The Crisis of Black Infant and Maternal Mortality:

Enabling Community Healing through Media

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Johanna Wolf

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Author's Note

A few years ago, I was working at a pregnancy resource center in Tacoma, Washington and was invited by a woman named Ameedah Hasan to share information about that ministry to a group of women at what was then Roosevelt Heights Church of God in Christ (it has since been renamed Greater Heights church). As I sat around this table I was introduced to Lea Johnson, an RN with the Tacoma-Pierce County Health Department, and about ten women sitting around a table, who called themselves health ministers. The name of the group was Black Infant Health (BIH), and that day around that crowded table, in that cramped church conference room, I was introduced to the problem of infant mortality in the black community. Profoundly moved by this group and what I was learning about this grave problem, I felt like I had discovered something extraordinary and important. Having seen only a snippet of this program and with a limited understanding of the problem, I began making sure my organization would refer as many women to this group as possible. After a couple of years, I was invited to attend a conference in Houston, where I learned more about not only infant mortality but maternal mortality, as well. The numbers astounded me. More women were dying of childbirth-related causes than in any other developed nation, and by far the greatest numbers were in the African American and Native American communities.

Much is being done to alleviate this problem. Many organizations are combining grassroots community efforts with public health strategies, as well as using a social justice perspective to call attention to black maternal and infant mortality. In determining to write about this, I wasn't sure there would be anything meaningful to add to this discussion. Yet, as I attended the meetings and spoke to people working in healthcare, public health, and community non-profits, I found that one common desire was for collaboration. In addition, everyone wants

to know what everyone else is doing, so groups can potentially work together and avoid duplicate efforts. No one entity is tying all these efforts together. Women need to know what resources are available in order to have the option to make use of them. So, I had an idea. What if I could harness the power of digital media to connect various organizations and employ health messaging principles combined with storytelling to create a black health hub online specifically for black women? So much negative is being promulgated in the name of awareness, and while bringing awareness to the problem of infant and maternal mortality in African Americans is the first step to finding answers, as Breastfeeding Instructor and Program Manager for King County Delores Baccus states, "I'm kind of feeling like we're stuck in awareness. We're aware of the issue. When are we going to start doing things to change, to make a corrective action?" (Baccus Personal Interview). I would agree, something must be done. Yet, perhaps media could be used to give voice to those who feel powerless and overlooked. Perhaps media could be used to foster dialogue or to change the narrative.

Introduction

Being born black in America is bad for your health. If you are born black in America, you have a lower chance than other babies of living to see your first birthday. (David and Collins). Even if you survive that first year, chances are, you still won't live as long as your white peers, "of the 10 leading causes of death, Blacks have lower death rates for only 2: chronic lung disease and Alzheimer disease" (David and Collins). You have a higher lifetime risk for all sorts of chronic diseases, and if you are poor you risk exposure to a host of environmental and lifestyle factors public health researchers call the social determinants of health (SDH) (Social Determinants). If you are black and pregnant in America, your chances of carrying your baby to term are lower than most of the general population, while the chance that you might be putting your own life at risk by being pregnant is higher than that of most women ("Infant Mortality"). Yet, not accounting for lifestyle, and environment, society has yet to figure out what to do with the enigma of your blackness and why it poses such a mortal danger. Throughout this paper I will use the terms *black* and *African American* interchangeably, furthermore, I will often substitute *people of color* to speak more broadly of those races and ethnicities who do not identify as white. Both the terms black and African American refer historically to Americans who are descendants of slaves. However, with the more recent influx of Africans immigrating to the United States, the terms have taken on disputed meanings, although black typically means being part of the African diaspora and to be black in most countries outside of the continent of Africa, means constantly being the *other*. This otherness coupled with centuries of trauma still creates feelings of inferiority and stress for blacks in the US. A stressful environment leads to diminished resiliency or "heightened stress vulnerability" (Andrasik), which impacts mental,

physical, and emotional health. For black women in the US, this stress has an adverse effect on their reproductive health.

Spiritual Foundations

Can we talk about race without invoking racism, and if so, are we being honest with ourselves? Examining the issue from the perspective of a black woman makes the discussion of race and racism personal, whether I want to or not. It is therefore imperative that I approach this topic with a spirit of love and self-reflection, first checking any biases I may have. My religious tradition teaches that we need to first view all people as made in the image of a loving God, and therefore as ontological equals. This forces us to think of each other as part of the same family or tribe. We include rather than exclude. Theologian Miroslav Volf in his tome *Exclusion & Embrace* sums it up thusly,

> The practice of 'embrace' with its concomitant struggle against deception, injustice, and violence is intelligible only against the backdrop of a powerful, contagious, and destructive evil I call 'exclusion' and is for Christians possible only if in the name of God's crucified Messiah, we distance ourselves from ourselves and our cultures in order to create a space for the other. (30)

Here is where I constantly have to check my own heart, even as I write about those who are the alleged oppressors in this difficult dance of academic neutrality. But I am not neutral. As someone who works in the field of maternal health, I have opinions, but I also see multiple sides of the problem and want to give them each their due. Furthermore, for me as a Christian, any social problem must be analyzed through a distinctive Christian lens. To that end, I borrow from Catholic social teaching, noting that "Catholic social teaching starts with the reality of the

pressing social questions…and then analyzes them under the light of the Gospel" (Groody 103). This means going deeper than just offering physical solutions. That is the public health approach. For Catholic social teaching, this entails starting with "an accurate description of the world as it is and then asks, what kind of world God wants, what kind of society humans need, and what kind of systems the environment can sustain (Groody 103). With that in mind, I present this lucubration on infant and maternal mortality as part of an ongoing exploration into what it means to be black, what it means to be a woman, and what it means to be healthy in the US.

Thesis Statement

Black mothers and infants in the US are dying at much higher rates than white women. "In the United States, women of color—particularly those living in areas of high poverty—experience high rates of poor birth outcomes, including cesarean delivery, preterm birth, low birthweight, and infant mortality" (Thomas et al.). This thesis will examine how intersectionality plays into the daily experiences of black American women, causing unique physical and psychic stress, and contributing to poor maternal and fetal health outcomes. I will examine some of the reasons behind the stress causing poor outcomes and offer a project that will suggest ways in which women can find resiliency, hope, and healing within themselves. Using a media platform involving storytelling, health messaging, and positive spiritual affirmation, I have created a blog and podcast allowing women to share their stories and create a compassionate community based largely on the resources currently existing in the Puget Sound area.

I obtained data gathered from interviews, as well as data from a large canon of scholarly literature; however, much of the research derives from emergent articles and websites devoted to this timely subject. There appears to be a real sense of urgency around the topic of maternal and

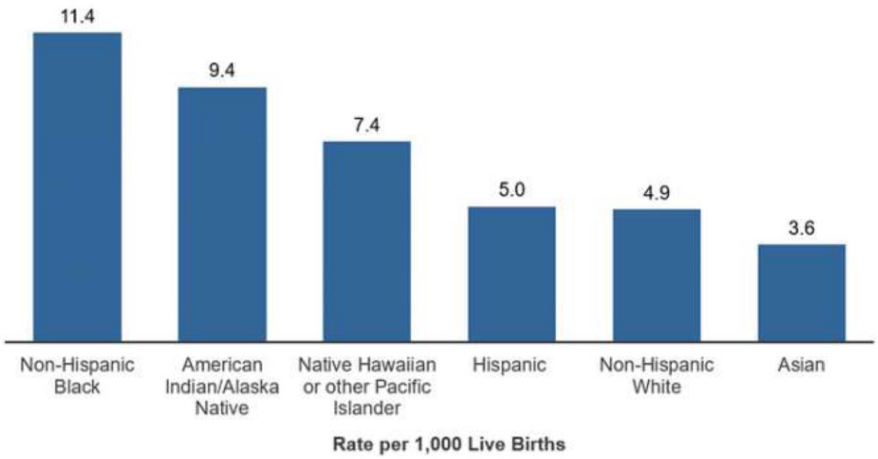
infant death at this moment in time. Viable solutions are being envisioned and created through both medical and community innovations in ways that aim to garner trust, and conducting this research has made me hopeful that these race-based disparities will eventually diminish. As the medical and black communities begin to make peace, grassroots innovation using smart strategies can come alongside structural advancements to create not only health but the societal healing that needs to occur for black people to thrive.

Babies are Dying

One of the most prominent and tragic indicators of the state of African American health is the rate at which our babies are dying. African American babies are dying at a rate of more than double the white and Hispanic population, with the black infant mortality rate at 11.4 deaths per 1000 live births, compared with 4.9 per 1000 in the white population (see fig. 1.).

Fig. 1

Infant Mortality Rates by Ethnicity



Source: Infant Mortality Rates by Race and Ethnicity 2016 "Infant Mortality | Maternal and Infant Health | Reproductive Health | CDC." Centers for Disease Control and Prevention, Centers

for Disease Control and Prevention,

www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#

Causes of infant mortality include birth defects, preterm birth, and therefore low-birth weight, Sudden Infant Death Syndrome (SIDS), maternal health complications, and injuries ("Infant Mortality"). Yet, while education and income are primary drivers in the white infant mortality rate, in the black community the risk tends in the opposite direction.

> The rate of babies being born with low-birth weights increases with both the age and level of affluence a black woman attains… This gap *persists* as the mother's education and income rises. Babies born to well educated, middle-class black mothers are more likely to die before their first birthday than babies born to poor white mothers with less than a high school education. (Matthew et al.)

It appears that the stress of racism may accumulate in the body over time, creating a toxic environment for a fetus to grow and develop.[1] Rather than surrounding a fetus in a safe healthy womb, the womb becomes inflamed. This striking factor figures into the weathering hypothesis put forth by Geronimus et al., which suggests that cumulative stress impacts women's reproduction. Doctors and researchers Nana Matoba and James Collins posit a "life-course" model to explain infant mortality disparities, reflecting, "a greater prevalence of pre-pregnancy risk factors and lower prevalence of protective factors among African Americans compared with whites. The hypothesized mechanisms include early life (fetal) programming of reproductive

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[1] This portion previously published in a paper for GLST 6423.

potential and cumulative wear and tear (weathering)" (356). Studies further suggest that instances of low birth weights (LBW) in women who "were themselves of LBW (compared to non-LBW) have greater rates of LBW, small-for-gestational-age (SGA) births, and preterm infants independent of traditional individual-level risk factors and neighborhood income" (Matoba and Collins 356). While most individuals, at least in theory have control over what they eat and drink, as well as their exercise habits, some of the factors over which one has no control are one's own birth weight and whether one is born into poverty.

Mothers are Dying

The rates at which African American women are also dying of pregnancy-related causes have skyrocketed over the last thirty years. According to the Centers for Disease Control (CDC), "the number of reported pregnancy-related deaths in the United States steadily increased from 7.2 deaths per 100,000 live births in 1987 to 18.0 deaths per 100,000 live births in 2014" ("Pregnancy Mortality"). A pregnancy-related death outcome is defined by the CDC as "the death of a woman while pregnant or within one year of the end of a pregnancy–regardless of the outcome, duration or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" ("Pregnancy Mortality"). The American College of Obstetricians and Gynecologists recently put forth that suicides due to high rates of perinatal and postpartum depression play a significant part in the maternal mortality rates. "Perinatal depression and other mood disorders, such as bipolar disorder and anxiety disorders, can have devastating effects on women, infants, and families; maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality" (ACOG Committee). This information warrants the need for rigorous mental health

screenings, and a thorough examination of the cultural aspects intrinsic within communities when it comes to mental health and the stigmas many face. However, this factor also effectively points the medical establishment away from any accusations of racial bias; the numbers reflect that women are killing themselves because they are depressed.

It is fair to say that most women experiencing mental health issues surrounding childbirth feel helpless and alone, but coupled with the fact that mental health is highly stigmatized in the black community and that many black women hesitate to get help makes this revelation even more challenging. In her article entitled "Postpartum Depression in Black Women Is a Silent Epidemic" Rochaun Meadows-Fernandez writes, "The Black community has a history of emphasizing personal strength and self-sufficiency, which can decrease the chance that Black women seek assistance when their sadness becomes more than 'the baby blues.'" The fact that more educated black women have higher maternal mortality rates, also says something about society's expectations for education and for the privilege that it intimates. Whereas there is a marked difference between higher education and health education, the knowledge and wisdom that comes with years spent attaining degrees cannot always prevent certain predispositions; it may, in fact, encourage them in some measure, as women accumulate more exposure to stress as they attain affluence.

The Black Body Misapprehended

Being viewed as physiologically different leads to ineffective care, as evidence also suggests that doctors and other healthcare practitioners hold critical misconceptions about black people's bodies. Medical practitioners have inherited long-held, fallacious notions about black skin being "thicker" (Hoffman et al.). and blacks having "higher pain tolerances" (Hoffman et

al.) for example, which tend to perpetuate the myth of blacks as subhuman or somehow fundamentally physiologically different from the general population. Many scientists and scholars today "continue to believe that the black body is biologically and fundamentally different from the white body and that race is a fixed marker of group membership, rooted in biology (Hoffman et al). A potential consequence of these beliefs for pregnant women could come in the form of doctors not taking the complaints of black women seriously. Professional tennis star Serena Williams' recent delivery experience provides a timely example. Williams has a history of blood clots and knew after the birth of her daughter, that when she had trouble breathing, she was likely suffering a pulmonary embolism (Scutti). According to Vogue magazine:

> She walked out of the hospital room so her mother wouldn't worry and told the nearest nurse, between gasps, that she needed a CT scan with contrast and IV heparin (a blood thinner) right away. The nurse thought her pain medicine might be making her confused. But Serena insisted, and soon enough a doctor was performing an ultrasound of her legs. "I was like, a Doppler? I told you, I need a CT scan and a heparin drip," she remembers telling the team. The ultrasound revealed nothing, so they sent her for the CT, and sure enough, several small blood clots had settled in her lungs. Minutes later she was on the drip. "I was like, listen to Dr. Williams!" (Haskell)

Williams' experience brought much-needed attention to the fact that traumatic birth experiences can happen to women in all socio-economic categories. As did the case of Kira Johnson, a 39-year-old successful, physically fit, and married young mother who flew airplanes, raced cars, and spoke five languages, and who died in 2017 at Cedar-Sinai hospital, one of the nation's top medical facilities (Helm). As she lay recovering from her C-section, her husband noticed blood

in her catheter around 4 pm and alerted hospital staff (Jones). At one point he was told "your wife is just not a priority right now," (Jones). By the time they ordered tests hours later, it was too late. She died of an internal hemorrhage (Jones). These examples show how even when people of color advocate for themselves, are healthy, are seen at the finest hospitals, and do everything right, somehow, they are still put back in their place and reminded that they are not as important, not as valued, and not to be trusted.

Health Equity

When we as a society value each other no matter what, we create what could be described as equity. The concept of equity has become ubiquitous in public health and social justice. How do we achieve the elusive goal of providing everyone a fair chance at an optimal, vibrant life? In aiming to create a healthier society, medical systems seek to promote health equity. The Robert Wood Johnson Foundation (RWJF) defines health equity as follows:

> Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination and their consequences-including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (What is Health Equity)

Health Equity goes beyond just health and focuses on the societal factors that allow people to flourish and therefore, to be healthier. The definition of health equity goes on to allude to the actions of creating equal access to health for everyone. "For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups" (What is Health Equity). According to the

Centers for Disease Control (CDC) race is absent as a direct social determinant of health. These determinants consist of "an availability of resources to meet daily needs such as safe housing, healthy food, transportation, and quality education… public safety … local emergency/health services, and environments free of life-threatening toxins (Social Determinants). They have to do with socio-economic status, and all the elements of life affected by poverty: "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Discrimination). These determinants point to racist structures which are remnants of practices such as red-lining, which prevented African American families from purchasing homes in white, suburban areas, relegating them to the inner-cities and the environmental challenges these areas produce (Pellow 15). These inner-cities subsequently became for whites "wild places, or a kind of frontier populated by shadowy, dark, subhuman others—places to be feared, avoided, or conquered" (Pellow 39) a place giving rise to an alien, a wild man in the category of Shakespeare's Caliban[2], black and monstrous. The inner cities, with their scarcity of grocery stores, natural environments, and safe, stable neighborhoods, don't provide marginalized people of color many opportunities to thrive. The policies that relegated people to this unhealthy milieu reveal that racism isn't just systemic, it is also endemic in its practice and can be invisible to all but those on the receiving end. Being born black in America does not automatically extrapolate to being born into poverty however, yet worldwide there still exists "a planetary correlation of darkness and poverty" (Pellow 42). Only 21.6% of African Americans live at or below the poverty level ("Health").

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[2] Caliban, a character from Shakespeare's *The Tempest* who is half-man, half-monster.

While that is still an unacceptably high rate, this factor alone does not account for the poor health outcomes of America's black mothers.

The State of Health in Black America

The health crisis in the US extends beyond the poor infant and maternal mortality rates. When compared with whites, black people rank near or at the bottom in every major health determinant. (Health) How is this possible in the twenty-first century? African Americans tend to have higher breast cancer mortality rates, and higher rates of diabetes per capita than the general population (Health). Yet, the high infant and maternal mortality rates among African Americans still confounds in its nuance and complexity. The infant mortality rate serves as an indicator of the general health of a nation: the "infant mortality rate (IMR) is more than a marker of maternal and child health; it is a symbolic benchmark of a society's overall health" (Matoba and Collins 354). With its comparatively high infant mortality rates and preterm birth rates, the US needs to address the overall health of its population. Problems that are systemic and ingrained within the health care system affect everyone but are magnified in marginalized communities.[3] It has often been said that "if America has a cold, black Americans have pneumonia" (Andrasik). Poor maternal and infant health outcomes are symptoms of an unhealthy society, one in which the state of healthcare badly needs reform. Guinier and Torres, authors of *The Miner's Canary* state that: "Those who are racially marginalized are like the miner's canary: their distress is the first

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[3] Previously published in GLST 6423, Social Justice ALA 3, November 6, 2018.

sign of a danger that threatens us all" (11). We should care that the US has a high infant mortality rate not only because of what it portends for the future but because it itself, is a tragedy.[4] Yet, to continue the metaphor, if the rest of America needs an aspirin, black America needs a transfusion. Ranking consistently at or near the bottom in any health outcome (Health Black Demographics), African Americans need deeper healing than what medical systems can provide. Health is more than just the absence of disease, and therefore to be truly well, we need to create a culture of wellness and develop a roadmap for getting there. We need a framework for thriving.

The Legacy of Racism on Health

In delving into the health outcomes of African American maternal and fetal health in particular, it's important to examine the historical context of the problem. Wilson et al. state that: "birth outcomes are influenced by maternal characteristics, which in turn are affected by the larger community and society" (363). Our larger society shows a healthcare system that is failing its patients and in need of repair. This broken system is predicated on a number of things: high costs, lack of access, overworked doctors, and the inability to adequately serve people of color. Still, approximately one hundred fifty years after the freeing of the African slaves, many societal structures remain in place that keep their descendants from thriving to the full potential promised every citizen of the US. Poor health remains one of the consequences of these structures. The

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[4] The Guinier and Torres quote and subsequent phrase were used previously in a paper in Social Justice class ALA 3, Nov. 6 2018, GLST 6423.

World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Constitution of WHO). Public health practitioners exist to ensure "conditions where people can be healthy" (Jackson and Sinclair 23). This is done by instituting policies around immunizations and preventing conditions leading to communicable diseases. From a medical perspective, health means having the means to heal and assuage illness with medications, antibiotics, and pain killers.[5] Still, there remains a connection between racism and poor health.

Anthropologist and medical doctor Seth Holmes completed an intense, immersive ethnographic study of Mexican Triqui migrant workers in his work *Fresh Fruit, Broken Bodies*. Of the clinicians treating migrant workers he writes, "the medical gaze…did not allow them to see social inequalities or how these inequalities produced sickness" (183). Rather than view people through the lens of their social afflictions, doctors "inadvertently blamed the suffering…on the patients themselves—their behavior, culture, or racialized biology—and consequently recommended interventions …complicit with the harmful social structure" (Holmes 183). They did their patients more harm than good. Now that the US is moving toward a more holistic health model, perhaps doctors should examine how factors such this "medical gaze" Holmes alludes to affects the patient. This gaze is based on the idea brought forth by Michel Foucault describing the way in which doctors couple their own subjectivity with their training, in assessing patients. "The gaze asserts a cognitive relativity, such that the facts about

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[5] Section taken from previous paper ALA 3 by Johanna Wolf for ICD Leadership class submitted on 12 August 2018.

the body are dependent upon the physician's medical gaze — his sensations, perceptions, experiences, etc." (Lang and Lu). This becomes problematic when a doctor doesn't share or understand the patient's background or culture; viewing her from his own preconceptions of who she is.

For Korama Williams' third pregnancy, the medical gaze of the anesthesiologist affected her psyche in a way that still moves her twelve years later. "The anesthesiologist comes in, nine times out of ten, they are male. He was a middle-aged white man, salt and pepper graying hair and he was rude from the very word go" (Williams Interview). Williams, a 43-year-old mother of three boys spoke about her painful birth experience for my podcast project. "I was just about a [size] 16/18 when I got pregnant. [I] gained weight, so, I was a large pregnant woman and so he began to speak about my obesity and how oftentimes it's really hard to get the epidural to work or get it in because there's a lot of fat" (Williams Interview). Weight was already a sensitive subject for Williams. Her husband had expressed his disgust to her in verbally abusive ways. Yet, the words of the anesthesiologist, spoken to her as she endured a long and painful labor process, left her feeling deflated and frustrated. A few hours later, the epidural slid out and the same doctor returned to redo the job. Williams' self-conscious reading of the doctor's gaze toward her as an overweight African American woman on Medicaid, "there is this black girl and this ghetto looking family possibly," only added to the distress of having troublesome labor and eventually, an emergency C-section. It's possible that the anesthesiologist was having a bad day. It's also possible that he would never perceive himself as someone who judged people by their race or skin color. He may even have had black colleagues whom he esteemed very highly. Yet, it was his treatment of Korama Wiliams in her laboring distress, which she interpreted as racially motivated, that still taints her birth experience twelve years later.

A Colorblind Society?

The narrative, particularly with white citizens, has leaned towards a post-racial society: *Slavery was awful, but it's over now. We've even had a black president to prove it.* Georgetown Law professor and critical race theorist Gary Peller states: "race has been understood through a set of beliefs—what I call 'integrationist' ideology—which locates racial oppression in the social structure of prejudice and stereotype based on skin color, and which identifies progress with the transcendence of a racial consciousness about the world," (Peller 127). This perspective causes whites to consider it commendable that they don't see color. It also justifies our society's determination to rise above race in treating everyone equally. Of course, while well-intentioned, no one can honestly say that a person's color is invisible, nor would most people of color feel truly seen and understood if it were. Even if a colorblind society were a fact, not enough has been done to mitigate the effects brought about by hundreds of years of oppression. "The ideology of color blindness reflects an attempt to deny, minimize/distort the fact that racism occurs and to avert a discussion about race (which is uncomfortable for many). Some suggest that color blindness itself is a manifestation of racial discrimination" (Talley and Talley 194). As such, many whites may feel they can never have the correct attitude towards race and feel frustrated and resentful. Miroslav Volf notes that: "To be white in the US is to enter a whole history of relation to African Americans" (91). The United States has failed to adequately deal with this history of racial domination and the legacy of slavery.

Historian David Barton Smith suggests that ignoring the history of slavery has permeated our health systems (3). Smith states: "Thus, from the failure to address the aftermath of slavery, a regionally intertwined caste system emerged in the United States. That caste system was, in turn,

reflected in the early organization and financing of its health system" (Smith 3). Our modern medical system and the current pattern of financing it, developed between 1894 and 1954 and operated on a socially exclusive basis:

> During this period other industrialized nations, faced with the same rapid improvements in medicine, explored ways to best distribute its benefits. The historical narrative of these other nations said, in essence, 'for all our differences we have a common identity, and, just as in any functional family, we look after each other.' The universal health insurance systems created in every other wealthy industrialized country became a way of expressing that common bond, the fundamental moral conclusion that no one should be denied needed medical care. (Smith 1)

Yet, the United States has, to date never created a universal healthcare system to protect and include in particular, those who would benefit from such a safety net the most (Smith 1). Therefore, Smith believes that the notion of American exceptionalism perpetuates ideas of racial exclusion: "the ideology of individualism, the opposition to public solutions, and the promotion of freedom of choice and free market solutions…have a disparate impact on blacks and other disadvantaged minority groups" (Smith 2). Whereas the healthcare systems have evolved to include the poor, the disabled and the elderly through Medicaid and Medicare until the more recent Patient Protection and Affordable Care Act of 2010 (Obamacare) many US citizens still did not have healthcare. This law had three primary goals: making healthcare insurance more accessible; expanding Medicaid, and to "support innovative medical care delivery methods designed to lower the costs of health care generally" (Affordable Care Act). While this law contains aspects that promote a more inclusive healthcare system, for many not eligible for Medicaid and Medicare, the law often fails to live up to the word affordable in its name and

leaves many of the working poor unable to afford healthcare. Not having healthcare contributes to fewer prenatal visits, which are essential for healthy birth outcomes. This again hits black women particularly hard.

Intersectionality

Black women exist, at a minimum, within a sphere comprising both racial discrimination and gender discrimination. This blending of two or more factors is what Kimberlé Crenshaw calls "intersectionality" (Crenshaw). Being both female and black figures into a complex historical narrative of slavery, servitude, and sexualization. Women of color are "further degraded as a result of ideologies that define them as socially and culturally worth less than others" (Pellow 52). The physiological damage isn't done by racism alone. "African-American women are confronted with particular stressors that emerge from the simultaneous experiences of race and gender, which makes them especially vulnerable to elevated levels of stress and health risks" (Paisley-Cleveland 35). Dr. Michael Lu, an obstetrician-gynecologist at UCLA states that: "For many women of color, racism over a life time, not just during the nine months of pregnancy, increases the risk of preterm delivery" (Paisley-Cleveland). This *intersection* of gender and race compounds her experiences in what Kimberly Crenshaw calls "intersectionality" a term she coined in 1989. In explaining the experiences of African American women, she states: "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" (Crenshaw, "What is"). In a Ted Talk she states:

> Intersectionality is just a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves, and they create obstacles

> that are often not understood within conventional ways for thinking about anti-racism and feminism or whatever social justice advocacy structures we have" (National Association 00:02-00:29).

Crenshaw argues that black women essentially exist at the intersectionality of gender and race and therefore have it twice as difficult. Civil Rights activist Dorothy Roberts sums up this view: "black women experience various forms of oppression simultaneously, as a complex interaction of race, gender, and class that is more than the sum of its parts" (Roberts 385). These regular experiences of being blamed for her own problems, considered lazy, fat, drug-addicted and poor pronounces a sentence of premature death upon her.

Racism and Stress

African Americans have been consistently fed a diet of negative messages around being black. Indeed, the stereotypes society perpetuates through media resonate loudly within the black community as well. Bryant Myers writes of the poor and marginalized that, "sadly, our view of them can become their view of themselves—they are defective and inadequate" (114). Of late, the news reports are filled with shootings of black youths, gaps in employment, finances, chronic diseases, and the rates at which black mamas and babies die. Myers' perspective on the poor also applies to blacks in this country, no matter their socio-economic status. They are part of a historically devalued community, and this awareness, along with small daily micro-aggressions that people of color encounter, causes a "heightened stress vulnerability" inhibiting one's ability to cope with daily stressors (Andrasik). Clinical Health Psychologist Michelle Andrasik of the University of Washington notes of microaggressions that:

> people who have devalued identities…experience everyday slights. We call these microaggressions, micro-assaults, micro-invalidations where people are telling you that you might not belong. [These are] chronic, commonplace, daily, verbal behavior, environmental indignities, and injustices. (Andrasik)

The consequences of these slights are manifested in a myriad of physiological, as well as psychological problems because as humans, we can't help but ruminate on what was said, or on what we should have said (Andrasik). Author Austin Channing Brown chronicles how she encounters these slights as she walks us through her typical workday. She begins with her arrival at work in the morning: "I arrive at work and walk through the lobby to get to my office. On the way, I am asked three times if I need help finding the outreach center. My white co-worker, whose footsteps I hear behind me, is never asked this question. *The message: I am a Black woman, so I must be poor and in need of help."* (Brown 71) This is just the start to an average day in Brown's life as a working black woman. The encounters continue as she feels singled out, misunderstood, and called upon to "educate white co-workers when they are confused about a racial issue in their lives" (Brown 71). Being constantly aware of one's *otherness* is stressful. According to researcher Arline Geronimus, this constant and persistent stress can precipitate premature aging of the body (Geronimus et al.) which can then create a toxic and inflamed environment for a fetus. This type of toxic environment can lead to low-birthweights, a leading factor contributing to infant mortality in the US.

Doctors and Providers

In a perfect world, healthcare would be compassionate, affordable, and individualized. Doctors would be humble and try to understand and learn from their patients. They would have

more time with patients and seek to overcome their challenges and alleged lack of compliance by tailoring care to the patient. They would explain things. Furthermore, they would represent the cultures of the community, not just the dominant culture.[6] In their 2004 study of how doctors' decisions affect disparities, Joseph Betancourt and Owusu Ananeh-Firempong found that throughout medical school, doctors are taught that clinical decisions should rely on the detailed exploration of two variables: the presentation of symptoms and the probability of disease (through the application of Bayes' theorem). Doctors are generally trained to consider multiple factors to make diagnoses, and therefore sometimes naturally incorporate stereotypes into the decision-making process (Betancourt and Ananeh-Firempong). It's important to understand: "how even well-intentioned physicians may be susceptible to stereotyping and may unknowingly contribute to racial/ethnic disparities in health care" (Betancourt and Ananeh-Firempong) because of the nature of their job and the conditions under which they are expected to perform. Doctors use heuristics—mental shortcuts to diagnose ailments quicker, yet are also taught to take their own background and biases out of the decision-making process (Betancourt and Ananeh-Firempong). To further analyze this, the authors turn to social cognitive theory, which "focuses on how the underlying social assumptions we hold shape our decisions and how our perceptions regarding 'group characteristics' affect our judgment" (Betancourt and Ananeh-Firempong). Most people are bombarded daily with so much information that the brain needs to sift through and filter what's important and what is not. This forces us to create mental shortcuts to make the decision-making process easier, which leads to stereotyping. Due to the pressures of time

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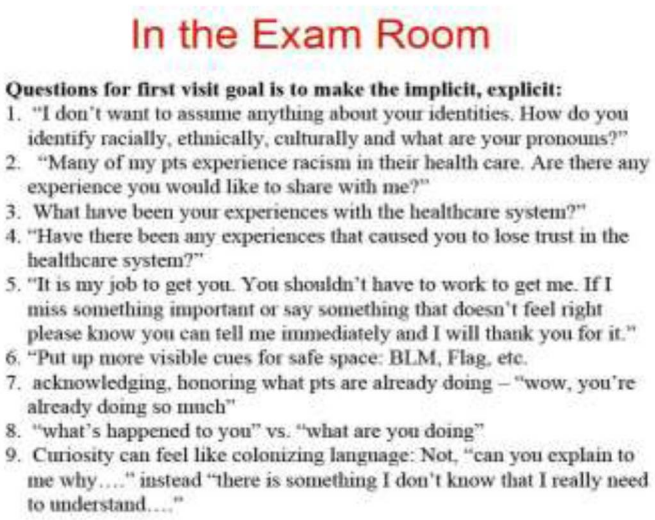
[6] Previously published in GLST 5923 Fieldwork

constraints and overwhelming patient loads, as well as the demands of health care systems, doctors, are driven to take shortcuts by seeing people as groups rather than individuals.

Medical providers need to recognize the extent to which their unconscious biases affect patients' health and even mortality. Yet, the overarching determinant of bias, while it informs the way in which patients react, should not bear the burden of change alone. Racism, while it may be the biggest factor keeping moms and babies from having optimal outcomes, cannot easily be fixed. We cannot educate it away. If so, we would have eradicated it by now. But some health equity training, when given practical tools for providers to implement, can be effective. Abigail Ortiz, the director of Community Health Programs at the Southern Jamaica Plain Health Center (SJPHC) in Boston, Massachusetts developed a series of questions providers could ask their patients. "The initiative started when physicians approached her with a simple but important question about how to end health inequity: 'What do we do in the exam room?'" (Endo). In her focus groups one doctor, whose patients were people of color volunteered that he would open his time with his patients with the following question: "Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?" (Endo) The doctor reported that the responses often led to open and honest dialogue. This led Ortiz and her team to develop a list of questions providers could open with (See Fig. 2.).

Figure 2.

Exam Room Questions



In the Exam Room

Questions for first visit goal is to make the implicit, explicit:

1. "I don't want to assume anything about your identities. How do you identify racially, ethnically, culturally and what are your pronouns?"
2. "Many of my pts experience racism in their health care. Are there any experience you would like to share with me?"
3. What have been your experiences with the healthcare system?"
4. "Have there been any experiences that caused you to lose trust in the healthcare system?"
5. "It is my job to get you. You shouldn't have to work to get me. If I miss something important or say something that doesn't feel right please know you can tell me immediately and I will thank you for it."
6. "Put up more visible cues for safe space: BLM, Flag, etc.
7. acknowledging, honoring what pts are already doing – "wow, you're already doing so much"
8. "what's happened to you" vs. "what are you doing"
9. Curiosity can feel like colonizing language: Not, "can you explain to me why…." instead "there is something I don't know that I really need to understand…."

Source: Endo, Jo Ann. "Institute for Healthcare Improvement." *Institute for Healthcare Improvement*, 27 Sept. 2016, www.ihi.org/communities/blogs/addressing-race-in-practice.

These questions convey respect for the patient and acknowledge whatever elephant might be in the room. "They convey humility in their admission that the doctor does not know all that may be important to understand about a patient. The questions acknowledge that racism isn't only a product of *intentional* bias" (Endo). It also transforms the doctor into an ally for the patient and builds trust.

Resources Available to Support Black Women

With the daily stressors of racism affecting black mothers and babies, and amidst the stories of death and despair, hope still abounds. When entities such as public health departments, health ministries, community health groups and grassroots activists get together they can form communities of caring. Groups such as Black Infant Health (BIH), Mahogany Moms, and Black Mamas Matter are some of the litanies of organizations rolling up their sleeves and tackling the

problems of maternal and infant mortality. Using collaboration to solve difficult social problems seems an ideal path to potential solutions, as bringing each stakeholder to the table to work together allows for more diverse perspectives. Petra Kuenkel, founder and executive director of the Collective Leadership Institute states that successful collaborations are "good containers" (93). These containers have people "who can drive change in their operational or decision-making role" (93). They must also have a mutual respect for one another and be "emotionally engaged with an envisioned future state" (Kuenkel 93). These organizations each demonstrate a passion for the health equity of black communities and families. While some take on policy changes through advocacy work, others work with women directly using health education models and case management frameworks. Coming together to form a type of black perinatal collaborative (Pierce County has its own Perinatal Collaborative) might provide a way to work together in a more focused manner by tackling a specific goal. However, creating yet another group with the intention to solve a problem would only work if the group is equipped with the skills to work together effectively, and if those in the group have the time and energy commitment required to do this work. Some of these organizations seem to have mastered the art of collaborating toward a common goal.

Black Mamas Matter

One of the most prominent organizations working to end maternal mortality is the Black Mamas Matter Alliance (BMMA), which held its first national conference on black maternal health in December 2018 (Home). On their homepage, they state: "We envision a world where Black mamas have the rights, respect, and resources to thrive before, during, and after pregnancy" (Home). Working as a multi-sector collaborative, BMMA partners with

organizations such as Sister Song and the National Birth Equity Collaborative to provide a united, national platform from which to do reproductive justice work. BMMA takes a strong social justice stance on the issue of maternal health by including it into their framework. On their website they clearly state:

> We align with the reproductive justice movement, which centers women of color in the struggle to recognize the human rights of every woman to: decide whether, when, and under which conditions she will reproduce; have a baby or end a pregnancy; and parent the children she has with the necessary social supports in safe environments and healthy communities, without fear of discrimination or violence. (BMMA)

Many such organizations take a comprehensive view of maternal health, which includes the freedom of women to choose for themselves whether motherhood will be detrimental to their health and well-being. This framework means women require access to both birth control and abortion. Viewing maternal health as a fundamental human right drives BMMA to delve deeper into the socio-economic factors affecting black women of childbearing age. Joia Crear-Perry, a medical doctor and founding member of BMMA pulls no punches when she states: "We—in health, advocacy, and media—need to stop saying and teaching that being Black is a risk factor for illness and death" (Greenlee). She makes the point that being black is not inherently the problem, even going so far as to say that the research documenting inherited trauma through epigenetics provides a convenient scapegoat for the medical community to deal with the current problem of racism. "I hear sighs of relief from those who understand the importance of this critical frame shift from the ahistorical and nonscientific belief that there is a gene or telomere that causes Black women's outcomes to be worse and that Black people have inherited it across the diaspora" (Greenlee). Factoring race into the maternal and infant mortality rate can backfire,

placing the problem back on Black people, and allowing policy makers and health care providers to approach it with cold scientific solutions, which actually put Black patients in more danger. For years, when examining the high black infant and maternal mortality rates, doctors have been asking themselves the wrong question:

> What are black mothers doing wrong? Common answers included eating poorly; being overweight or diabetic; smoking or drinking during pregnancy; not going to the doctor; not being married; getting pregnant too young; or smothering their newborns in their sleep. In the 1980s, health officials began focusing on access to prenatal care as a way to reduce these perceived risk factors (Carpenter).

However, according to Dr. Crear-Perry, race isn't the problem, racism is (Greenlee). These semantics show an important and life-saving distinction.

Black Infant Health

In the Tacoma area, the Tacoma-Pierce County Health Department (TPCHD) in partnership with the State Department of Health (DOH) and the Health Care Authority (HCA) fund the Black Infant Health (BIH) program. Run on the passion and energy of a single public health nurse named Lea Johnson, Black Infant Health (BIH) provides community-based support to black perinatal and post-partum women in an effort to prevent maternal and infant deaths. Johnson enlists volunteers through church health ministries in the Tacoma area to help with this work. Each church has a representative health minister charged with being an advocate to women in her congregation and community needing resources and assistance. She then connects them to a larger network of support through BIH. Health ministers utilize the community health worker model of providing culturally competent peer support.

In serving families as a maternity support home visitor, Johnson saw the need early on to provide culturally appropriate care. "I realized that when I would go in as the public health nurse to work with a family and they were Spanish speaking, by having an interpreter with me or having that [Spanish speaking] family support worker just made that situation go so smoothly because you had somebody that spoke the same language and understood the culture" (Johnson, Interview). Johnson made the connection that African Americans could benefit from having interpreters as well—cultural interpreters who understood the unique aspects of this community and could speak to the client's hearts: "and so I started thinking about having folks that were of the culture for African American families because I could see that that was the missing link: somebody to translate culture. … if we had folks that understood the culture of people then that would help improve outcomes" (Johnson Interview). As an example of cultural dissonance, Delores Baccus, a BIH supporter, and an Internationally Board-Certified Breastfeeding Consultant (IBCLC) says that black women generally feel uncomfortable with a white nurse coming into their homes. Baccus says there is fear of not living up to white expectations and that they will be found to be unfit mothers, and have their babies taken away. They feel judged "what is she going to think about my house? Is it clean enough for her?" (Baccus Interview). BIH consists mostly of black women and takes a peer-helping-peer approach to supporting prenatal and post-partum mothers.

The support BIH provides includes breastfeeding and safe-sleep classes, regular social times involving playgroups, and cooking and nutrition classes. In addition, women are connected to resources such as Care Net for material support like diapers and clothing, as well as to parenting classes; Women Infant and Children (WIC) for nutritional support; Early Head Start for parenting support and education; and to health navigators who can help them get health

insurance if needed. Due to the higher prevalence of infant mortality, a black baby surviving its first full year marks an important milestone. These babies receive a huge birthday party or a Celebration of Life gathering in which all the babies who are a year old or more, are given a party with gifts for the babies, and food, baby clothing and diapers for all families in attendance. According to Johnson, in the eight years of this program only one mother and one baby have been lost. Shortly after the baby was born, I visited her mother Carmetrus Parker at Children's Hospital in Seattle. The baby had Trisomy 13, a genetic disorder in which she was not expected to live beyond a few days. Little Tyshay lived for four months.

Health Ministers

One of the many benefits of the BIH program is the social support provided by church health ministers. Many churches have health ministries, however, in the African American church, health ministries, act as trusted sources of health information both to the congregants as well as the larger community. As some of the oldest African American institutions, "churches provide guidance related to the spiritual, physical, emotional, and social needs of their congregations" (Harmon et al. 1412) and are "a trusted source for health education materials and programming" (Harmon et al. 1412). Many public health strategies aimed at reaching communities of color are targeting church health ministries for that very reason. The women who volunteer as part of BIH each represent a church or organization. Along with BIH, many of the church health ministers also organize church health fairs that allow sponsorships from community organizations in order to distribute materials to congregants and the larger community. These fairs offer free blood-pressure screenings, health talks, cooking demonstrations and the like. Healthy snacks are generally provided, however, since these are

black church events, the obligatory fried chicken is often also on the menu. As a BIH supporter, I often shared information about Care Net, the pregnancy resource organization I worked for.

Mahogany Moms

Fellow BIH supporter, Delores Baccus recently started her own organization called Mahogany Moms. "We're hoping to offer support to African American families, not just breastfeeding but [for] the whole family unit. My vision is to one day have a building that supports African American families from birth to [the] elderly…because I have a passion for both" (Baccus Interview). Baccus has her hands in multiple pots. While heading the breastfeeding peer counseling program for King County, she teaches breastfeeding classes, and participates in BIH as well. She also has a Maternal and Infant Mortality and Morbidity Awareness conference coming in August of 2019. Baccus is a big proponent of self-advocacy, stating: "we in our communities need to be empowering one another. When African American women come to my class, I tell them doctors, nurses, practitioners they work for you and not the other way around" (Baccus Interview). Black women often face barriers to receiving the support of a doula, for example.

The Doula Option

The concept of a doula can be confusing, as many confuse them for midwives. They primarily act as labor coaches and patient advocates. But many women can't afford their services outright, and insurance doesn't always pay for them. Yet, their value in promoting healthier birth outcomes is being widely acknowledged. LaQuita Thurman, a young mother I spoke to, was not able to afford a doula (Thurman Interview). Her experience with her doctor's nurse left her

feeling diminished. She wanted to have a vaginal delivery after having had a previous C-section. As she states: "by the time they had the talk with me about vbac—vaginal delivery after C-section—they did some kind of statistics and they were saying to me, oh, 'we put your BMI and your weight and your height into this little data thing and … you're black' and so they were like you are a high risk" (Thurman Interview). If given the opportunity have a doula, Thurman might have been able to attempt to deliver the way she wanted.

A study of low-income women in Brooklyn, New York has shown that providing doulas proved a positive complement to the home visiting programs already in place (Thomas et al.). Doulas act as advocates to pregnant moms by providing prenatal guidance and support, as well as coaching and aid, during and after the birth of the baby. "Doula support during pregnancy and childbirth is associated with improvements in many outcomes, including lower rates of cesarean section and preterm birth, higher rates of breastfeeding initiation and increased satisfaction with the birth experience" (Thomas et al.) However, accessing a doula isn't cheap. According to the website Mamanatural.com, prices for doulas range from $300 to $1000 depending on where one lives, and as of August of 2018, only Minnesota and Oregon reimburse Doula services for those using Medicaid Insurance (State Policy). This creates a barrier for the women who could benefit from doula services the most: those who are low-income, single, or without an adequate maternity support system; clients typically served by Medicaid. Doctors also, lack comprehensive understanding of what doulas do. Obstetrician Dr. Robert Snyder of Franciscan Women's Clinic in Federal Way, Washington says he's not sure what education they have, and has felt that some doulas can interfere with patient care: "I don't know exactly what training a doula has to help support and guide decision-making" (Snyder Interview). He did concede that women without any support in the delivery room can benefit from a doula, but stressed that

midwives and nurses do a great job. Dr. Snyder, an OB with more than 30 years-experience, makes clear that one of the barriers to getting better outcomes is getting the medical establishment to accept non-classical solutions like doulas. However, studies show that doula care can improve outcomes as, "a doula's respect for the autonomy of the client and emphasis on positive goal-setting during prenatal visits have been shown to increase women's empowerment and confidence regarding their ability to influence their own pregnancy outcomes" (Thomas et al.) This was echoed by Tonnetta Wade, a doula student in San Francisco. She feels that doulas are part of the patient's team and that "nurses…have 7-8 other patients [and] that they can't be in the room and labor with that person" (Wade Interview). She recognizes that her actions are on behalf of the client. "I can't bring in any of my ideas," Wade stated via phone interview. If things aren't progressing, she can encourage the client to try other things before medical interventions become necessary, but she never intervenes or gives her opinion (Wade Interview). As women begin to seek out doulas, hopefully doctors and insurance companies will see the potential for improved birth experiences and outcomes.

CenteringPregnancy

CenteringPregnancy, a group prenatal care model, also shows promise as a potential remedy for poor birth outcomes. It provides social support as cohorts of eight to twelve women with similar due dates attend prenatal visits during a group timeslot. Strickland et al. argue that CenteringPregnancy improves the overall patient experience in the following ways: "the added time during visits allows for a dynamic dialogue between the women in the group and their providers; such dialogue would be difficult to achieve during a fast-paced individual visit" (Strickland et al.) I asked Dr. Snyder if he had ever heard of this model, he stated that they had

tried it. "The first time I had four and then it went down to two. By the end of it and it just wasn't worth my time to devote two hours of office time to two people that I would have seen in a half an hour in the office" (Snyder). The program does require a designated space, and marketing it to women is difficult.

While none of these solutions on their own can provide a barrier impervious to racism, they offer options that can deliver an overwhelming sense of support and well-being. In an ideal world, doctors and providers would offer not just culturally competent care but view each woman as a unique individual, recognizing that her biggest risk-factor is not her ethnicity or culture, it's the way the provider sees her. Therefore, fostering a community of support for black women can provide some insulation against a world in which structures and systems largely give white people the advantage.

The Project: Community Healing Through Changing the Narrative

The structural violence of racism is at the heart of the high mortality rates in Black America. The concept of structural violence as defined by James Gilligan of Harvard Medical School seems fitting in this context. He states that it is "the increased rates of death and disability suffered by those who occupy the bottom rungs of society" (Moe-Lobeda 72). Physical health needs to be tackled with specific medical and lifestyle improvements and interventions in a partnership between provider and patient. Yet, the healing of community requires a deeper engagement of body, mind, and soul. The black community needs healing before we can approach the topic of healthy pregnancies and healthy babies. To encourage this healing is more than just to promote good health outcomes; it is to cultivate community, trust, and hope. As part of this thesis I am incorporating a project in the form of a health-focused blog aimed at a Puget

Sound area African American audience, focusing on promoting health and healing by changing the narrative from that of blacks as victims, to one of blacks as victors; from those who receive ill-treatment, to those who demand to be treated as individuals, and to shift the power dynamic in the doctor-patient relationship. In addition, there will be health tips, information on community resources and a podcast in which people can share their projects, programs, and experiences in the field of black maternal and infant health. My hope is for this project to expand to incorporate other health topics relevant to African Americans.

The Social Cure

Hospitals, clinics, and other healthcare facilities currently seek to educate their staff by offering cultural competency workshops. Providing cultural competency classes for providers, as well as health education for women are good starts, but at best, they can only solve part of the problem of racism in healthcare. At worst, health education can perpetuate negative self-perceptions that contribute to even more stress for black women. Clinical Health Psychologist Michele Andrasik calls these "internalized stigmas" (Andrasik). "We take those messages about our identities and we internalize them" (Andrasik). The knowledge that as a black woman, my risk of dying is higher, may just cause me to panic at the mere mention of a C-section. Constant messages of inadequacy, susceptibility, inferiority all due to race are bound to create a collective inferiority complex. True agency comes from what Pulitzer Prize winning author Tina Rosenberg calls the "social cure" which uses what we know to be peer pressure to encourage behavior change. If other people who are similar to us are doing it, we want to join in as well. In solving social problems, Rosenberg believes we have to ask ourselves: "Is this a problem where it might be possible and fruitful to provide people with a new peer group that can encourage

them to think of themselves in a new way?" (283) Having a powerful peer support mechanism doesn't preclude education. Principles of healthy pregnancies such as regular prenatal visits, and classes stressing post-natal factors such as safe sleep for baby, and breastfeeding provide vital, life-saving strategies. Yet, attending these classes can of themselves also be considered healthy behaviors that may need encouragement from a group.

Tina Rosenberg examines social problems that have been successfully tackled through innovative means using positive peer pressure. When it comes to remedying bad health behaviors she writes: "There are many factors conspiring to push us into destructive behavior but the strongest of these is culture, because it is the very expression of our bonds as a group" (Rosenberg 42). We are social animals and we want to belong but just as community development should rely on what the people say they want; public health messages should also be informed by what the public identifies as necessary. Rosenberg contends that public health practitioners are using messages that would work for them, however, they are already vested in the change they seek to promote, ordinary people are not (49). "People selling cars and toothpaste know this; people selling healthy lifestyles…have treated this as an afterthought" (Rosenberg 50). One way to determine what people want is to ask them. This is where social media can be effective because people are more likely to engage in real time, and the financial investment is low. Social media has the ability to create movements, shifting cultural norms. Therefore, creating health messages has to be about taking a topic and making it cool, something people want to be a part of.

Media and Self-Efficacy

Many movements such as Black Lives Matter (Herstory) and #Metoo have started online. These catch on because they touch on a cultural moment that resonates with the masses. Serendipitous moments can't be counted on to propagate effective health messaging. In addition, most health messages come across as somewhat moralizing and simplistic. "Merely tweeting broadly about the importance of seasonal flu vaccination is not likely to be sufficient" (Huesch et al. 1274). Harnessing the media's power to influence by tapping into social norms can produce promising results, as advertisers know all too well. Therefore, in the field of public health, "it is reasonable to ask whether we have fully exploited technology-based solutions to empower and better inform patients" (Huesch et al. 1274). With these newer paradigms, exciting ways of creating community and disseminating information are developing more and more.

Most young mothers today fall into the millennial or post-millennial generation. Millennials process information differently from previous generations "and prefer multiple streams of information with frequent interaction with content" (Mahoney and Tang 8). Today's educational resources need to meet the needs of these learners. Media platforms such as blogs and videos offer subscription-based information for any area of interest. Social media such as Instagram, Facebook and Twitter also provide quick doses of information throughout the day. However, health messages tend to be didactic and dry. People aren't inspired to do things just because they are the right thing to do. People need more compelling reasons, which can be brought about through the development of Bandura's self-efficacy model.

> Self-efficacy is a person's belief in their ability to produce desired results by their own actions…[through]: mastery, social modeling, social persuasion, and managing one's

> physical and emotional states. Efficacy beliefs influence whether people think optimistically or pessimistically by regulating four major processes: cognition, motivation, emotion, and decision. (Bandura 07:31)

In building self-efficacy, we need to override the negative discourse women overwhelmingly receive and believe. Notions that black women don't breastfeed, or that black women prefer C-sections, don't have healthy eating habits, and so forth dominate not only in medical circles but in the black community as well. Messages should show groups of beautiful, vibrant black women breastfeeding, talking about natural childbirth, and eating healthy foods. This would have the dual effect of giving black women a more positive sense of themselves, while also normalizing this behavior. Messages would come in the form of Tweets, blog posts, interviews and from other shared content on the web.

Content Strategy

The first podcast uses the element of storytelling to promote dialogue and healing. It features interviews with two women who have had difficult birthing experiences. In writing about a peacemaking conference in Nairobi, Kenya the authors note that: "if violence enslaves, then an open space for storytelling can free people to form new identities, recall old wisdom, and transform conflict by imagining alternate endings to familiar patterns" (Haitch and Miller 391). By sharing experiences, women can take charge of the narrative of their experiences in a way that can be both therapeutic for the teller, and healing for those who listen.

In order to have healthier babies and safer births, women need know about and make use of the resources available to them. This is one area in which digital marketing and media can work effectively. The internet can disseminate information efficiently. It can also provide a sense

of community to those who share similar life experiences, and it can be a powerful agent for social change. Ritu Sharma, the CEO of Social Media for Nonprofits states in a piece in the Huffington Post that, "What once seemed like a trivial way to keep in touch with friends, sharing photos and jokes, has become a force for societal change, shining light on subjects previously unknown, deepening conversations and empowering citizens of the world to unite and effect change". As such, social media, with its ready accessibility can be a powerful force for common, everyday people to create movements.

A substantial number of neighborhood groups and coalitions exist to tackle health disparities at the grassroots level. Yet, too often these groups work independent of one another with no real knowledge of what others are doing or how to work together. The abundance and vibrancy of both local and national groups focusing on health disparities, coupled with the recent experiences of high-profile mothers such as professional tennis champion Serena Williams, show the extent to which this problem affects black women. In order to tackle the difficult problem of health disparity and in particular, lower the maternal and infant mortality rates, these community groups need to come together. My aim is to bring all this work together and tell the local story of this movement toward health, wholeness, and survival. For this project, I have purchased the blackhealthnorthwest.com domain name, and currently have a Twitter feed @blackhealthnw. The goals of this venture are as follows:

- To be a central location for all things related to health disparities in the community
- To provide relevant and accurate health information
- To inspire and invoke positive behavior change regarding health
- To continue to tell stories of people or entities in the community who are affected by health disparities or are addressing them

- To empower and inspire African American women to use their agency to make choices that can contribute to healthier birth outcomes.

Initially, I will introduce the project to some of the collaborations and coalitions I attend and hope that it will catch on through word-of-mouth and through the connections of the people I interview on the podcast.

Conclusion

With this exploration into the realm of maternal and infant mortality in the black community, groups such as Black Infant Health show that when women receive social supports such as peer mentorship, health literacy education, and access to quality care, they can over-come some of the factors preventing them from thriving. Through community, a sense of personal agency, and the hope that comes with relationship, women can develop a sense of self-efficacy for their lives. Since so much of racism, or the perception thereof, depends on being the object or victim of a power structure beyond one's control, having self-efficacy empowers the person to step out of the victim role and take charge of their own destiny. In most cases, this requires a team of support and encouragement. Yet, access to these supports varies greatly, and while each is beneficial on its own, the greatest potential for overcoming adverse maternal and fetal outcomes depends upon their combined usage, incorporating both community and medical resources.

African American women are suffering ill-health and death as society both blames them for their predicaments and imposes their worldview upon them in offering solutions. Yet, the problem doesn't lie only with the systemic racism, but also with our view of ourselves. As such,

the solutions don't shouldn't come from one top-down approach from the healthcare systems. They need to begin with black women.

Furthermore, as a Christian I don't view suffering and social injustice as mere temporal, earthly problems. Challenges need to be approached from a variety of angles, the spiritual perspective notwithstanding. Understanding how my faith and race intersect has helped me to synthesize these perspectives, and gain a greater understanding of what it means to have that kind of intersectionality. Taking this deep dive has allowed me to find my voice amidst all the din surrounding this important societal malady. Part of that voice should be used to speak up for those who can't always speak for themselves. Using a podcast to enable marginalized voices to speak can create a means for catharsis, as well as inspiration. Mothers who tell their stories can find meaning in their experience by sharing it with others. People who listen can feel encouraged that they are not alone in their predicaments. The problem of infant and maternal mortality will only be solved if doctors and medical systems do their part to understand it by listening to and learning from the women affected; and if women come into the doctor's office with a healthy, positive view of themselves as human beings worthy of kindness and respect. I hope this project will at least help accomplish the latter.

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