., Bridgewater, F.D., Harley, A.E. (2013 Dec). "You learn to go last": perceptions of prenatal care experiences among African American women with limited incomes. *Maternal Child Health Journal*. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/23180190

Santana, M. J., Manalili, K., Jolley, R., Zelinsky, S., Quan,H., Lu, Mingshan. (2017). How to practice person-centered care: A conceptual framework. Wiley Online Library

Schatzman, L. (1991). Dimensional analysis notes on an alternative approach to the grounding of theory in qualitative research. Social Organization and Social Process: Essays in Honor of Anselm Strauss. New York, NY: Aldine de Gruyter.



المنارة للاستشارات
www.manaraa.com

Shim, J.K. (2010). Cultural health capital: a theoretical approach to understanding health care interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior*. https://di.org/10.77.0022146509361185

Serbin, J.W. and Donnelley, E. (2016) The Impact of Racism and Midwifery's Lack of Racial Diversity: A literature Review. Journal of Midwifery and Women's Heath. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27926804

Smedley B. D., Stith A. Y., Nelson AR.(2009). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25032386

Tello, M. (2017). Racism and Discrimination in Health Care: Providers and Patients. *Harvard Health Blog*. Cambridge, MA: Harvard Health Publishing. Retrieved from www.health.harvard.edu/blog/racism-discrimination-health-care-providers-patients-2017011611015

Vedam, S., Stoll, K., Khemet Taiwo, T., Rubashkin, N., CHeyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, M., Schummers, L., and Declercq, E, & GVtM-US Steering Council. ().The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reproductive Health Journal. Retrieved from https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2



المنارة للاستشارات

www.manaraa.com

Wallace, M., Green, C., Richardson, L., Theall, K., & Crear-Perry, J.(2017). "Look at the Whole Me": A Mixed-Methods Examination of Black Infant Mortality in the US through Women's Lived Experiences and Community Context. *International Journal of Environmental Research and Public Health*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5551165/

World Health Organization. (2004). Health statistics and information systems: Maternal mortality ratio (per 100,000 live births). *World Health Organization website*. Retrieved from http://www.who.int/healthinfo/statistics/indmaternalmortality/en/

World Health Organization. (2010). Trends in Maternal Mortality: 1990-2008 estimates developed by WHO, UNICEF, UNFPA and the World Bank. *World Health Organization*. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

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