Hating Girls

An Intersectional Survey of Misogyny

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Contents

CHAPTER 12

Misogynoir and Health Inequities

Giving Voice to the Erased

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Black women in America have long been silenced, erased, and left without voice. This *voicelessness* is a great detriment, particularly to Black women and children. For example, Black maternal and infant mortality rates are significantly higher than any other racial groups in the United States. Despite the wide racial gap and the national attention, the disparities have persisted. In this chapter, quantitative data details the problem of maternal mortality alongside qualitative data giving voice to the experience of Black women as they confront racism, sexism, and classism during pregnancy, labor, and delivery.

In September 2000 leaders from around the world met at the Millennium Summit to discuss the plight of the impoverished. The aim of the summit was to develop goals by which countries could measure and benchmark the health outcomes of their citizens. This resulted in eight Millennium Development Goals (MDGs) that focused on equitable allocation of resources and improving health.[1] Two of the eight MDGs specifically addressed maternal and infant health, aimed at improving maternal health and reducing infant mortality (MDGs 5 and 4 respectively). Significantly, MDG 5 set an explicit target of reducing maternal mortality rates by 75% within fifteen years.[2] Despite their good intentions, global data indicated that this target was not met. Developed countries showed the least amount of improvement towards the goal. In fact, developed countries only saw a 35% reduction in maternal mortality rates with one notable exception.[3] During this same time period data from the National Center for Health Statistics (HCHS) showed an *upward trend* in the United States for maternal mortality rates.[4] While the goals were specifically developed to target developing countries with extreme widespread poverty,

1 United Nations, *The Millennium Development Goals Report*. New York (2015).

2 Ibid.

3 Ibid.

4 L.M. Rossen, L.S. Womack, D.L. Hoyert, R.N. Anderson, S.F.G. Uddin, *The impact of the pregnancy checkbox and misclassification on maternal mortality trends in the United States, 1999–2017*, National Center for Health Statistics. Vital Health Stat 3: 44 (2020).

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these goals also provide metrics by which to evaluate developed, high-income countries, such as the United States. While developed countries have significantly lower rates of maternal death than developing countries, the rates in the United States for Black women are higher than two of the World Health Organization's (WHO) listed high priority regions.[5]

Pregnancy-related maternal mortality in the United States remains one of the highest among developed countries. In fact, the United States currently ranks 64th in the world for pregnancy-related maternal mortality.[6] The Center for Disease Control & Prevention (CDC) has reported an upward trajectory over the last thirty years, between 1987 and 2017. Data from 2017 reveals that the United States' pregnancy-related maternal mortality ratios (PRMRS) (defined as the number of maternal deaths per 100,000 live births) was 17.3 deaths per 100,000 live births. Black women have experienced the highest rates of PRMRS of any racial/ethnic group in the United States. The PRMRS for Black women between 2014 and 2017 were 41.7 deaths per 100,000 live births. During the same timeframe, white women experienced 13.4 maternal deaths per 100,000 live births.[7] The disparity between Black and white women in the United States is significant, with Black women experiencing maternal death 3.1 times more often in birth.

Numerous factors can contribute to pregnancy-related deaths in women as data from the CDC demonstrates. During 2014–2017, the most frequent cause of pregnancy-related death was cardiovascular conditions (15.5%). Cardiovascular conditions, such as cardiomyopathy (11.5%), hemorrhage (10.7%), thrombotic pulmonary or other embolism (9.6%), cerebrovascular accident (8.2%), hypertensive disorders of pregnancy (6.6%), and amniotic fluid embolism (5.5%) comprised the vast majority of causes of pregnancy-related deaths in the United States.[8] Many of these conditions are related to obesity, hypertension, diabetes, and chronic heart disease. Black women are disproportionately affected by obesity and chronic disease. Many reasons for the higher rates have been posited.[9] K.M. Flegal and colleagues, for instance,

5 United Nations, *The Millennium Development Goals Report*.

6 Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, (2017) https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#:~:text=Since%20the%20Pregnancy%20Mortality%20Surveillance,100%2C000%20live%20births%20in%20 (Accessed November 2020).

7 Ibid.

8 Ibid.

9 K.M. Flegal, M.D. Carroll, C.L. Ogden, and L.R. Curtin, "Prevalence and Trends in Obesity Among US Adults, 1999–2008," *The Journal of the American Medical Association*, 303, no. 3 (2010) 235–241.

examined the prevalence of obesity in the United States, using the National Health and Nutrition Examination Survey (NHANES). This important examination collects national data for a representative sample of the population. In addition to observing the increasing rates of obesity, investigators also noted the trend of disproportionate rates of obesity between Black and white people. The most striking rates of obesity were noted in Black women, prompting campaigns and interventions to address this disparity.[10] As with other interventions the focus was short-sighted and narrow, prescribing solutions to mitigate downstream health determinants such as improving access to care and creating programs that target individual health behaviors. However, these interventions lacked the incorporation of methodologies to address racism as a significant determinant of health and thus did not yield the results witnessed in controlled clinical studies.[11] Many disciplines (e.g. public health, psychiatry, psychology, and education) have expressed concern with transitioning clinical-based interventions to real-world settings in an attempt to identify confounding factors.[12] The problem with the intervention lies with the basic understanding of etiology (the causes of disease) within the field of medicine and health. Most often, physiological explanations are frequently cited as the cause of these medical conditions and chronic diseases. However, the development of a chronic disease or medical condition is far more complicated and involves numerous external inputs, related to an individual's race, societal structure, political system, and history.

Race/ethnicity is of particular interest in examining PRMRs, as the construct of race further complicates health and the delivery of care.[13] Race/ethnicity is linked to social disparities, that can adversely impact health.[14] Racial differences in health risks and outcomes can be attributed to a number of factors that reflect differences in socioeconomic status, housing, and social positionality/strata.[15] Additionally, individuals minoritized due to not being

10 Ibid.

11 H. Yoshikawa, "Placing Community Psychology in the Context of the Social, Health and Educational Sciences: Directions for Interdisciplinary Research and Action," *American Journal of Community Psychology, 38* (2006) 31–34.

12 Ibid.

13 D. R. Williams, "Race and health: Basic questions, emerging directions," *Annals of Epidemiology*, 7, no. 5 (1997) 322–333.

14 P. Braveman, S. Egerter, and D.R. Williams, "The Social Determinants of Health: Coming of Age," *Annual Review of Public Health*, 32 (2001) 381–98.

15 B. Smedley, A. Stith, and A. Nelson, eds., "Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care" in *Unequal treatment: confronting racial and ethnic disparities in healthcare.* Washington D.C.: The National Academies Press (2003). https://doi.org/10.17226/10260.

part of the dominant cultural reference group may face individual racism as well as systemic racism. Ford and Airhihenbuwa (2010), in their commentary in the *American Journal of Public Health*, introduced Critical Race Theory (CRT), as a framework by which public health and healthcare professionals can understand the embedded nature of racism in the United States.[16] In CRT, the first premise is the centrality of racism. Race theorists posit that racism is an ingrained feature, which due to its ordinariness becomes almost unrecognizable. This inability of whites to be able to identify racism leaves them blind to the marginalization of nonwhites and to the privileges afforded them due to their whiteness.

The construct of race has always been rooted in white supremacy. In America race has been structured in a way to create a binary opposition, bifurcating whiteness from otherness. This division promulgated a narrative of superiority and inferiority, which positioned the other into the role of deviant. This notion of a deviant/underclass conjures specific imagery, which for African American women has been depicted by two iterative representations, the mammy and the jezebel. The mammy with her black face and rotund body nurtured the household of the master. She was self-sacrificing and obedient, while the jezebel was a temptress, exposing her breasts and acting in lewd ways to lure men to her.[17] Black women were forced into one of the two roles that the dominant culture had constructed for her, placing her in a position to be demonized. The mammy and the jezebel have appeared in media and in social text as early as the 1800's and both were misrepresentations of Black womanhood which stripped away the humanity of Black women. This dehumanization means that the individual is devoid of agency and power, allowing other actors to dictate the circumstances of one's existence. Whiteness, in conjunction with maleness, has privileged these two characteristics and established them as the standard by which to measure individual value.[18] The privileging of these specific characteristics means those embodying these traits get to create the narratives for and about those occupying a positionality perceived as inferior. In the case of Black women, being doubly minoritized, the ability to effect change in their lives is limited by the power exerted on them by the

16 C.L. Ford and C.O. Airhihenbuwa, "Critical Race Theory, race equity, and public health: toward antiracism praxis," *American journal of public health*, 100 Suppl 1(2010) S30–S35. https://doi.org/10.2105/AJPH.2009.1710581.2.

17 Patricia Hill Collins, *Black sexual politics: African Americans, gender, and the new racism.* New York: Routledge (2003).

18 A.K. Sesko, and M. Biernat, "Prototypes of race and gender: The invisibility of Black women," *Journal of Experimental Social Psychology*, 46, no. 2 (2010) 356–360.

White male esthetic. This esthetic reifies Blackness in women as hypersexual and depraved or subservient and docile. However, the cultural reproduction of these images and narratives has conflated these two constructs into the *welfare queen*, a misrepresentation coined by late President Ronald Reagan. This construct when evoked allowed for the reform of federal aid programs, shifting millions of dollars from programs established to assist in feeding and housing families in poverty to the military and governmental pet projects. Through the construction and reproduction of social text, whiteness is able to maintain supremacy and assert control over Black bodies.[19] The process of control is insidious, due to the entrenchment of images and narratives. These images and narratives do not only operate at a personal level, but also through institutions and systems.

Racism in healthcare can manifest itself through two primary means. In addition, it can exert its impact via several mechanisms. Dr. Camara Jones, former president of the American Public Health Association (APHA), identified institutional racism and personal mediate racism as determinants of health for African Americans and a factor in health disparities. Likewise, Dr. David R. Williams, chair of the Department of Social and Behavioral Sciences at the Harvard T.H. Chan School of Public Health, cited institutional/structural racism and cultural racism (referring to racial ideology of Black inferiority) as contributing factors of adverse health outcomes for African Americans/Blacks.[20] Institutional racism informs the material conditions of the lived experiences of African Americans/Blacks through policies, laws, and practices embedded in society, which can impact the physical environment and access to services. Both personal mediated and cultural racism can result in implicit bias and/or discrimination. Williams and Mohamed (2013) link racism to stress and physiological responses which impact morbidity and mortality.[21] Several models exist linking racial stress due to discrimination and institutional racism to adverse health. Additionally, co-occurring societal factors—such as socioeconomic status, geographical location, neighborhood/community cohesion—can have an additive effect upon racism. For example, racial housing segregation (institutional racism) which presents several mechanisms by which it acts on health

19 Hill Collins, *Black sexual politics*.

20 D.R. Williams, J.A. Lawrence, B.A. Davis, "Racism and Health: Evidence and Needed Research," *Annual Review of Public Health*, 40, no. 1 (2019)105–125. doi:10.1146/annurev-publhealth-040218-043750.

21 D.R. Williams, S.A. Mohammed, "Racism and Health," *American Behavioral Scientist*, 57, no. 8 (2013)1152–1173. doi:10.1177/0002764213487340.

has been linked to increases in adult and infant mortality.[22] Likewise, personal mediated and cultural racism, can manifest as dismissing a patient's request for pain management, due to the belief that they have a higher pain threshold or that they are more likely to be a drug addict because of stereotypical narratives assigned to Black bodies.[23]

Racism remains a persistent and pervasive risk factor for Black women giving birth.[24] C. Prather and colleagues conducted a literature review to examine the historical events related to the reproductive health of African American women. Their researchchronicled the mistreatment and abuse of Black women, during four distinct periods: slavery; Jim Crow; civil rights era; and post-civil rights era.[25] During all four time periods Black women endured racist assaults and structural barriers due to the color of their skin, resulting in deleterious impacts on maternal health. Over the last couple of years there have been dozens of news stories reporting the death or near-death experience of Black women giving birth in the United States. The issue of maternal mortality disparities was often linked to the expectant mother's education and income. This perspective, however, totally disregards racism and racial bias as significant factors of analysis. Yet, when Beyoncé and Serena Williams shared their birthing experiences, it facilitated a national conversation about the willful negation of agency and presence of Black women. In the case of Beyoncé and Serena, their money and social position should have offered them protection and both of their births should have been unremarkable. However, their race placed them in situations that are common and so familiar to other Black women. Being educated, articulate, or well-to-do does not provide protection from racial bias. All Black women are at risk of a medical crisis during birth.

Black women have been dying at the hands of the white medical establishment in the United States since they first disembarked from the hull of slave ships on the shores of North Carolina.[26] After an arduous journey where men, women, and children had been stacked next to and on top of each other for

22 D.R. Williams, J.A. Lawrence, B.A. Davis, "Racism and Health: Evidence and Needed Research," *Annual Review of Public Health*, 40, no. 1 (2019)105–125. doi:10.1146/annurev-publhealth-040218-043750.

23 Ibid.

24 C. Prather, T.R. Fuller, W.L. Jeffries IV, K.J. Marshall, A.V. Howell, A. Belyue-Umole, W. King, "Racism, African American women, and their sexual and reproductive health: a review of historical and contemporary evidence and implications for health equity," *Health Equity* 2:1 (2018) 249–259, DOI: 10.1089/heq.2017.0045.

25 Ibid.

26 H.A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation On Black Americans From Colonial Times to the Present*. New York: Doubleday (2016).

months, with limited nourishment, slave traders cleaned up their property so that the enslaved appeared healthy with the help of physicians. Throughout the South, physicians were an integral component in the slave trade. Slave owners relied on physicians to verify the health of slaves prior to sale and to determine if slaves were malingering. The relationship provided reciprocity for the physician, as he would be allowed to experiment with new treatments, dosages of medicine, and would take possession of slaves who succumbed to their ailment or the prescribed treatment. In addition, slave owners served as the gatekeepers to medical care. As medical attention was expensive, it was often financially beneficial to withhold care to extract the maximum amount of labor from the enslaved, until they believed care was absolutely necessary.[27] Harriet Washington, in her book *Medical Apartheid*, has shown the medical neglect and abuse of the enslaved due to their lack of power.[28] Additionally, she presented modern cases exhibiting similar medical neglect due to systemic and cultural racism, which continues to leave Black women powerless.

Systemic racism in the United States has relegated Black women to an inferior social space, which often erases and leaves Black women voiceless and vulnerable. The silencing of Black women due to occupying a positionality that is deemed inferior means Black women are less likely to be heard, and medical issues that would normally be deemed non-life threatening with appropriate medical care, devolve into crisis situations which extinguish life.

As healthcare systems and providers continue to struggle with bleak maternal mortality numbers, it is clear that a paradigm shift how we address this issue needs to occur. Solutions frequently focus on developing anti-racist policies, awareness of implicit bias, and providing cultural competence training. Research on the efficacy of implicit bias and cultural competence training as a means to reduce health disparities has been mixed.[29] Policy solutions to eliminate and/or reduce disparities requires a multilevel approach targeting the social determinants of health, such as housing, income, education, and community development. While policy approaches have been successful in improving some health outcomes, they have yet to be successful in reducing racial disparities with maternal mortality.

In the case of maternal mortality, while policies need to be explored and implemented, they cannot continue to be done in a vacuum. Meeting rooms filled with the same individuals who perpetrate acts to erode the humanness

27 Ibid.

28 Ibid.

29 Aidan Byrne and Alessandra Tanesini, "Instilling new habits: addressing implicit bias in healthcare professionals," *Advances in Health Sciences Education* 20, no. 5 (2015) 1255–1262.

of Black women, should not have their thoughts and voices privileged as an authority on how to address the very problem they created. Positionality often places Black women on the periphery of decision-making processes, even when it relates to their lived realities. Black women must be included in envisioning, developing, and implementing any proposed solution. They must be in positions of leadership in this process. Healthcare providers and systems need to center Black women by listening, hearing, and letting them lead. In pursuit of giving voice to the birth experiences of Black women, a community-based research study was conducted using focus groups and in-depth interviews.

1 Background for Our Study

The aim of this study was to explore the labor, delivery, and post-partum experiences of Black women, with the intent of gaining insight into challenges and triumphs during pregnancy and birth. Maternal mortality rates for Black women remains significantly higher than any other racial/ethnic group in the United States. Additionally, the current rate is at a level higher than two WHO high-priority regions in developing countries without the medical and technological resources of the United States. Currently, there is limited literature examining the experiences of Black women aimed at understanding and addressing this disparity. Study procedures were approved by the University Institutional Review Board (IRB).

2 Methodology

In this study, a phenomenological qualitative research design was used to conduct focus groups and in-depth interviews. Phenomenology is a type of qualitative research rooted in both psychology and philosophy. The phenomenological approach focuses on lived experiences and meaning making.[30] Phenomenological research engages in this process by asking questions related to specific phenomena shared by a group of people. In this study, Black women eligible to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and who had given birth within the last

30 V.E. Worthen and B.W. McNeill, *A Phenomenological Investigation of "Good" Supervision Events. In Merriam, S. Qualitative Research in Practice. Examples for Discussion and Analysis*, San Francisco, CA: Jossey-Bass (2002) 96–117.

two years were recruited to participate in several focus groups as well as in-depth interviews.

Focus groups were conducted to provide a more natural social space for participants to have a conversation about their experiences. All focus groups were led by the same two Black women group facilitators/researchers. Focus groups consisted of two to four women in a group. Multiple sessions were held over the course of the study with each participant attending two focus groups. Participants were provided several times and locations in close proximity to their residence for focus groups and interviews. In-depth interviews were used to elicit richer data by asking probing questions building upon themes that emerged from the focus groups. Focus groups and in-depth interviews were concluded after data saturation was met. Sessions were conducted between April 2017 and June 2017. Focus groups and interviews used a semi-structured format. All sessions were recorded and transcribed.

This study was conducted in the community setting, within neighborhood recreational centers, in a midwestern city. All recreational centers were located near metropolitan housing authority owned rental units and public transportation for ease of access.

3 Recruitment

Black women eligible for WIC were recruited through snowball sampling using African American and Black mothers birthing and breastfeeding Facebook Groups. A recruitment script and a recruitment video, providing study details and contact information for the primary investigator were posted on several group pages administered by local Black women groups dedicated to breastfeeding and birth experiences (see appendix). A follow-up script was posted two weeks later. Women interested in participating were instructed to contact the primary investigator. Women meeting the inclusion criteria were scheduled for small group interviews.

4 Participants

Participants included in the study met the following criteria:

- Participants were current residents of the Greater Cincinnati area.
- They must be women at least eighteen years old.
- They self-identified as African American, African, and/or part of the African diaspora.

– They self-identified as cis-gendered female.
– They spoke and read English fluently.
– They qualified for WIC subsidies.
– They initiated breastfeeding with their infant child.
– They were either currently breastfeeding or previously breastfed.
– It had been no more than two years since they gave birth.
– They were eligible, and they were willing to give informed consent.

From the cohort of volunteers, eight women who aligned with the criteria above were selected to participate in focus groups and in-depth interview sessions from April through July 2017. Each of the selected participants completed a demographic survey prior to the focus group sessions. One participant was a recent immigrant from South Africa, one was African American, and six of the participants were bi-racial (African American and European American descent). The six bi-racial women self-identified as African American. All of the women except one were married or were cohabitating with an African American partner.

5 Data Collection and Analysis

Data was collected during four small group interview sessions and eight in-depth interviews, with each participant (see appendix). All small group interviews and individual in-depth interviews were recorded via a digital record and transcribed. We analyzed the data after independently creating memos of the interview experiences that included our observations, impressions, as well as our perceptions of the overall emotions of participants during each session. The memos and the transcribed interviews were used to develop and cluster recurring themes. Additionally, data analysis software Nvivo 12 was used to perform a word and phrase query, and nodes were created by grouping the common words and phrases. Investigators compared themes and nodes for congruence. Concepts which were clustered together and reflected a specific node, but were not included, were added to the node created within Nvivo 12.

6 Results

In the Landmark text *Unequal Treatment*, B. Smedley details the pervasiveness of racial bias within the medical system.[31] Not surprisingly, all of the

31 B. Smedley, A. Stith and A. Nelson, eds., *Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care* (2003). *Unequal treatment: confronting racial*

participants in our study reported having experienced racial bias and microaggression from their healthcare providers during various stages of pregnancy, labor, delivery, and post-partum. The racial bias experienced by the participants manifested in several ways in participant interactions with healthcare providers. Three of the participants indicated they experienced intimidation and coercion. Half of the women had experienced a traumatic birthing experience and reported the avoidance of the healthcare system subsequently. Analysis of the textual data led to the emergence of four primary themes based on the experiences of the study's participants:

– Invisibility/Disregard,
– Distrust/Fear,
– Control, and
– Cultivating Social Capital.

6.1 *Theme 1: Invisibility/Disregard*

> They don't listen. I tried to let them know from the beginning that I wanted to be natural and I know you are here to support me and help keep me safe, but don't tell me what I can't do.
>
> So, I remember telling the nurses um that I felt dizzy because everybody was focused on the baby no one had checked my blood pressure. I told them that they didn't check my blood pressure. Something is really off.
>
> And they were like, that's nice, but no. Here is what you are going to have to do. We should schedule a c-section and if she is not here by the 12th then we should go ahead and induce. This is at the first appointment and I literally had my birth plan right there. I was like so you didn't listen to anything I had to say.

As these participant quotes illustrate, these women reported repeatedly that they did not feel as though healthcare providers listened to them. This contributed to their belief that they were being neglected due to their invisibility. Without exception, participants indicated that during their pregnancy, labor, and/or delivery they received substandard care due to caregivers' total disregard when they expressed their questions and concerns. Often these women reported that healthcare providers went through a well-rehearsed checklist without ever acknowledging them as a person. These providers never engaged

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and ethnic disparities in healthcare. Washington D.C.: The National Academies Press. https://doi.org/10.17226/10260.

these women in conversations concerning their care. Expectant Black mothers throughout the country have reported similar experiences. In summary, Black mothers' pain, symptoms, and inquiries are frequently minimized or ignored.[32]

6.2 *Theme II: Distrust/Fear*

> I was like well I just don't really feel like dying when I'm giving birth to my child … I don't trust the system that has consistently and was built to constrain black women and reproduction, so.
>
> They kept throwing things at me and they never explained and never wanted to provide me time to look up information. Their response was always, your baby is going to die.
>
> I had no information, and I was not provided information. I was told early in my pregnancy that I needed to have a C-section. They were really pushing it. I was told my pelvis was too small and with the weight I had gained they said he would be 10lbs. He wouldn't be able to get out. He could die. They would have to break his arm. I was so scared. I had no idea what was going on.

In the second theme, participants discussed their fear of interacting with healthcare providers and their distrust of providers due to perceived racial and class bias. Many participants discussed unethical and deleterious experiments that had been conducted historically on African Americans, for the sake of medical advancement. Significantly, many participants cited historical as well as their personal lived experiences as women of color being mistreated and victimized due to systemic racism founded on our country's practices of imperialism and colonization. Low levels of trust and difficulty in building rapport with African American patients have been cited in several studies as potential factors in the gaps in health related outcomes.

6.3 *Theme III: Control*

> My OBGYN actually gave me the hardest time because when I went in for my 6-week checkup she told me that I was fine. I could go back to

32 D.C. Owens and S.M. Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery," *American Journal of Public Health*, 109, no. 10 (2019) 1342–1345. doi:10.2105/AJPH.2019.305243.

> work, but I said my job gives me 12 weeks. She said well are you just going to be getting paid to not be working? I was like, what business of that is yours?
>
> I feel like doctors are so out of their place sometimes. We are coming to you for you to assist us. We are not coming for you to take over our bodies and control us.

Control emerged from the data as the third theme. Participants believed that their healthcare providers had an overwhelming need to control their bodies, the situation, and the environment. Participants reported having no options presented to them. Many indicated that birth decisions were made unilaterally by the physician without involving them in the decision-making process. Participants expressed feeling that their healthcare providers not only exerted control within the context of their pregnancy and delivery, but also imposed themselves on other aspects of their private lives. These women did not welcome these invasive intrusions.

6.4 *Theme IV: Support Systems and Social Capital*

> I didn't have any support. Her dad backed me up with what I wanted. All the anger I had from my first baby, all the bullying. … I refused to let it happen again.
>
> I think the idea too of just building the sisterhood and building the trust in our community. Um to be able to say like come talk to me. Like let's go through this journey together.

The fourth theme focused on support systems and social capital. Participants shared that their birthing experiences had been difficult, and they often had to find strength and support from their partners, family, and friends. For those participants with limited contact or support, they expressed the need for Black women to form a supportive birthing community. Participants discussed relying on unconventional nonphysician providers for support and guidance. Many of the participants reported working with doulas or midwives. Additionally, several of the women after their birthing experiences sought training to become a doula or a Certified Lactation Consultant (CLC). Their experiences also prompted some participants to empower other women, so they developed blogs and social media communities to support Black expectant mothers.

7 Conclusion

Kimberlé Crenshaw argued the impact of being doubly minoritized when she coined the term *intersectionality* in her 1989 essay.[33] Crenshaw asserted that the oppression of systematic racism for Black women was different from either sexism or racism. The combination of these two oppressive forces of sexism *and* racism combined to act in a way that does not align with the categorization of either singular oppressive force. The inability to categorize the experiences of Black women to align with the sexism experienced by white women and racism experienced by Black men, leaves Black women with few remedies.

The entrenchment of whiteness in America has fostered an insidious and pervasive cultural of anti-Black racism that devalues Black bodies. The intersection of gender along with race has created a space of double stigmatization for Black women. This marginalized space often erases Black women, as their societal worth is reduced exponentially due to the intersections of sexist and racist oppression. In this study, participants experienced the double burden of being Black and a woman. Additionally, women in this study experienced triple oppression due to their low-income status. Several theories have posited that multiple subordinate identities can significantly impact one's social interactions and life experiences.

Black women operate within the margins of these two marginalized identities. This space of femaleness and Blackness means Black women do not fit the expectations for what is considered female or male. V. Purdie-Vaughns and R. Eibach (2008), hypothesized that the overlapping of subordinate-group identities leads to the invisibility of Black women, due to being non-prototypical group members.[34] Similarly, in a study conducted by A. Sesko and M. Biernat, results showed that white study participants had difficulty recognizing and distinguishing Black women's faces more often, and they noticed the presence of Black women less than other groups.[35] Additionally, this study found that Black women's voices often went unheard, due to their statements being misattributed. In healthcare, the issue of invisibility is a major theme for Black women trying to receive care, as many women report not being listened

33 Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics," *University of Chicago Legal Forum* (1989) 139–67.

34 V. Purdie-Vaughns and R.P. Eibach, " Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate-group identities," *Sex Roles*, 59 (2008) 377–391.

35 A.K. Sesko and M. Biernat, "Prototypes of race and gender: The invisibility of Black women," *Journal of Experimental Social Psychology*, 46, no.2 (2010) 356–360.

to by providers. Sesko and Bienat describe invisibility as another form of discrimination that is often directed towards Black women. Although their study did not investigate the consequences, the qualitative data collection reported in this chapter illustrates the implications of invisibility.

Additionally, the racism and sexism experienced by Black women has eroded trust in institutions in this country. The women participating in this study all expressed fear and distrust in the healthcare system. The feeling of being controlled through coercion and manipulation was a universal theme for the women. Many of the women discussed historical abuses by the medical establishment, in addition to their own stories of intimidation and mistreatment. The experiences of the women in this study have been well documented by other researchers, with results showing significant abuses against expectant mothers. Women in several other studies reported being yelled at, verbally abused, forced to accept interventions that they did not want, and provided delayed care.[36]

Black women continue to die preventable deaths during labor and delivery. Despite substantial recognition of this issue and increased funding to address maternal mortality, the rates for Black women remain high and the gap between white women is significant. In the United State, the CDC has set goals to reduce health disparities for the last thirty years but has consistently failed to meet their proposed targets. Likewise, cities and hospital systems have set agendas to reduce maternal mortality by,

– increasing funding for initiatives,
– providing implicit bias trainings,
– and recruiting diverse healthcare providers.

However, these actions are only a starting point. This cannot be the sum total of the efforts to undo over 400 years of atrocities. The racialized experiences of Black women must be centered, and an equity lens must be used to develop inclusive spaces to hear Black women. Additionally, healthcare systems and healthcare providers need to take a step back and allow Black women to lead in this work. Shifting to a community/patient-healthcare provider partnership is a departure from the status quo, but it is a needed paradigm shift that has the potential to remove the death sentence that coincides with childbirth for too many Black women.

36 L.P. Freedman and M.E. Kruk, "Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas," *Lancet,* 384, (2014) 42–44 and L. Rosenthal and M. Lobel, "Explaining racial disparities in adverse birth outcomes: unique sources of stress for black American women," *Social Science and Medicine*, 72, no. 6 (2011)977–83.

8 Appendix

Recruitment Advertisement

Community Health Research Study

Be a part of an important research study focused on African American Women who are or have breastfed!

- Are you African American?
- Are you 18 or over and WIC eligible?
- Have you or are you breastfeeding?
- Are you interested in sharing your experiences about that?

If you answered yes to these questions, then you could be eligible to participate in this research study.

The purpose of this research study is to assess the socio-cultural barriers and assets to help promote breastfeeding.

This study is a one-hour interview about your breastfeeding experiences. No Medications, invasive procedures, or additional information is required.

Interview Question Guide for Qualitative Data Collection

Black Women, Breastfeeding & WIC

RE: Social-Cultural Environmental Barriers

Demographics:

- Age
- Race
- Marital Status
- Number of children
- Education level
- Occupation
- Work status
- Religion/spiritual preference
- Sexual orientation
- Geographic location (urban, rural, suburban or Kentucky vs Ohio)
- How many reside in your household?
- Who resides in your household?

Discussion Questions

1. Can you tell me about your birth experience (prenatal visits, birth plan, method of delivery, length of labor, etc.)?
2. Tell me about the support you had during labor, delivery, and postpartum?

3. What was your experience/relationship with your healthcare provider?
4. What did you find most challenging about giving birth?
5. What did you find most beneficial in aiding you through giving birth?
6. Were you breastfed? (For how long?) (Did anyone else in your family/circle of friends breastfed?)
7. Were you planning to breastfed?
8. Did the type of birth (vaginal vs. C-section) impact your decision? (Explain.)
9. Did anyone help you with the decision to breastfeed? (If Yes—how did they help?)
10. Did WIC impact your decision to breastfed? (Explain. How did it impact your decision and what was the impact?)
11. How does the media represent breastfeeding? How did this representation impact your decision?
12. Are you an exclusive breastfeeder? Predominantly a breastfeeding? How did you choose your specific breastfeeding pattern?
13. How soon after birth did you initiate breastfeeding? Could you tell me about that experience?
14. How frequently did you breastfeed in a 24-hour time period? What was that experience like for you?
15. How long did you breastfeed?
16. How long did/do you intend to breastfeed?
17. When did you begin introducing complementary foods? And how frequently did you provide complementary food during a 24-hour period?
18. What do you most value about breastfeeding?
19. What do you most enjoy about breastfeeding?
20. What do you find most difficult/challenging about breastfeeding?
21. What do you find most helpful/beneficial in aiding you with breastfeeding?
22. What/who could have made breastfeeding easier for you?
23. What did your family and friends think about your decision to breastfeed?

** These questions serve as a guide for areas to probe if the participant is having a difficult time opening up about her birth and breastfeeding story. The goal is to allow the participant to share her story naturally.**

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