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University of San Francisco

Between Life and Death: Reimagining Black Reproductive Healthcare

A Thesis Presented to

The Faculty of the School of Education

International and Multicultural Education Department

In Partial Fulfillment

Of the Requirements for the Degree

Master of Arts in Human Rights Education

By

Briana Britton

May 2023

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CHAPTER I: INTRODUCTION

When I think about my multigenerational family, I am in awe. I am a product of a matriarch who birthed 11 children, a grandmother who birthed two of her own, and a mother who gave birth to me. I think of the many birthing journeys and stories in my family; some of which I had the honor of witnessing or being a part of. I think about what it must have taken in order to bring a life into this world while also maintaining one's livelihood and health. I am grateful to those that have and continue to contribute to our family's growth for in many ways, our existence is a gift.

Our existence also makes me reflect on people who embarked on these same journeys, but did not live to complete them, often due to the treatment they endured from a place that is supposed to prioritize one's health and life: The United States (U.S.) healthcare system. To give life, nurture and maintain it is a gift; doing so as a Black person in a world and within systems not made for us is a miracle. My research is influenced by exploring why this "miracle" is not the norm; why reverence for Black health and lives is not held with the same regard as others. Why are we being harmed while seeking care and healing? How are we giving life while simultaneously losing ours?

Statement of the Problem

The state of Black reproductive¹ health is in crisis with mortality rates of birthing people² in the U.S. being the worst in the developed world (Black Maternal Health Caucus, n.d.). What compounds this issue is historical and cultural evidence of unethical and inhumane treatment of Black people – Black birthing people in particular – by the U.S. healthcare system primarily due

¹ I use the term "reproductive" in lieu of "maternal" to be inclusive of trans and nonbinary people who give birth.

² Please see the note about this term in the definition of terms section.

to racism and sexism.

Those who do not identify with the binary and heteronormative structures of our healthcare system are at further risk of discrimination and health disparities. Besse, Lampe, and Mann (2020) found that people who identify as LGBTQIA+ – particularly transgender people – “often experience significant forms of discrimination, stigma, and erasure in medical settings from providers, administrative staff, and organizational infrastructures” (p. 518). Due to social and cultural ideals, stigma, and other structural forces, Black, Black birthing and Black LGBTQIA+ individuals have been left to endure various forms of violence that impact their lives.

Research on the relationship and intersection of these populations, their reproductive rights, and the U.S. healthcare system is lacking. The research that is available gives promising suggestions on how to rectify these issues, but within a system that reinforces racism, sexism, and other discriminatory tactics with little to no alternatives. This study will examine those relationships and highlight how the U.S. healthcare system’s discriminatory foundation historically contributed and continues to contribute to the healthcare crisis impacting Black people. It will also discuss what safe and competent care would and should look like for these populations.

Background and Need

According to the Centers for Disease Control and Prevention (CDC), statistical data found that pregnancy-related deaths were highly influenced by racial and ethnic disparities. Between 2016-2018, non-Hispanic Black people accounted for 41.4 deaths per 100,000 live births, over three times the rate in comparison to non-Hispanic White people (Centers for Disease Control and Prevention, n.d.). The data highlighted various contributing factors

including access to and quality of care, prevalence of chronic disease, structural racism, and implicit biases.

As race and ethnicity play an influential role in the quality of care that Black people receive, gender identity and sexual orientation are also identity markers found to contribute to these barriers as well. Researchers have begun taking note of the barriers that transgender men and trans-masculine people face regarding pregnancy and childbirth. Pregnancy and childbirth are reproductive experiences often perceived to be central to contemporary cultural constructions of womanhood and as a result, often treated as an exclusively female experience (Besse, Lampe, & Mann, 2020, p. 518). These cisnormative assumptions about pregnancy status and experiences exclude trans and non-binary people, an issue that will be further explored in chapter two, and further emphasize the need for safe, comprehensive gender-affirming healthcare.

Historical violence and trauma in the forms of lack of informed consent, lack of acknowledgement or compensation, coercion, and criminalization, has contributed to Black communities not wanting to seek or receive healthcare from U.S. physicians or institutions (Black Mamas Matter Alliance, 2020, pp. 399-404). The lack of systemic acknowledgement of these atrocities and their continued perpetuation in the name of science has led to barriers including gatekeeping of resources both within and outside of the U.S. healthcare system for Black and other communities of color. Before the modernization of medicine, culturally specific healthcare advising; homebirths with the presence of midwives, doulas, and one's family, and an environment of calmness, compassion, and safety were a norm. African midwives, who were brought to the U.S. and enslaved, were more than birth workers. They were traditionally seen as spiritual healers, counselors, and helped the birthing person throughout their postpartum journey, including nursing support and cooking (Hanna Hill Photography, 2021). However, many of

these options have become commodified into an experience primarily accessible to non-Black and other communities of color.

With Black lives on the line, how can we reimagine and renovate reproductive healthcare in a way that maintains our safety and dignity? How can we reintroduce and implement practices and resources that are not only our birthright, but human right as well?

Purpose of the Study

Dismayed by the testimonies of Black, Black birthing, Black LGBTQIA+ people, and their families detailing harmful, traumatic, and even fatal experiences, I investigated the barriers that impede access to safe, comprehensive, ethical, and culturally competent reproductive health care. I explored alternatives to understand what resources would allow for said care and birthing experiences in a safe and dignified context. To accomplish this, I documented the stories of people from these populations that uplift their voices, shed light on their experiences, and their desires and needs from the U.S. healthcare system.

Research Questions

The large social justice question that motivates this research is why are Black people dying at disproportionate rates when seeking healthcare, specifically in the reproductive field? Given that Black people and our identities are not mutually exclusive or monolithic, I seek to answer the following research questions:

- How do intersecting identities impact Black people's access to reproductive healthcare?
- How do Black, Black birthing, and Black LGBTQIA+ people define and envision safe, comprehensive, and culturally competent reproductive healthcare?

Theoretical Framework

The theories and frameworks that ground my study examine how facets of one's identity

such as gender and gender identity, race and ethnicity, and sexual orientation, impact the experiences and overall livelihood of Black people. Early academic or community-based works examined how these identity markers either granted or impeded access to social, cultural, or political power to Black people and other systemically marginalized communities. The Combahee River Collective, a group of Black feminists, scholars, and writers, recognized that despite the objectives and efforts of the Civil Rights and Feminist movements, the political, societal, and communal needs of those who identified as Black women were far more complex. This led to the Combahee River Collective statement (1977), in which the collective emphasized the establishment and importance of Black Feminism as a political movement in order to “combat the manifold and simultaneous oppressions that all women of color face” (p. 1). The collective’s recognition of their individual and shared experiences as Black women with racism, sexism, and other forms of oppression was one of the first to publicly address how these issues were “embodied in the concept of identity politics” (p. 4). Society in the U.S. often centers the existence and experience(s) of those who identify as White, cisgender, male, heterosexual, able-bodied, and Christian. However, it has been historically difficult to examine and understand the experiences of those who do not identify within those parameters, or whose identity markers coexist with one another.

A decade after the Combahee River Collective Statement, Kimberlé Crenshaw (1989) coined the term intersectionality, which addressed the complex layering of identities of Black women who must simultaneously deal with compounding societal factors that may posit them in areas of privilege or discrimination. This framework is significant and influential not only due to its ability to name the concept of interlocking oppressions that the collective addressed, but also because it directly analyzes and defines how systems of power profoundly impact marginalized

individuals and communities. Crenshaw argued that:

Black women are sometimes excluded from feminist theory and antiracist policy discourse because both are predicated on a discrete set of experiences that often does not accurately reflect the interaction of race and gender. These problems of exclusion cannot be solved simply by including Black women within an already established analytical structure. Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated. (p. 140)

Patricia Hill Collins (1990) continued this discourse by reemphasizing the importance of Black Feminist Thought, as well as intersectionality, and how they exist in proximity of varying systems of oppression, or as she described “a matrix of domination” (p. 557). Collins stated that with the cognizance of these the two frameworks and by “emphasizing the power of self-definition and the necessity of a free mind” (p. 557), the matrix is not only a site of domination, but also resistance.

With the state of Black reproductive health in crisis, the creation of reproductive justice was a desperately needed intervention. As a founding member, Loretta J. Ross (2017) and 11 other women created the reproductive justice framework because they “believed that true health care for women needed to include a full range of reproductive health services” (p. 290). For those that identify as Black and female, any health care plan must include coverage for a myriad of services such as abortions, contraceptives, well-woman preventive care, pre- and postnatal care, infertility, infant and maternal morbidity and mortality, HIV/AIDS, and other sexually transmitted infections (Ross, 2017). Due to historical and cultural evidence of unethical and inhumane treatment of Black and Black birthing people at the hands of the U.S. healthcare

system, this new collective centered their framework around three tenets:

1. The right to have a child under the conditions of one's choosing
2. The right not to have a child using birth control, abortion, or abstinence; and
3. The right to parent children in safe and healthy environments free from violence by individuals or the state. (Ross, 2017, p. 290)

Additionally, reproductive justice was created “to shed light on the intersectional forms of oppression that threaten Black women’s bodily integrity, [and] provoke and interrupt the *status quo* and imagine better futures through radical forms of resistance and critique” (pp. 291-292).

While these theories and frameworks center the needs and advancement of marginalized groups, they also center the binary and heteronormativity. The societal persecution and erasure of LGBTQIA+ presence and experiences has led to further discrimination and invalidation of basic human rights, including access to essential needs such as reproductive health care. It is essential that I utilize queer theory to represent the ideologies and voices of those who exist outside the binary and exclusive heteronormative structures. McCann and Monaghan (2019) state that despite its fluidity, the foundation of queer theory is a combination of contributions from and at times, critiques of gay and lesbian studies, lesbian feminism, lesbian of color theory and activism, and various other main areas of thinking or political action. Through the work of Cohen (1997), they posit queer theory with intersectionality by describing an intersectional queer approach in hopes for better understanding the limits of political identities; tools to recognize intersecting oppressions and how these intersections limit or provide access to power, and an understanding of how heteronormativity is not separate from forms of oppression, but interacts with them (Cohen, 1997, as cited in McCann and Monaghan, 2019).

The combination of these seminal works has contributed to the creation of theories, frameworks, and definitions in order to center the voices and experiences of Black, Black birthing and LGBTQIA+ people, validate their human rights, and their resistance to systemic oppression. My study aims to build upon this by investigating barriers that impede access to safe, quality, and (culturally) competent reproductive health care, while also exploring how to mitigate them, provide alternatives and access to resources that would allow for birthing experiences in a safe and dignified context.

Methodology

The purpose of this study is to center the voices of Black, Black birthing, and Black LGBTQIA+ people, their experiences with seeking reproductive health care services, and their perspectives on what an ideal setting would look like when seeking those services. After learning about qualitative methodologies and drawing upon my previous experience of conducting an oral history interview, I decided that conducting narratives via semi-structured interviews would be the best option for my research. While my proximity to people of like identities – Black, cisgender, and heterosexual – and that I knew personally would be plentiful, I challenged myself to seek the participation of anyone who identified as part of the populations I described above. As described in the following section and in chapter three, I ended up with a small number of participants that shared common identities, but it was their physical commonalities as well as those of their experiences that highlighted deep rooted issues within the U.S. healthcare system.

While the subject matter of my study is extremely personal and vulnerable to speak about, I am grateful for their participation and hope that this mode of data collection provided a level of safety and care, while simultaneously allowing them to share their thoughts and

experiences. Black people are often discouraged from dreaming or reimagining spaces that consider their overall experiences. I wanted to give them that opportunity through this study.

Limitations of the Study

There are several limitations to this study: a) the timeframe, b) sample size, and c) the quality of the data (due to the sample size). While the study was comprehensive and qualitative in nature, the completion deadline as well as my capacity as the sole researcher may have impacted its full potential and execution. The premise of the study was to center the reproductive experiences of Black people of varying gender identities/expressions and sexual orientations. However, the desired sample size and variance of the sample was not fully achieved as I was unable to incorporate voices and perspectives from Black LGBTQIA+ communities. While the harmful treatment and traumatic experiences of Black people within the U.S. healthcare system are widely noted, the experiences of the participants in this study cannot be generalized and do not represent Black, Black birthing, or Black LGBTQIA+ people and communities as a whole.

Lastly, I am cognizant of how my intersecting identities simultaneously straddle the dimensions of privilege and discrimination, as well as impact my access and perspective on this topic. I have never experienced pregnancy or childbirth, thus through this study I was intentional about the involvement of and centering of participant voices. Without them, their lives and those like them will continue to be at stake.

Significance of the Study

This study and collection of personal narratives is not only significant to those most impacted, but to those who have the opportunity to reimagine, improve, implement, and practice reproductive healthcare. This may include physicians, nurses, medical school students and other

emerging medical professionals, as well as the leaders of these institutions. The study examines how the current U.S. healthcare system is centered around preserving and saving certain lives, and questions how deeply engrained biases need to be eradicated in order provide ethical care for Black, Black birthing, and Black LGBTQIA+ people.

It will also be relevant to state, national, and federal leadership, and their perspectives on reproductive healthcare. City officials, governors, policy makers and others are responsible for representing the needs of people throughout the country, but have demonstrated how their personal biases are influencing the implementation of policies, laws, and access.

Lastly, this study is significant for Black, Black birthing, and Black LGBTQIA+ people in order to inform them of their vast reproductive health options, their right to health care, to empower, and instill advocacy.

Definition of Terms

Birthing people/person: While most of the sources used in this thesis center the reproductive and birthing experiences of Black, cis-gendered women, I use the term “Birthing People” to refer to a person (or people) – regardless of gender – who is pregnant, will give birth, or has given birth. I first learned of the term in June 2020 from Black psychotherapist, doula, and researcher, Suzanne Mungalez. Her research and dissertation, “But Will You Catch Me Too?” (2021) examines the perceived impacts of doula-assisted care on perinatal experiences of anti-Black racism. Mungalez can be found on Instagram at @dr.suzannemungalez.

Black: I use the term “Black” to refer to descendants of the Transatlantic Slave Trade who were abducted, enslaved, and brought to the Americas – specifically North America.

Doula: There are different types of doulas, but I will be referring to what is known as a Birth Doula. Birth Doulas, also known as a “birth coach” or “birth companion”, provide

comprehensive non-medical support to birthing people (including their partners and families) before, during, and immediately following childbirth (Deliver Birth Justice, 2023).

LGBTQIA+: I use this term to represent people who identify as Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, or Asexual. As this acronym is an umbrella term, the plus (+) symbol is utilized in order to represent other individuals from vast and diverse communities such as Two-Spirit and Pansexual.

Midwife: Midwifery care includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling from infancy throughout the lifespan. They provide initial and ongoing comprehensive assessment, diagnosis, and treatment in various areas such as pregnancy, childbirth, and the postpartum period; sexual and reproductive health, gynecologic health, and family planning services (American College of Nurse-Midwives, 2021).

CHAPTER II: REVIEW OF THE LITERATURE

In this chapter, I provide a historical, social, and cultural overview centered on the relationship between Black people, their reproductive rights, and the U.S. healthcare system. I begin by detailing how racism and sexism have been deeply entrenched in U.S. healthcare since the slavery era, and how little to no change has been conducted in the foundation or practices of healthcare to this day. Unethical and negligent practices have contributed to what the U.S. is now calling a Black reproductive health crisis. Next, I explore these same practices through the lens of gender, gender identity, and sexual orientation to understand how they cause further disparities for people who are Black and part of LGBTQIA+ communities. Lastly, I address how Black reproductive healthcare needs to be reimagined and renovated for these communities after generations of violence and trauma.

The Historical Impact of Racism and Sexism in U.S. Healthcare on Black Women

Over a span of 400 years, the sexual and reproductive health of Black people has been detrimentally affected resulting in generations of disparities. Prather et al. (2018) examined how historical factors were essential indicators and causes to the current healthcare needs of Black women by breaking down and defining the 400 years by era: Slavery, Jim Crow, Civil and post-Civil Rights. During the near 250 years of the Slavery era, enslaved women experienced legalized sexual and reproductive exploitation via rape, nonconsensual genitalia and reproductive mutilation (p. 251). With laws and practices implemented to benefit slave owners, traders, and medical doctors, enslaved women were defined as property and had no legal protection against these forms of sexual assault and exploitation. Ultimately this led to these women being the sole producers of the enslaved workforce as childbearing was the key to maintaining the economic system of slavery. Lack of legal and human rights protection also contributed to the lack of and

inadequate access to healthcare, as enslaved women were utilized as medical guinea pigs for research and experiments that helped build the current U.S. healthcare system, and establish medical practices and procedures that are still used to this day (Prather et al, 2018).

Cooper Owens details said origins in her 2017 book *Medical Bondage: Race, Gender, and the Origins of American Gynecology*, chronicling the initial period that led to a plethora of medical advancements within the gynecological field. However, this period was also rife with findings steeped in eugenics, fetishization and hypersexualization of Black women's bodies. Given the economic value of childbearing and the burgeoning reproductive health field, enslaved women were ironically both revered and disposable to doctors:

In slavery, healthy black people who labored diligently made the system economically valuable. Within the professional women's health-care world, deceased and living black women's bodies were also profitable. Doctors used the diseased reproductive organs of black cadavers to facilitate gynecological research and provide education in the field of gynecology. Career benefits also accrued to these medical men, who achieved their professional goals through the publication of their research in medical journals. (p. 17)

Cooper Owens describes how in both life and death, the unethical experimentation, torture, and trauma performed on the bodies of enslaved Black women could not "escape the gaze and ownership of White men" (p. 20).

The slavery era created a foundation of health disparities and generational trauma that are contributors to the current marginalization of Black people and communities throughout the U.S. While legal systems have improved, they do not equitably protect or benefit these communities thus trapping them in a cycle of negative societal stereotypes, poverty, and limited to no access to essential resources. Once deemed and utilized as the main source of the country's workforce,

the Civil and Post-Civil Rights eras saw the eradication of rights of Black women and communities, transforming into shaming them for having too many children, and targeting them for relying on state and federal resources to care for themselves and their families. The Jim Crow era continued the legalization of sexually violent crimes against Black women, lynching, nonconsensual and unethical medical practices (Prather et al., 2018, p. 252). Many of these unethical practices resulted in forced abortions and sterilization of both Black women and men.

Over the next three decades, many of these acts were politicized and codified into laws or policies that further stripped Black women and men of their basic human rights and ultimately impacted their reproductive rights. The 1990s displayed a political agenda centered on population control targeted at communities of color – specifically Black ones. Roberts (2017) describes how the introduction of a controversial contraceptive insert called Norplant was part of a targeted campaign by U.S. legislators and policymakers “to push the drug on poor Black women in hopes of decreasing their birthrate” (p. 104). Marketed as an ideal contraceptive due to its ability to prevent pregnancies for up to five years with ease (by being inserted directly into the body), the distribution and implementation of Norplant was a ploy for Black reproductive control in hopes of curbing inner-city poverty and expansion of the underclass, in which Black people have systemically been the majority. Black women and their bodies were once again utilized as pawns and left to endure detrimental side-effects including headaches, depression, weight gain, hair loss, organ swelling, irregular cycles, and the horrific dangers that came with its design. The ulterior motives of federal and state entities became further apparent when stories of coercion from medical staff regarding implementation, and the difficulties endured by women when requesting that the contraceptive be removed emerged:

The very features that enhance Norplant’s convenience for women also allow for its

coercive deployment. Women's inability to remove the inserts without medical assistance facilitates abuse in several ways. It currently gives doctors and other health care workers the opportunity to impose their own judgements upon poor minority patients by refusing to remove the device. [...]. Even aside from these deliberate abuses, Norplant is designed to deprive women of control over their reproductive health [and] places poor women at the at the mercy of a health care system the remains insensitive to their needs. (Roberts, 2017, p. 129)

While the side effects and business reasons ultimately led to Norplant being taken off of the U.S. market by 2004, these unethical practices have contributed to a culture of generational fear and mistrust of physicians and medical institutions within Black communities. As a result, it has impacted how Black people are educated about sexual and reproductive health, receive, and go about seeking care. An issue brief by reproductive justice organization If/When/How (2016) stated that over 60% of Black pregnancies were unintended, and the infant mortality rate was more than twice the national rate. Black birthing people also had one of the highest abortion rates in the U.S. due to healthcare disparities, and domestic violence and sexual abuse at disproportionate rates (p. 3). Living in a country post-Roe v. Wade has only further compromised reproductive health access and the lives of Black people; especially for those simultaneously navigating the intersections of gender identity and sexual orientation.

Racism, Sexism, and the Reproductive Health of Black LGBTQIA+ People

While research on the barriers to reproductive healthcare access for the LGBTQIA+ community is still emerging, an article by Wingo, Ingraham, and Roberts (2018) looked into this issue by interviewing a sample of individuals who were assigned female at birth, but varied in their gender identity and sexual orientation. The authors found a variety of issues including

[health] provider fertility focus, LGBTQIA+ erasure and health competency, discrimination by healthcare providers, and the impact of previous experiences impacting reproductive healthcare-seeking behavior. In particular, the centering of patriarchal ideals regarding interviewees' decisions on having top or other gender affirming surgeries, beginning hormone replacement therapy, and blatant examples of homophobia and transphobia were unfortunate shared experiences. When it comes to family planning, Black and other LGBTQIA+ couples of color are often at a disadvantage due to racial, sexist, and other discriminatory biases within the medical field. Karpman, Ruppel and Torres (2018) interviewed a sample of lesbian, bisexual, and queer (LBQ) couples of color (which also included a single queer woman of color) to analyze how they understand and navigate family formation decisions within systems that center White, heterosexual parents and heteronormative pathways.

The study found that discriminatory tactics against this population have evolved over the decades; beginning with refusal to inseminate openly queer couples in the 1980s (Agigian, 2004; Batza, 2016 as cited in Karpman, Ruppel and Torres, 2018), to the overemphasis of heteronormativity in their policies, procedures, and services. It also found that the participants “often arrived at the selection of a known [sperm] donor [e.g., a family member or close acquaintance] because the desired characteristics of a donor were unavailable through commercial sperm banks, particularly with regard to the intersection of a desire for a person who could be known and a desire for specific racial, ethnic, and cultural characteristics” (p. 123). In the event that they did not have the privilege of a known donor, the participants resorted to an anonymous one or began strongly considering adoption instead. The findings highlight the lack of accommodating and alternative resources that are needed for those with various intersecting racial and sexual identities.

Transgender people continue to face harmful discrimination, violence, and erasure not only while navigating medical systems, but in birthing spaces as well, as described in an article by the California Preterm Birth Initiative. As racism and sexism perpetually play a role in reproductive healthcare, Black transmasculine men often experience more harm as birthing people compared to White transmasculine men (California Preterm Birth Initiative, 2021). The article centered the experience of Kayden Coleman, a Black trans father of two, whose reproductive health experience while pregnant was marred by culturally and gender incompetent healthcare providers, misgendering, and a detrimental impact on his mental health. The lack of postpartum support provided difficulties for the new father as well, something he attributed to anti-Black racism:

I was low-income, living inner city as a Black person, and when I found out I was pregnant, I qualified for Medicaid. I didn't have many choices in terms of care.

[...]When Black people enter medical spaces, there is a high chance that we are not taken seriously or listened to. Add [being] trans on top of that and the focus becomes being Black and trans and not what we are there for. Our issues are not being taken into account. There's been many times when I've gone in for one thing and my entire visit has turned into this trans Q&A thing. Or they spend most of the time trying to gauge our level of whether or not we are mentally ill or not. The health system is based off White supremacy. There are things in place that are meant to keep us where we are. (California Preterm Birth Initiative, 2021, para. 9-10)

Black Reproductive Healthcare Reimagined

With historical evidence and a current unflattering spotlight on reproductive rights in the U.S., it appears that the damage done to access, obtain, and maintain said rights is irrevocable.

The establishment and passing of restrictive and in some cases life-threatening laws in various states has made it difficult to recognize the advancements that are occurring in the name of reproductive justice. However, promising developments on how to reimagine, remodel, and reestablish safe, competent, and comprehensive healthcare are emerging.

Utilizing historical and medical statistics to develop and reform policies related to maternal healthcare and resources, Congresswoman Lauren Underwood, Congresswoman Alma Adams, Senator Cory Booker, and members of the Black Maternal Health Caucus introduced the Black Maternal Health Momnibus Act of 2021 (Black Maternal Health Caucus, n.d.). Building on existing legislation to address the maternal health crisis in America, the act is a standalone bill comprised of 12 titles each introduced by a member of the Black Maternal Health Caucus. The titles address essential health, economic, and access needs, such as critical investments in social determinants that influence maternal health outcomes (e.g., housing and nutrition), reinforcements to maternal mental health services and substance abuse treatment, and funding to community-based organizations. On November 19, 2021, the act passed the House of Representatives and on November 30, 2021, President Joe Biden signed the Protecting Moms Who Served Act into law. Under this law, the VA maternal health care program will be reinforced and include access to community resources, resources to address mental and behavioral health risk factors during prenatal and postpartum periods, and a variety of educational resources such as childbirth preparation, parenting, and lactation classes (Black Maternal Health Caucus, n.d.). Additionally, this law will launch a comprehensive study regarding maternal mortality among veterans. Other accomplishments include the Maternal Vaccination Act, which passed the House and will hopefully be signed into law.

Evaluating its role in the Black reproductive healthcare crisis, the medical field is taking

accountability by investigating how educational curricula play a key role in perpetuating discriminatory practices against people seeking care from LGBTQIA+ communities. Walker, Arbour, and Waryold (2016) found that graduate medical, nursing, and midwifery curricula often have limited amounts of time to focus on issues related to cultural competency in clinical practice, and respectful sexual and reproductive health care for all individuals (p. 737). This lack of focus is not only harmful to clients, but dangerous in that future medical practitioners are not being properly trained to care for diverse clientele. The article addressed the barriers, lack of or discrepancies in current medical resources for emerging medical professionals, and provided strategies on how to mitigate them while providing safe, competent, and respectful care for LGBT³ clients. A key strategy was introducing sexual reproductive health educational content for medical students that centers LGBT clients and their needs, and would include terminology, identification of personal bias, sexual health history taking, determination of appropriate referrals, and application of learned content through an exemplary case study. It would be delivered in traditional on-site, hybrid, or online systems so that students may feel comfortable disclosing sensitive self-reflective information in blogs and journals because such settings support privacy (p. 738). Addressing personal bias would assist in developing cultural competence in one's own beliefs and biases about persons who are perceived as different, as perceived provider bias can be a barrier to care for LGBT clients. Utilizing clinical case studies, this experience would allow the students to examine personal experiences, upbringing, background, and personal cultural factors that might impact their beliefs regarding LGBT people, and hopefully stop the perpetuation of harmful discriminatory practices within the medical field.

Despite these advances, a crucial step in reimagining Black reproductive health care is

³ While I speak of or refer to LGBTQIA+ communities, the article specifically named and spoke of those who identify as Lesbian, Gay, Bisexual or Transgender.

centering the voices and needs of Black people. Given the experiences they are subjected to or have suffered at the expense of the healthcare system, many do not feel empowered to seek care or if they do, they dare not question the type of care or remedies they receive. Black people have also been gatekept from medical alternatives that may be better suited for them. To combat this, writer and feminist policy analyst Anushay Hossain (2021) listed nine ways that people (specifically birthing people) can advocate for themselves during their medical appointments:

1. **Be prepared** – In order to maximize your time with your doctor and other practitioners.
2. **Gather your personal and family health history** – If you are able to procure records from other facilities where you were treated, that is great information for the physician.
3. **Research your provider** – Google them, look at past [client] reviews, see if they are on social media and ask your community groups about them.
4. **Inform yourself about pregnancy [if applicable]** – Knowing more about what’s “normal” and what is a warning sign can help you better advocate for yourself when something feels wrong.
5. **Make a paper trail** – This can include any surgical records, [...] annual lab results, prenatal and delivery records.
6. **Change doctors if you don’t feel safe** – There is no rule that says you must remain in the care of a provider who doesn’t make you feel safe.
7. **Prepare your partner [if applicable]**
8. **Don’t be neglectful during the postpartum period**
9. **It takes a village** – Your health is a team effort, in which you, not the doctor, play the

most important role. (Hossain, 2021, pp. 197-200)

Conclusion

In this chapter, I detailed the complex relationship between Black people, their reproductive rights, and the U.S. healthcare system. The historical and continuous impacts of racism, sexism, and discrimination against one's gender identity and sexual orientation have created barriers in receiving safe, comprehensive culturally competent healthcare for people of this population. Black reproductive healthcare needs to be reimagined and renovated in a manner that centers their voices and needs – not those based on binary and heteronormative structures. In the next chapter, I will explore and expand this effort via dialogue with Black, Black birthing and Black LGBTQIA+ people.

CHAPTER III: VOICES FROM THE MARGINS

A significant portion of this study seeks to investigate the barriers that impede access to safe, comprehensive, ethical, and culturally competent reproductive healthcare by documenting the stories of people from targeted and marginalized populations. In this chapter, I will document my journey and process for doing so, first by chronicling its challenges and limitations, followed by conducting interviews and the emerging themes from interviews I conducted in the spring of 2023. By reading participants' responses, I encourage readers to think about their own experiences while navigating the healthcare system, and how they can advocate for marginalized individuals and themselves against systems which via policy, procedures, laws, oppression, and privilege, infringe upon human rights.

Challenges and Limitations in Data Collection

As stated in the Limitations section of chapter one, this study encountered challenges from its inception. Examining and reimaging a structure such as the U.S. healthcare system could be infinite, thus my niche focus on Black reproductive healthcare, but ultimately, I had a limited amount of time to do so. With this in mind, I created a digital flyer that marketed my study and invited participants that I was hoping to speak with. While I (with the assistance of supportive friends) placed the flyer in spaces and on platforms with vast, diverse audiences, a week went by without any response. I decided that I needed to reconfigure and be strategic with my approach, as well as rethink the number of interviews I initially planned to conduct. I moved forward by asking two people I know personally to participate and luckily, they agreed. I was considering using material from an oral history I conducted in March 2022 when the final participant reached out to me after seeing my flyer on Facebook. Eagerly hoping to participate, my participant pool came to a total of three.

My study investigates how intersecting identities impact Black people’s access to reproductive healthcare, specifically ethnicity, race, gender, and gender identity. Given historical and the current societal and political climate that is discriminately targeting LGBTQIA+ individuals and their rights, I felt that my knowledge and research would be further enriched by learning about their experiences in accessing reproductive healthcare. However as previously stated, I was unable to find or speak with someone who identified as Black and part of LGBTQIA+ communities. It is my hope that my study and those like it continue to create space and include marginalized individuals in mainstream research.

Table of Participants

The following table provides an overview of the participants in this study. Interviews were conducted and recorded via Zoom, and were no more than an hour. Due to the sensitive nature of this study, pseudonyms will be used to further protect the privacy of the participants.

Participant	Age	Race/Ethnicity	Gender Identity	Sexual Orientation	Number of Children	Date of Interview
“Carla”	43	Black/African American	Cisgender Female	Heterosexual	4	02/23/2023
“Jasmine”	35	Black/African American	Cisgender Female	Heterosexual	1; 1 in utero	03/06/2023
“Kelly”	38	Black/African American	Cisgender Female	Heterosexual	1	03/07/2023

After the conclusion of the interviews, data analysis found the following and recurring key themes: disparities in provider-patient interactions, personal and professional biases against patients – especially those with multiple intersecting identity markers, and the fight to feel empowered and advocate for one’s bodily autonomy in healthcare settings. These themes are

further explored in the following sections.

It Just Didn't Feel Very Nurturing or Individualistic in Care: Disparities in Provider-Patient Interactions

One of the key contributors to the mortality rates of Black and Black birthing people is the disparities in provider care toward patients. It is often said that interpersonal or “soft” skills cannot be taught, but in the medical field this lack of knowledge co-mingled with implicit biases is a death sentence for Black people. A study by Jain & Moroz (2017) reviewed a survey completed by members of the Society for Maternal-Fetal Medicine (SMFM). The survey, which assessed the providers’ knowledge of disparities and consideration of implicit bias in their practices, found that most agreed that disparities impact their work, but few believed that their personal biases were an additional factor. However, the study also found that providers often underestimate the differences in outcomes between Black and White women, including the “maternal mortality risk and the difference in risk of preterm birth among Black women with high-risk pregnancies compared to White women with the same complications” (p. 324).

White VanGompel et al. (2022) expanded research by studying the psychometric validation of patient-reported experiences of obstetric racism. While harmful treatment experienced by Black birthing people is not new – but rather the public and societal recognition of it is – the researchers created the PREM-OB scale “in order to quantitatively measure and monitor the lived experiences of birthing while Black in hospital settings in the United States” (p. 519). The most telling part of the study were the three independent scale definitions developed and used to measure patient experience:

- Racism: Anti-Black misogynoir as demonstrated by the hospital enacting acts of degradation and humiliation [...] whereby Black mothers and birthing peoples feel they

must physically, emotionally, mentally, and spiritually activate particular types of mechanisms to mitigate the onset, frequency, duration, and repetition of violence and abuse during hospital childbirth.

- Kinship: Disruption and interruption of biological and social ties by hospital policies and practices manifested as acts of obstetric racism enacted against Black mothers and birthing people [...].
- Humanity: Violations of safety and accountability during service provision as demonstrated by perpetuation of physical, emotional, and mental harm; delayed, dismissive, or neglective care; or inappropriate or rushed care (p. 521).

All three participants in my study are unfortunately no strangers to these definitions and have experienced various instances of lack of empathy, abrasiveness, and neglect while seeking and receiving reproductive healthcare. When asked about positive and negative experiences while accessing care, the positive experiences appeared to be few and far between, and were established primarily due to the participant's direct involvement. This included emphatically advocating for one's self by meeting with hospital staff and writing letters to hospital management so that they could receive care that was in alignment with their needs, or utilizing doulas and midwives to support them throughout their pregnancies. It was during the negative experiences, when they were extremely vulnerable, in need and in search of supportive guidance, that they were often treated in an undignified manner as described by Carla. After giving birth to her first child, she suffered a miscarriage in an attempt to become pregnant a second time:

Not really being knowledgeable about miscarriages – how they happen, why they happen – I was very distraught. In the midst of that we had went to a...parenthood-like type place, and they were just really nonchalant. Just, you know, "Sorry this happened..." but more or less,

“These things kind of happen; it's normal...follow up with your primary and you'll be all right...” Send you along your way, like that kind of thing. For me it was just very abrasive, and the magnitude of emotions that I felt in the midst of that – you know just being disheartened for the loss, but then not receiving that support and empathy...it made it worse. [...] Had I not had the community and tribe around me that I had, I probably would have really went into a depression.

Hospitals proved the most precarious to the lives of the participants as all three had at least one if not all of their children in a hospital setting. Wanting to give birth vaginally and as naturally as possible, they spent time creating and communicating birthing and overall care plans only to be met with pushback from medical staff, who often cited policy and procedure as their reasonings for not being able to meet their needs. The experience of Jasmine’s first birth describes how the healthcare system and those employed by it may utilize unethical power dynamics and tactics, such as weaponizing language, in order to get patients to adhere to what they want. Assigned to a rotating OBGYN team of six doctors, her healthcare journey started off positively, and included a White, male doctor who she described as patient, compassionate, and empathetic:

What did make me feel heard and cared for...was eye contact, the repeating of questions back to me to make sure I was heard correctly, the taking of the time to answer questions, or if he wasn't able to answer the questions, the printing out of materials and making sure I had them in my hand before I left. Any test that he ordered for me, he explained why I was taking that test, the importance of it, and the knowledge he would gain from having the test results back. When I was in labor and he came in to check on me; he touched my hand, he actually asked for consent, he just acknowledged that I was a person going through a human

experience [...].

A staff shift change would eradicate the previous experiences entirely. After laboring naturally in the hospital for 12 hours, Jasmine was forced to birth her baby in an unwanted manner by a doctor whose identity and behavior was surprising:

The rest of those other five doctors, they were women; one of them was a Black woman. She was the most dismissive; she was the most abrasive, she was the most willing to tell me things like, “Well, that's just the way things go...” It just didn't feel very nurturing or individualistic in care and nature. Then the shifts changed while I was in labor...and that Black woman doctor ended up being the next one on-call. She said I had been laboring for too long and said I was gonna go get a C-section. I begged her “No, no, no, I don't want a C-section – I just wanna wait longer...” She said “No, you've been here all day, that's long enough. We don't have time to keep waiting on you to be in labor, so we're just gonna cut you now.”

Floored, I asked how the treatment of the Black doctor further impacted her birthing experience in comparison to the care she previously received:

She did not give me eye contact and she did a lot of shoulder shrugging and her general disposition was “Well, that's life.” [...] She was just so...not friendly. Just mainly that the lack of eye contact, the lack of asking for consent; she just came in and started doing things and didn't explain herself. I would say that I tried to advocate for myself and that my son's father tried to advocate for me. We asked questions: Why? Are you sure? Is there no other way? And she was just straight up like, “Nope, we're going for it.”

In the aftermath, both women described feeling traumatized, ostracized, and as if their bodies had failed them. With little to no opportunity for advocacy or follow up from their care

providers, they were left to process and internalize these experiences privately. As demonstrated by White VanGompel et al. (2022), disparities in provider-patient interactions are not only a personal issue, but a social, cultural, and structural one as well.

The System is Failing Us Every Day: Intersecting Identities as Barriers to Reproductive Healthcare

Cooper Owens (2017) states that during the Antebellum era, most American doctors believed that Blackness was not only a skin color, but also a racial category that per biological theory, proved Black women could be the same species as a White woman, but simultaneously biologically distinct and inferior (p. 2). As the medical field and healthcare system have evolved over the generations, this mentality has not. Regardless of intent, Black, Black birthing, and Black LGBTQIA+ people are inherently and adversely impacted by societal and cultural biases, and stereotypes often in spaces that effect their lives and livelihoods. This treatment is often influenced by their intersecting identities related to gender, gender identity, and sexual orientation. Within the medical field, research and data collection show a plethora of disparities in how biases influence health care outcomes for Black people including inequities in socioeconomic and educational status (Hill, Artiga, & Ranji, 2022), heterosexism and heteronormative assumptions (Agénor et al., 2015), and implicit ethnic and racial bias from healthcare professionals (Hall et al., 2015).

Over the course of her pregnancies, Carla has learned to be cognizant and prepared for instances with implicit bias, macro- and microaggressions:

It's detected in conversations; detected in comments, how things are said – the fluctuation, the tone. Even in how they are trying to familiarize themselves with you, to make *you* feel comfortable. I am very keen to how [they] transform from doctor mode

into “let's be friends”; make this a friendly experience and I don't need that. I'm in a professional environment; I need you to be a professional, I don't need you to befriend me. It's all of those subtle things that if you're not paying attention, it gets brushed under the rug. But it all does impact how you receive the care that you should be getting and that should be quality.

However, an incident early in her last pregnancy during a routine prenatal appointment made her question the treatment and care that she received:

This is my fourth pregnancy, so I'm pretty acquainted with things that you have to do and fill out. This particular form requested my signature that I could be tested for drug screening at any random time. It caught me off guard; it was mixed in with the other papers, and in the moment, it registered but it didn't. Because I was so shocked that it was in there, I went ahead and signed it, and put it back with the paperwork. But I could not rest; I didn't have any peace about it.

Additionally, she was told that she would need to be tested for STDs/STIs when she did not have to do so previously. She was a routine patient, and the medical staff had access to her history in her medical file. When Carla questioned the nurse about whether it was a new procedure and the reason for it, she was rebuffed:

My following visit I spoke with a nurse about it; I asked a different nurse. I said “Is this routine? I've never ever been presented with this form, and being a Black woman, I feel that it's biased that I have to sign it for you to do a random drug screening. Nothing in my medical history suggests that I've been a drug user, there's nothing that I've said or done to come in here that makes you think that I'm abusing drugs. Why do you need to screen me for drugs when *you* feel like you need to? That doesn't make any sense.”

Appalled by the nurse's assumptions under the guise of care, and her answer that the form was standard by giving them the authority "to make sure that there's nothing in your system that could be harmful or anything of that nature..." Carla asked for the form to be removed from her medical file. She went on to say that thankfully, she did not incur any other issues after that incident.

As someone who has spent significant personal and professional time navigating the U.S. healthcare system, Kelly was well aware that despite her privilege and access to resources, her identity markers would influence the type of care she would receive as a new mother:

I had my baby I would say later in life; I was in my mid-30s. I would say that initially the treatment was just...I think it doesn't matter if you're a teen mom, if you're poor mom, if you have access to resources, if you have a partner or not, everybody accessing care should be treated with respect, right? The utmost respect. From the beginning, I was treated like I was a teen mom that didn't know anything; from the questions that were asked, from the comments that were made. [...] Many times, I had to let them know I have a partner; I have resources.

Her experiences in fighting and advocating for her care needs during her pregnancy made her reflect on how the numerous barriers within the system are more damaging to those with compounding intersecting identities, and little to no access to resources that they need:

I've always been aware that as Black people, we live in this racist society and I realize how we are treated – I think it's something that I've kind of always known. But [...] I believe that once you are nonbinary or trans or anywhere on the LGBTQIA+ spectrum as a Black person? I believe that it is way worse. Not only are we in [a] racist society, we are in a patriarchal society. If you're not male and or female; if you don't identify that

way, anything that goes against the colonized way of thinking or being, it's going to be ten times worse. [...] Black trans women are not even living; like they're not even making it past I think it's 34? And the reproductive care – I mean me as a Black woman...I'm getting subpar treatment as it relates to my reproductive care, so I can only imagine what that looks like for a Black trans woman. Also, provider wise I have a hard enough time finding a Black woman provider, so do we have Black trans women providers supporting folks that are experiencing reproductive health issues which might be different than mine? I just think that you add that extra layer of identity that is not conforming to the colonized way of thinking or being, you just add an extra layer of oppression. I often think about that.

Despite present and emerging data about the adverse impact of societal, cultural stereotyping and biases on Black people, it is alarming that there appears to be no accountability or effort to eradicate them from the U.S. healthcare system. As described in Prather et al. (2018), Black people have suffered ancestral, historical, physical, mental, and emotional trauma since being brought to American soil, and largely due to the healthcare system. Said traumas must be taken into consideration by medical practitioners, as well as knowledge on how they metastasize in Black bodies, instead generalizing and assuming one's lifestyle and personal care practices. Additionally, it is imperative that Black people learn to empower themselves to seek and demand the quality care that they deserve.

I Have Power and Autonomy Over Myself, My Life and My Body: Advocacy and Empowerment

Although Kelly did not want to have her baby in the hospital, she and her partner compromised and decided to do so, but not without a specific set of rules:

I wanted to have her as natural as possible, and the hospital is not a natural setting...so I didn't want to lay down and give birth - I wanted to squat. I didn't want to be connected to any machines. I didn't want any medication. I didn't want the monitoring; like we could do periodic monitoring, but I didn't want the typical things that they do in the hospital. I wrote all that out and shared that with the doctors [and] with the midwife. [...] I wanted to breastfeed and no vaccines; none of the routine things – you take the baby, weigh the baby, all these things. I was very clear.

Her birthing plan may have sounded restrictive or outlandish; the medical staff thought so and initially tried to dissuade her from pursuing it with their dismissive and apathetic demeanor. But Kelly remained steadfast because of her personal and professional knowledge of the system. She was also aware of her bodily and general autonomy, and right to quality care. Black people are often the victims of medical care practices that are not safe, quality, or culturally competent, and many are not aware of, taught to ask, or advocate for that kind of care. Even when we do, we are patronized and ignored, leading to detrimental and fatal results. This, along with historical violence and trauma perpetuated by the healthcare system, makes Black communities less likely to seek care or other forms of medical treatment. Hostetter and Klein (2021) describe these exhibited characteristics as medical mistrust, “an absence of trust that health care providers and organizations genuinely care for patients’ interests, are honest, practice confidentiality, and have the competence to produce the best possible results” (para. 4).

Given their experiences while navigating the medical system, the participants in my study knew that they did not want the negative ones replicated. Instead, they decided to educate and empower themselves on advocacy in medical settings, not only for themselves, but for other birthing people as well. Jasmine, who is due in August with her second child, decided on a new

approach for her second birth:

I actually embarked on a birth work journey myself, so I am now a birth worker. I now advocate for women; I now stand in place and hold space for birth givers. This pregnancy will be different from the last in I'm not even going to put myself in a situation to be in a systemic type of environment. I have a team of midwives; I have a team of doulas, I plan to free birth quite honestly, I plan to birth in the freedom of my own space. I have the Medi-Cal, so if an emergency happens, I'll be covered and I'll be able to seek medical attention. But I've learned that if you're an otherwise healthy human, then you should be able to have a healthy physiological birth without medical intervention. I just know that because I was such a novice to birth the first time I gave birth, I let the fear of the unknown take over and I rushed to a hospital situation. I just feel so empowered now to know that I don't have to rush to a hospital because giving birth is not an emergency, it's natural.

After giving birth three times over the course of almost 20 years, Carla attributes her age, attained wisdom, and knowledge of her body and its capabilities in aiding the process of her fourth birth:

I was induced, and because this is not my first child and I know my body, I literally told [the medical staff], "You're gonna break my water, and it's not going to take long. If I can just labor in the way that I desire, we'll be all right." [...] And sure enough, everything flowed the way I anticipated, and they didn't have any interventions. I was very grateful that they listened. If they tried to prescribe a certain medicine, I told them "No, I prefer not to take that" and they listened in spite of all their information. They will repeat it and continuously remind, but they never said "No, you need to take this..." or

“You need to do this...” They just noted it as “patient declined.” That I do appreciate.

It is admirable that despite their harrowing experiences, the participants have developed an approach that honors their health needs and their boundaries when seeking care. However, they are aware that many Black, Black birthing, and Black LGBTQIA+ people do not, or do not know how to. Knowledge of the healthcare system as well as the autonomy one’s possesses is key per Kelly:

I think having the knowledge of the system and knowing the power that you possess is really important. [...] Also having a team of people that are going to be on your side and supportive when you are fighting this system – because you will have to. Having them support you and to tag people in when you need to because you can't fight 100% of the time all the time by yourself. [...] What I've learned is the power piece for Black women specifically, going in feeling like I'm in control. I think that the system strips that power away from you, so sometimes folks go in hopeless or feeling like “I don't know what's going on.” Maybe [they've] never been pregnant before, they might want to ask questions, or they might need more support medically, and they might have an innate trust for the medical system. [...] But I think that it starts with really a knowledge and understanding of the history, the statistics and where we are as a society.

With this type of mentality, Black people can take the first steps to creating the patient-provider relationships that work best for them, mitigate bias and other forms of discrimination that reduce their quality of care, and step into their power as advocates not only for themselves, but others.

In an Ideal World...

In each of my interviews, I asked the participants to describe what Black reproductive

healthcare looks like in an ideal world. I wanted to know what would make them feel safe, cared for, and heard. I also wanted to know what steps were needed to achieve this ideal. With my goal of centering their experiences and voices, this section will solely feature their words on how to turn this ideal into a reality.

Changing the Lens, Being Able to See People Where They Are and What Their Need Is -

Carla

I think the first step is to remove the bias. I think that is a personal obligation of the professional provider – that's not the responsibility of the patient, but of the provider coming into this field to look at things through a different lens. I don't know what type of training they receive, and it may not even be pertinent for them in their educational process, but it should be. Coming into a field where you were dealing with universal community, it's not just one race, you know. I [also] think being knowledgeable. If you are going to approach patients with “I *see* you as a Black woman...” if you are going to come from that angle, then be knowledgeable. Be able to provide the information that's pertinent to that patient, not umbrella the situation – no generalizing that patient based off of what you think you know, but really coming to an understanding with that individual patient.

Having a skilled team: I prefer midwives, but because I have to see doctors and nurses, having some that are empathetic – sincerely empathetic – [and] that are well versed in their craft and their profession. Then resources, whether it be counseling...and when I say resources, literally pairing patients with what they need. Oftentimes pamphlets are put in hands, or you're given a website or something that's gonna require you to go look for it. But literally just being a liaison and pairing resources with the patient – being that middle person to get them what they need, even postpartum.

Before You Even Get Pregnant, Knowing Your Body - Jasmine

I think the first step in Black reproductive health is before you even get pregnant, knowing your body, and then anyone that gets to answer or explore your body also has the responsibility of knowing your body. I think it's important to make healthy habits a lifestyle: smoking and excessive drinking, eating junk food and processed foods, all of those things are just not good for your health or your reproductive health, so I think that nutrition is important. I think that exercise is important, I think that knowing your ovulation cycle is important. I think that it's time for us as Black people to divest from birth control and any other types of toxic medications that affect the outcome of our babies; vaccinations that we're unsure about and anything that can potentially affect the health and longevity of us and our children – any type of environments.

Even more so than what we can do for our health as individuals, it's important as a system for us to have access to clean spaces; to not have to only be able to afford living in the industrial spaces and places where there's heavy pollution and I could go on and on. There's so many things that are counted against us that are beyond our control, that really matter when it comes to whether or not we're obese, whether or not we are predisposed to asthma or to autism. I think it really all boils down to systems - whether or not red dye #40 should be allowed in food at all, whether or not we should be having food deserts, it just shouldn't be a thing. We should have access to produce that's affordable; it shouldn't cost more to eat healthy than it costs to buy junk food.

It's still important to get out into these communities and provide education about what a doula is, what a birth worker is, what's the difference between a doula and a midwife. A lot of people think if I get a doula, that means I can't get an epidural and it's like no, it's not what that

means. I think it's important to also remember that there was a system of barter - trade and barter. Everything does not have to be cash on hand, or cash on demand or, pay for play. If you have something to offer and the midwife has something to benefit, maybe you can offer a trade. I think it's really important also that more and more Black people remember that herbs and vegetables are healing to us; the land is here for us and we should love the land so we can love us back.

I think it's just so important for us to remember again who we are, where we came from, and that we can do things in indigenous ways again.

Free Access to Quality Healthcare and Reproductive Care; That Is a Start for Me - Kelly

I would say free access to quality health reproductive care providers that look like you, but not only providers that look like you, but providers that have similar lived experience. So trans providers, like we need that because although I feel comfortable in supporting a Black trans woman, I am not one, right? There's going to be blind spots for me so that person should have access to someone that truly understands that walk. I think that that free care should include a doula for all women that are that are considering becoming a parent, have lost a child, that's even thinking about it [but] don't want to. I believe that doulas should be easily accessible because like I said, I paid a lot of money for my doula. I'm grateful that I was able to do that, but it should be a free service and it's not.

I think that education – support and education for Black women educating them on their bodies, educating them on the system and what to expect, and empowering Black women in terms of their body. I think that the knowledge of understanding and knowing your body, and access to quality care are really important things. I think that collective, communal sharing of experiences – that is why I tell my story so much because I think that there is healing [in] sharing

stories. I want Black women to know you can do this too; you can speak up, you can advocate for yourself. You don't have to accept that – you don't have to do anything you don't want to do as it relates to your health. You have 100% autonomy over your body, so if you don't want to receive this treatment, or engage in treatment in this way or with this provider, you have the right to do that, and you can request another provider. You are in charge of your care and that is the biggest message I want Black women to know. It's the difference between life or death, really.

Listening to Carla, Jasmine, and Kelly's words, there is nothing about their ideas or suggestions that are inherently difficult to correct or implement so that the needs of Black people in healthcare settings are met. In addition to historic and oppressive systemic structures, it is also the dehumanization of Black people and their experiences that has led to the Black reproductive health crisis. It occurred to me that their definitions and ideals of Black reproductive healthcare not only spoke to the care that they deserved and wished to receive, but also their desire to be seen and validated as human beings. Anti-Blackness is a global issue embedded in most systemic, social and cultural entities; it is evident given the lives that are not prioritized and valued. When we can begin to center, save, and liberate populations most adversely impacted by the current state of the U.S. healthcare system, we will create a better standard of care for everyone.

Conclusion

In this chapter, I highlighted overarching and overlapping themes and barriers that impede access to safe, comprehensive, competent, and quality reproductive healthcare for Black people. I also present the vision and desires of the participants for safe, comprehensive, competent, and quality reproductive healthcare for Black people. Through historical evidence as

well as the experiences and voices of the participants of this study, it is evident that the U.S. healthcare system needs deep restructuring in order to achieve its intended purpose: to enhance the quality of life of the people it serves (Institute for Healthcare Improvement, 2018).

Simultaneously, it is imperative that Black people educate and empower themselves in order to exhibit autonomy not only in their healthcare matters, but in their everyday lives as well.

CHAPTER IV: BLACK REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS

In December of 1948, the Universal Declaration of Human Rights was adopted by the United Nations General Assembly. The declaration, which details an individual's basic rights and fundamental freedoms, states that "everyone has the right to a standard of living adequate for the health and well-being of [them]self and of [their] family, including [...] medical care and necessary social services..." (United Nations, 1948). Despite the reverence of this document, it has been continuously proven that this is not the case. The disparities in treatment, care, and overall recognition of Black, Black birthing, and Black LGBTQIA+ lives are what led to this study, and to understand how their intersecting identities impact their access to reproductive healthcare. As evident in chapters one and two, the treatment of these populations is complex and rooted in systemic racism, sexism, and other discriminatory practices that continue to uphold ideals and practices centered in White supremacy and privilege. The current U.S. healthcare system is not structured in a manner that supports or centers the needs and experiences of Black and other marginalized lives. But before reconfiguring this system from the ground up, we must first consider the lives and listen to the voices and needs of those most impacted in order to not perpetuate further harm.

In reflecting on my interviews with the participants of this study, I conducted these interviews to not only give them an opportunity to share their experiences, but also to reinforce that their answers should not stop at ideals or dreams – they should be a reality. Inspired and empowered by those conversations, I would like to address the populations identified in the significance section in chapter one of this study:

To state, national, and federal leadership, and policy makers: Over the last two years I have watched the majority of you go against the core tenets of what your role supposedly

represents. Instead of protecting your citizens, you have infringed upon their individual and collective rights, and continue to adversely impact their lives and livelihoods under the guise of being “pro-life.” How you can make this claim as you simultaneously eradicate healthcare services; harass, threaten, and incarcerate healthcare practitioners and other advocates; and force the closures of reproductive healthcare clinics throughout the country, is beyond comprehension. But as the guise continues to be lifted, it is evident that the majority of you are “pro” a certain type of life: One that is of the dominant culture, upholds patriarchal, supremacist ideals, and seeks to erase anything and anyone that appears to be a threat to that. Due to your racist, sexist, and other discriminatory legislative rulings, it is Black and other marginalized lives that are left to deal with the repercussions. If my Black life and others like mine are considered a threat to your own, I implore you to ask yourself why you believe that is. I invite you to think about why your life is and should be weighed as more worthy than others. I suggest that you evaluate how this privileged mentality has impacted and influenced your personal and professional lives, and the daily decisions you make. Lastly, I advise that the decisions you do make moving forward are ones that allow for the improvement and protection of all lives.

To physicians, nurses, medical school students and other emerging medical professionals: A core component of the modernized version of the Hippocratic Oath states “I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug” (Tyson, 2001). While the content of oaths may vary, common decency, empathy, and humanity toward a patient should not. It is imperative that medical schools and other educational institutions review their curriculums and practicum for blind spots that perpetuate biased, culturally incompetent, and unethical practices. This is something that needs to happen on a continual basis; as society and

the types of people seeking medical care evolve, so should the healthcare system. Bias and cultural competence also need to be addressed on a personal level. It takes a tremendous amount of courage and trust to place your life into someone else's hands; if someone's race, ethnicity, gender, gender identity, or sexual orientation impedes you from remembering that, ask yourself if being in the medical field is the right place for you.

Lastly, **to Black, Black birthing, and Black LGBTQIA+ people:** We live in a world that looks for an opportunity to end our lives physically, mentally, emotionally, and spiritually every day. We are often discouraged from doing anything that validates our humanity, but after first learning about the reproductive health crisis almost six years ago – in addition to everything else hindering Black lives – I knew that I could no longer sit and be silent. The Human Rights Education program, this study and those that participated in it, and those advocating for Black lives and Black reproductive health, have taught and empowered me to know we deserve to be here; we deserve to dream, excel, and live. It is my hope that this study is the first of many that promotes alternatives and advocacy when it comes to our bodily and overall autonomy. I urge you in the face of White supremacy and privilege; internalized misogynoir, homophobia and transphobia, and other forms of erasure to continue telling your stories, raising your voices, and supporting us – regardless of gender, gender identity, and sexual orientation. This work is for us, but we must ensure that we are fighting for *all* of us. When ignorance, violence, discouragement and exhaustion threaten to steal joy, think of the future generations that will be here because of the work we did. You are seen, valued, and loved, and I am grateful to stand alongside you.

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