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# Healthy Birth Initiatives: The Road Toward Reproductive Justice

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# Healthy Birth Initiatives: The Road Toward Reproductive Justice

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**Prepared for: Multnomah County Healthy Birth Initiatives**

# Author Information & Acknowledgments

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# Guidance for Readers and Intended Uses of Report

Research and evaluation can serve many purposes; we have written this report in such a way that HBI, Multnomah County, mainstream healthcare institutions, and other interested stakeholders might all benefit. Some of our intentions and hopes for this report include:

- To document and celebrate achievements of HBI as a culturally-specific organization
- To lay out an aspirational vision of Reproductive Justice and take stock of HBI's efforts towards this horizon
- To contextualize HBI's work within larger cultural, economic and political contexts - both historical and contemporary
- To give power and voice to the unique experiences of HBI participants and staff
- To provide concrete suggestions on how HBI might continue its work - both internally and externally as it intersects with mainstream healthcare institutions

To these ends, the report is organized as follows. First, we provide an **executive summary** that briefly introduces the study and synthesizes key findings and recommendations. Next, the study **context** section reviews key concepts including racism, racism-related stress, maternal and child health disparities, reproductive oppression, and Reproductive Justice; this discussion aims to situate HBI and the families they serve within larger cultural and political contexts. This section concludes with a brief introduction to the HBI organization. The **Current Study** section then provides a discussion of research methods. Next we provide in-depth findings, which are organized into three distinct sections. **Section one of the findings** takes a narrative dive into the unique experiences of racism faced by Black women; this corresponds to the first finding listed in section two, but we felt it warranted a dedicated and extended discussion. In **section two of the findings** we offer lessons for healthcare providers (external to HBI) related to racialized experiences of reproductive oppression among Black women. For each finding we provide: a) a discussion of how HBI currently addresses that issue; b) recommendations for action from research participants; c) recommendations for action from researchers; and d) illustrative direct quotes from research participants. In **section three of the findings** we offer lessons for HBI and Multnomah County Health Department. For each finding we provide: a) recommendations for action from researchers; and b) illustrative direct quotes from research participants. The report concludes with a discussion of **final takeaways**.

# Executive Summary

## Introduction to Study

This study concerns racialized experiences of reproductive oppression among Black women and the efforts of one organization - Multnomah County's Healthy Birth Initiatives (HBI) - to combat this oppression and move towards Reproductive Justice. This study explores how Black women experience and respond to racism-related stress and its impacts on their health during and after pregnancy and subsequent parenting. The project was informed by a pilot focus group conducted in 2016 by Drs. Jenna Ramaker and Roberta Hunte in partnership with HBI, which asked HBI clients about the role of toxic stress and racism-related stress in their lives. The current study - led by Drs. Roberta Hunte and Susanne Klawetter - expands that initial focus to include the perspectives of current and former clients, as well as HBI staff.

The following research questions guided the current study:

- How do Black women describe the experiences and impacts of racism-related stress as it relates to their pregnancy, health and parenting?
- How does HBI mitigate the impact of racism-related stress on clients' pregnancy, health, and parenting, and how can program activities be enhanced?
- What is the shared impact of racism-related stress on Black women's health between HBI staff and former HBI clients, as well as the lasting impact of HBI in building resiliency among Black women?

## Methods

In 2019 Dr. Roberta Hunte conducted two focus groups with current and former HBI clients, one focus group with Black HBI staff who work directly with mothers, and a fourth focus group of HBI staff and former clients to provide member checking and deeper analysis of emergent themes from the previous groups. A total of 27 individuals participated in the focus groups. Focus groups were audio-recorded, professionally transcribed, and checked for accuracy.

Drs. Hunte and Klawetter conducted a thematic analysis of the data focused on understanding client and staff perspectives on the impacts of racism-related stress in their lives, namely: within birth experiences; parenting children; navigating institutions; and processing racism and discrimination. Analysis was performed with a systematic, iterative process supported by ongoing discussion of developing themes. Sherly Paul, an HBI nurse and nursing graduate student, joined the analysis process to develop the findings and recommendations.

## Findings Section One: Racism and Black Women

Healthy Birth Initiatives nurses and community healthworkers, and the past and current clients who participated in this study, identify as Black women. Women discussed the chronic presence of racism-related stress that ebbed and flowed through their lives as pregnant people, mothers, and professionals. They offered vivid descriptions of how they experienced racism within their communities, the medical system, and in the workplace. They talked at length about how this impacts them as people, as parents, and as professionals. As Black women they talked about stress at the rising racial tensions within Portland. Women talked about exposure to overt and subtle forms of racism across these various contexts.

## Findings Section Two: Lessons for Healthcare providers

1. Racism is a chronic factor in Black people's lives. Black women in Portland experience racism in multiple forms and in multiple domains of life - as individuals, as parents, and as workers.

- Recommendations: Providers should openly acknowledge the reality of racism within their respective institutions and directly with women. Fight systemic racism, not individual clients.

2. Anti-racism advocacy is the critical work of public health and healthcare. Acknowledging social determinants of health and the holistic needs of Black women requires acknowledging anti-racism advocacy as a critical public health intervention.
    - Recommendations: Understand the necessity of holistic services, including advocacy on behalf of and alongside Black women. Incorporate advocacy skills training for clients at both the micro and macro levels. Healthcare institutions and providers should regularly seek education about the impact of non-healthcare systems on the health of women and families. Healthcare professionals must learn how their profession has and continues to contribute to systemic racism.

3. Black women need dedicated mental health supports. Racism is psychologically and emotionally damaging. The strong Black woman is a myth.
    - Recommendations: Support peer led mental health programming, and the recruitment and retention of Black mental health providers. Explicitly ask women how they are doing in a way that acknowledges the impact of structural racism on mental health and well-being.

4. Expressing weakness or struggles to providers and asking for help - especially as it relates to mental health - subjects Black women to various forms of institutional control and punishment, including child welfare.
    - Recommendations: Form authentic relationships with women based on positive regard. Further integrate HBI within medical teams; consult with HBI and consider them a vital resource before involving other systems like child welfare.

5. Medicalized birth trauma is pervasive among Black people, and affects both individuals and communities.
    - Recommendations: Women need dedicated space and resources for processing birth trauma, including peer support groups. Access to Black doulas should be expanded.

6. Distrust and disrespect hinder relationships within healthcare settings. Black women's interactions with traditional medical providers are often characterized by distrust, disconnection, and disempowerment. These experiences contribute to medical misinformation, as lack of trust makes it hard to accept medical information and recommendations. Black people are aware of the history of medical racism, and worry that involvement with traditional medical providers can lead to entanglement with other systems.
    - Recommendations: Medical providers need to address racist assumptions they may hold of Black women and Black communities. Implement bias training; specifically, implement anti-Blackness training. Regularly evaluate Black women's experiences with providers and course correct when needed.

7. Black women take a holistic view of pregnancy, birthing, and parenting; these things are embedded in wider familial, community, and societal contexts. For Black women, pregnancy and parenting supports often go beyond the nuclear family and interventions need to support a variety of actors.
    - Recommendations: Understand Black women and their health within larger societal contexts, including racism and the need for long-term, stable resources. Fund a dedicated resource navigator for clients. Invite key members of pregnant people's communities to support pregnancy and postpartum care. Support advocacy efforts that target institutional

barriers to family cohesion - especially barriers to Black men's involvement with their families.

8. Culturally-specific knowledge and services are necessary in healthcare to address racism. Black people who can become pregnant need access to culturally-specific services and providers across the healthcare spectrum, but are often dismissed when they ask for this within mainstream institutions.
    - Recommendations: Take seriously the desire of HBI clients for culturally-specific services and providers; be prepared with up-to-date referral information. Incorporate practices of culturally-responsive care. Hire and retain more Black medical providers.

9. Stronger collaboration between HBI and medical providers is necessary. Women need HBI and providers to work closely together.
    - Recommendations: Be aware that clients may be working closely with HBI; ask about this relationship and how it can be enhanced. Welcome HBI as part of interdisciplinary continuity of care teams and intentionally work to integrate HBI when providing care.

## Findings Section Three: Lessons for HBI and Multnomah County Public Health

1. Anti-racism advocacy is critical. One of HBI's most powerful features is its advocacy on behalf of and alongside Black women and the way it models and teaches advocacy skills to clients.
    - Recommendations: Emphasize HBI's advocacy activities as a public health intervention in funding proposals and promotional materials. Strengthen HBI's advocacy activities by educating clients about parental rights, patient rights, and housing rights in pamphlets or other written materials.

2. HBI's medical partnership-building changes systems. Pregnant people and families will continue to benefit from stronger collaboration between HBI and community partners.
    - Recommendations: Continue to expand the reach of HBI throughout the Portland-metropolitan area and strengthen relationships with community partners, including local social work, public health, and community health worker educational programs. Consider expanding partnerships by improving outreach to professional Black women.

3. HBI is simultaneously part of the Black community and the public healthcare system. HBI's work requires a delicate balance between two practice frameworks: holistic, community-oriented Reproductive Justice and professionalized medical health services.
    - Recommendations: Emphasize the holistic and community-based nature of Reproductive Justice. Acknowledge that boundaries and roles of Black women serving Black people within the same community might be slippery sometimes, and implement policy where appropriate to manage this complexity.

4. HBI staff are impacted by racism-related stress. Being Black women serving distressed Black communities exposes HBI workers to cumulative racism-related stress, as their professional lives are geared towards addressing many of the same systemic issues that impact their personal lives. This racism-related stress impacts mental health and can cause HBI staff to feel undervalued.
    - Recommendations: Implement structural changes to support staff such as higher quality office space and KSA designation. To relieve pressure on individual programs to advocate for their existence, the County can better explain and widely communicate its racial equity funding priorities.

5. Cultivate community care practices within the HBI community. Intentional work around issues of conflict resolution, trauma healing, and the collective protection of privacy will further strengthen the HBI community.
    - Recommendations: Consider bringing back peer support groups. Develop a conflict resolution protocol and group agreements for engaging with HBI community. Consider formalizing HBI's Afrocentric trauma-informed care lens.

# Context: Moving from Reproductive Oppression to Reproductive Justice

This report concerns racialized experiences of reproductive oppression among Black women and the efforts of one organization - Multnomah County's Healthy Birth Initiatives - to combat this oppression and move towards Reproductive Justice. Before discussing research methods and findings, we will offer definitions of key terms and a brief review of relevant literature from academic and activist sources. This discussion aims to situate HBI and the families they serve within larger cultural and political contexts.

## Racism

Ruthie Wilson Gilmore (2007), prison abolitionist and geographer, defines racism as "the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death." This means racism is a legal or outside-the-law racial caste system built on the exploitation of some based on racial categorization, resulting in catastrophic consequences including early death. *Racism shortens lives*. Systemic racism manifests in the lives of Black people as reproductive oppression, which limits the choices of Black people in terms of when and how they can become pregnant, limits the care they receive during and post pregnancy, and can expose parents to institutional oppression. Exposure to systemic racism contributes to high rates of maternal and infant mortality and morbidity among Black people who can become pregnant in the U.S. Public health scholars describe systemic racism as a pandemic in this country that is a public health crisis (Jones, 2018; Jones, 2020). Individual, systems, institutional and cultural interventions are needed to rectify this public health crisis.

## Racism-Related Stress

Racial disparities not attributable to social-behavioral maternal risk factors (Kleinman & Kessel, 1987) have led scholars to propose that race-related stress is associated with racial disparities in maternal and child health (Collins & David, 2009; Collins et al., 2000; Lu & Halfon, 2003; Rosenberg, Palmer, Wise, Horton, & Corwin, 2002). Although the body has mechanisms to combat stress, the repetitive stress associated with racism and discrimination may push the body to its allostatic load, marked by an inability to recover from the damaging effects of stress (Jackson, 2007; Lu & Halfon, 2003). In this report we modify the term race-related stress to racism-related stress as we argue that it is not race that causes stress, but racism.

Extant research explores the causal relationship between racial disparities in chronic stress and racial disparities in maternal and child health. Mixed findings suggest a nuanced relationship: racism-related stress may function *directly* by physiologically altering stress pathways and *indirectly* by restricting access to social resources and facilitating unhealthy physical environments (Alhusen, Bower, Epstein, & Sharps, 2016; Alhusen, Gross, Hayat, Rose, & Sharps, 2012; Lu & Halfon, 2003). Further research is needed to understand the sources of racism-related stress, causal relationships, and how racism-related stress manifests over the life course to affect maternal and child health.

## Reproductive Oppression

Reproductive oppression refers to the public policies, ideologies, and cultural practices that hinder people's ability to exercise their reproductive autonomy. In the lives of women of color, Loretta Ross describes reproductive oppression as "reprocide" (2017, p. 24) based on white supremacist notions of population control and ideologies of eugenics meant to control and constrain communities of color and other reproductive bodies. Reproductive oppression can occur in medical settings, within family and religious arenas, and as parents strive to maintain their families against economic inequality.

## Black Maternal and Child Health Disparities

Adverse maternal and birth outcomes are a key indicator of a population's health across the lifespan and are linked to social inequality (Lu & Halfon, 2003). Research has established persistent Black maternal and child health disparities. While U.S. maternal mortality rates overall fell between 1915 and about 1990, rates have increased since then with Black women bearing 2-3 times the maternal mortality rate compared to white women (Lu, Highsmith, de la Cruz, & Atrash, 2015). The gap between Black and white maternal mortality rates increases along with maternal age and widens dramatically with educational attainment. Black women with a college degree are 5 times more likely to die due to a pregnancy-related cause compared to white women with a college degree (Petersen et al., 2019).

In terms of racial disparities in infant outcomes, Black people are twice as likely to give birth to low weight babies, 60% more likely to give birth prematurely, and experience more than double the rate of infant mortality compared to non-Hispanic whites (Ely & Driscoll, 2019; March of Dimes, 2015; Matthews, MacDorman, & Thoma, 2015). Non-Hispanic Blacks have the highest rates of preterm birth, low birth weight, and infant mortality of all racial and ethnic groups in the U.S. (Matthews, MacDorman, & Thoma, 2015). Black women and infants also experience the highest rates of preventable death in pregnancy and birth. Major contributors to these various forms of reproductive oppression include implicit bias in healthcare, limited access to quality healthcare, and medical neglect (Petersen et al., 2019).

## Reproductive Justice

Reproductive Justice is the antidote to reproductive oppression. Created by Black women in 1994, Reproductive Justice is a theoretical framework and movement steeped in human rights, social justice, and the lives of women of color. This movement was born as a response to the ways that the pro-choice movement in its advocacy for abortion rights, which remains a need and right for Black women, failed to take seriously the real oppression Black women faced in their efforts to have children and see those children into adulthood. SisterSong, a women of color led Reproductive Justice advocacy coalition, defines Reproductive Justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong, n.d.). Reproductive Justice asserts that people's various identities of race, gender, sexual orientation, physical ability, nationality, age, and so forth expose them to various forms of reproductive restriction that harm their lives and families. Reproductive Justice seeks to address structural, cultural, and interpersonal sexual and reproductive oppression, while moving society towards sexual and reproductive freedom. Dorothy Roberts, sociologist, says "[Reproductive Justice] is a model not just for women of color, nor just for achieving reproductive freedom. [Reproductive Justice] is a model for organizing for human equality. The world needs radical Reproductive Justice" (2017, p. 10).

## Healthy Birth Initiatives and Reproductive Justice

HBI is a Multnomah County-based Reproductive Justice initiative that supports the agency and autonomy of Black women and Black people who can become pregnant to make the best choice for themselves regarding when and how to become pregnant, to exercise their bodily autonomy throughout that experience, and to support their right and ability to parent their children in a sustainable environment through the first 18 months of life. It reflects a culturally-specific approach to the Nurse-Family Partnership Program and seeks to improve maternal and child health outcomes among Black families living in the Portland-metropolitan area.

HBI carries out its mission to provide Afrocentric perinatal services for Black women and their families from pregnancy through children aged 18 months by providing:

- Provider-client racial concordance as a service delivery model
- Individualized in-home case management
- Access to home visiting nurses and other relevant healthcare specialists
- Breastfeeding support
- Pregnancy, child birth, and newborn classes
- Coordination of care with healthcare providers and community agencies
- Material support (e.g., car seats, transportation to healthcare appointments) (Multnomah County, 2020).

# The Current Study

Evidence points to the effectiveness of HBI's culturally-relevant approach to the Nurse-Family Partnership Program. However, further research is needed to understand how racism-related stress manifests and impacts Black women, as well as how programs such as HBI address and mitigate racism-related stress among client and staff.

Black families persistently experience disproportionately high rates of maternal and infant mortality and morbidity despite advances in medical technology and efforts to improve access to prenatal care. While evidence suggests an association between racial discrimination and racial health disparities, research is needed to expand our understanding of these experiences and their effects on maternal and child health among Black women. This study was conducted in partnership with Multnomah County's Healthy Birth Initiatives (HBI), a public health program designed to support Black perinatal health in Oregon. The study explores how Black women experience and respond to racism-related stress and its impacts on their health during and after pregnancy and subsequent parenting. *Racism-related stress* refers to stress associated with experiences of, anticipation of, and responses to racism and discrimination. These dynamic interactions occur between individuals and their environment over a sustained period of time (Utsey et al., 2013). This project was informed by a pilot focus group conducted in 2016 by Drs. Jenna Ramaker and Roberta Hunte in partnership with HBI, which asked HBI clients the role of toxic stress and racism-related stress in their lives. The current study - led by Drs. Roberta Hunte and Susanne Klawetter - expands that initial focus to include the perspectives of current and former clients, as well as HBI staff.

## Methods

Focus groups are an effective way to build community among people with shared experiences and to collectively create meaning (Wilkinson, 1998). Researchers pursued a Black Feminist approach that centered the lived experiences and perspectives of Black women to identify structures of racial and gendered oppression in their lives and to bring forth solutions (Collins, 1989).

In 2019 Dr. Roberta Hunte conducted two focus groups with current and former HBI clients, one focus group with Black HBI staff who work directly with mothers, and a fourth focus group of HBI staff and former clients to provide member checking and deeper analysis of emergent themes from the previous groups. Key questions guiding this study were:

- How do Black women describe the experiences and impacts of racism-related stress as it relates to their pregnancy, health and parenting?
- How does HBI mitigate the impact of racism-related stress on clients' pregnancy, health, and parenting, and how can program activities be enhanced?
- What is the shared impact of racism-related stress on Black women's health between HBI staff and former HBI clients, as well as the lasting impact of the HBI intervention in building resiliency among Black women?

Focus groups lasted an average of two hours each. All focus groups were conducted on-site at HBI and included a meal, childcare, and transportation as needed. Participants were recruited through HBI's email networks, fliers posted at HBI, and word-of-mouth. All focus group members voluntarily consented to participate in the study. A total of 27 individuals participated in focus groups. Client participants received a $40 gift card as an honorarium. Focus groups were audio-recorded, professionally transcribed, and checked for accuracy.

Drs. Hunte and Klawetter conducted a thematic analysis focused on understanding client and staff perspectives on the impacts of racism-related stress in their lives, namely: within birth experiences,

parenting children, navigating institutions, and processing racism and discrimination. Throughout the analysis, focus was given to individual, family, community, institutional and structural factors which impacted Black women's lives, as well as the protective and risk factors which shaped their experiences. Analysis was performed with a systematic, iterative process supported by ongoing discussion of developing themes.

Dr. Hunte then presented this set of preliminary themes from the first three focus groups to the fourth focus group consisting of HBI staff and former HBI clients. Members of this focus group were asked to reflect on these themes and identify what resonated with them, what did not resonate, and what they thought needed to be deepened or contextualized. Themes from the fourth focus group were incorporated into the analysis.

Sherly Paul, an HBI nurse and nursing graduate student, joined the analysis process to develop the final set of themes and recommendations described below.

# Findings Section One: Racism and Black Women

HBI nurses, community healthworkers, and past and current clients who participated in this study all identify as Black women. Together they offered vivid descriptions of how they experienced racism within their communities, the medical system, and in the workplace. They talked at length about how this impacts them as people, as parents, and as professionals. As Black women they talked about stress at the rising racial tensions within Portland. Women talked about exposure to overt and subtle forms of racism.

Women's descriptions pointed towards the chronic presence of racism-related stress that ebbed and flowed through their lives as pregnant people, mothers, and professionals. A nurse shared, "*The other thing that's frustrating is that just being Black in America, it's almost like we always are in a position where we feel like we have to justify who we are and why we are."* Overt forms of racism included racial slurs from strangers and a need to protect themselves from unexpected racialized violence and discrimination. Subtle forms of racism included experiencing microaggressions such as being followed by clerks when they went to stores, being stereotyped as less qualified for their jobs, being treated as incompetent when engaging with institutions, encountering surprise or suspicion of their intelligence, and having their ability and right to parent questioned. Women talked at length about their Black children and concerns for their safety in regards to police brutality and in school settings. Staff discussed the compounding stress of supporting Black clients in crisis, being impacted by racism in their professional settings, engaging in anti-racism advocacy within the County and broader healthcare settings, and leaving the workplace encountering the realities of what it is to be a Black woman in the broader community.

*"It's not just low-income women that are dealing with the health disparities. It's people that are educated. Black women that are dealing with trying to climb the corporate ladder, trying to break through that ceiling, feeling that pressure, that stress, and then it affects their birth outcomes even more." – HBI staff*

*"The perception of who we are, internally and externally, are all over the place. From one end, we're hostile, we're angry, and overbearing, and then some other end we're nurturing, we're mothering, so it's all along the spectrum. It's all over the place. So you don't know what you're going to get when you encounter people." – HBI staff*

*"There's a lot of racist people on jobs. They don't want to get shunned on publicly by not hiring us. So they hire us and still treat us a certain type of way. I done seen it and I've gone through it. I actually got a settlement because of what I had to go through." – HBI client*

# Findings Section Two: Lessons for Healthcare Providers

**1. Racism is a chronic factor in Black people's lives**
Black women in Portland experience racism in multiple forms and in multiple domains of life - as individuals, as parents, and as workers**.** Racism is enacted against Black women in interpersonal and systemic ways: from frequent microaggressions and stereotypes, to cultural assumptions of inferiority and incompetence, to systematic denial of resources, and the institutional weaponizing of surveillance and punishment against Black families and communities. HBI clients repeatedly encountered the "strong Black woman" stereotype, and discussed how any perceived weakness exposes them to involvement with child welfare or law enforcement systems. They also reported healthcare providers doubting their ability to make reproductive health decisions.

These manifestations of structural racism strip Black women of their autonomy and threaten their basic rights to parent and to receive responsive, quality care. Such experiences of racism are part of what can be traumatic about pregnancy and childbirth; both HBI clients and staff identify these experiences as a fundamental barrier in the fight to keep Black families safe.

**How does HBI address this?** HBI works to help individuals recognize subtle and overt forms of racism in healthcare, and strategize responses to experiences of racism related to pregnancy, birthing and parenting. Doing this work in community and organizational settings also combats isolation and builds a positive sense of Blackness; clients report that their involvement with HBI reinforces a positive view of Black identity, which HBI achieves by using a strengths- and asset-based approach to Black parenting. Clients see HBI's work as a form of culturally responsive trauma informed care.

**Participant recommendations:** Women encourage their providers to openly acknowledge that racism is real and directly impacts physical health, mental health, and overall well-being. These conversations are necessary and welcome. Women want providers to offer them the quality care that is offered to their most favored patients.

**Researcher recommendations:** Providers must deliberately engage with the reality of racism if they are serious about holistic care. Fight systemic racism, not Black clients. Providers should routinely discuss racism within their respective institutions and critically examine policies, practices, and client outcomes. It is imperative that healthcare providers learn more about how systemic racism has, and continues to, impact Black people's access to and experiences of healthcare in the U.S.

*"I think just being Black in general, you're always going to be profiled. So it's just like, to be honest, it just seems like it never ends." – HBI client*

*"You feel this unspoken pressure" – HBI staff*

**2. Anti-racism advocacy is the critical work of public health and healthcare.**
Anti-racism advocacy within the medical system is fundamental to the Black community. Caring for health necessitates engagement with systems outside of healthcare, as these systems often actively harm Black people and withhold resources critical to their well-being. For example, racism related stress manifests within medical contexts and can require discrete medical attention, but also manifests and originates in systems related to housing, employment and child welfare. Anti-racism advocacy within these systems is just as important of a health intervention as is treating individual medical symptoms.

**How does HBI address this?** HBI addresses the systemic racism that impacts the health of Black people who can become pregnant. HBI engages in work to dismantle racism at the County, State, and Federal levels. HBI's advocacy across micro and macro levels is a core part of their service. HBI advocates for members of its community through the provision of culturally-specific supports including: Black nurses and community health workers; pregnancy and child birth classes; referrals to Black providers including doulas, therapists, and healthcare providers; holistic, community-based prenatal and postpartum care for over a year in clients' homes; and active participation in clients' engagement with the healthcare system. HBI teaches clients self-advocacy skills such as how to communicate and respond effectively to providers and those with institutional power. HBI provides education to clients about their rights and responsibilities within the various systems they encounter, including the healthcare, child welfare, and public education systems. HBI provides macro-level advocacy through policy change and training of healthcare and child welfare systems.

**Participant recommendations:** Continue and expand opportunities to discuss racism, its impacts, and advocacy for change for both individuals and the broader Black community. By addressing racism, people's lives improve.

**Researcher recommendations:** Advocacy is the medicine for client self-sufficiency, institutional responsiveness, and social change. Programs need to incorporate advocacy skills for clients at micro and macro levels. Healthcare institutions and providers should regularly seek education about the impact of non-healthcare systems on the health of Black women and families. They should integrate this knowledge when working with individual women and understand the necessity of holistic services, including advocacy on behalf of and alongside Black women. Because of the intensity of clients' need levels, HBI could consider hiring a full-time resource navigator dedicated to helping clients navigate various systems.

*"I was very confident with my first born son, but it's just when it came time, it was like, you're vulnerable, you're in a vulnerable state, and you just want the support, you want someone to be able to speak up for you if you need, if you're just too tired to do it for yourself." – HBI client*

*"Having Black nurses in the home is working. I think that has opened the doors tremendously, because not only are we teaching them how to advocate, but we're giving them almost permission to use their voice, and to know that you can affect change in your own life. This is how you can do it. Clients sometimes feel stuck. For example, with a care provider, and it's like, 'If you're not feeling happy about how you're being treated, you know you can change providers, right?' […] it's kind of just having that discussion, I think. Being able to bring education into the home about what's going on." – HBI staff*

**3. Black women need dedicated mental health supports.**

Racism is physically, psychologically and emotionally damaging. The "strong Black woman" stereotype is a harmful myth. Stress hormones related to experiencing racism age the body and weaken reproductive systems. Black women need dedicated mental health support. The pressure for Black women to *always* be strong makes it hard for Black women to say, "I just can't do this," and to be met with a caring response. Both HBI clients and staff describe how they "stuff", repress, hide, and intentionally do not acknowledge pain associated with racism-related stress.

**How does HBI address this?** HBI offers dedicated mental health support by having a Black mental health provider. Participants talk at length about valuing this provider and valuing her authenticity - she's personable, they feel like they belong with her, and they can talk through their issues and come up with solutions.

**Participant recommendations:** Develop and implement peer-led mental health programming; during focus groups, HBI clients reported feeling more connected to their peers, less mental health stigma, and more able to process difficult birth experiences with members of their own community. HBI must keep the Black mental health provider on staff!

**Researcher recommendations:** Support peer-led mental health programming by having a community health worker present to offer information and debunk medical myths and misconceptions. For medical providers, explicitly ask women how they are doing, and do so in a way that acknowledges the impact of structural racism on mental health and well-being. One example could be, "There's a lot going on in the world right now - how are you holding up? Can I be of assistance?" Finally, don't try to do everything in-house - this might not always be the best option for clients. Develop stronger networks with Black mental health workers, and actively increase the workforce capacity of Black people in the mental health field. Be prepared to refer clients to Black mental health workers. Ask, "Would you like to be referred to a culturally-specific provider?"

*"Honestly, I think that's what's lacking with the Black women. Is that there's no place for them to go and speak and not be judged. Knowing that they can sit in a room full of people that going through the same as that they're going through, and not be judged. Is something that we need." – HBI client*

*"Some of these clients didn't even know they were getting impacted by systemic racism, to be honest. They didn't even know that this could affect their birth outcome. Because I think, as a race, we've been conditioned to be resilient, because it's that or find a cliff to jump off. […] people have just dealt with it and not even realize that they were dealing with it. We go to the beauty salon and talk to our cousins. I think that's what people do. A lot of people never even consider mental health until we brought it up." – HBI staff*

*"I was surprised how many people were open to mental health, from my perspective of how I expected people to react. You still get those people who are like, "Oh, I'm fine." And they literally falling apart at the seam because of that mentality we have, that we're too blessed to be stressed, you know? But I'm surprised how many people be like, "Oh, yeah, refer me. I'll talk to someone." And probably, to me, that's like a light at the end, that we're finally starting to see that it's okay to go talk about our problems. The hairdresser can't really give you some really good therapy." – HBI staff*

**4. Expressing weakness or struggles to healthcare providers and asking for help - especially as it relates to mental health - subjects Black women to various forms of institutional control and punishment, including the child welfare system.**
Interactions with medical providers are a site of significant anxiety. Not talking openly with providers for fear of being judged or fear of becoming system-involved directly threatens one's health and ability to receive appropriate care.

**How does HBI address this?** Women report not being judged by HBI; this leads to clients feeling they can be honest with HBI workers, which can help providers address issues and needs that arise. HBI's Black mental health provider minimizes the need for clients to seek services elsewhere. Through prenatal and postpartum visits, HBI provides critical health and parenting information. HBI workers also directly advocate with social workers and medical staff to support a child staying with the parent. This reduces child welfare system involvement.

**Participant recommendations:** Women need to talk with providers without fear of being judged; they need medical providers to form a real relationship with them based on positive regard so that it's safe to talk about their needs. Participants recommend that HBI bring back the peer-led support groups to create a dedicated space for support, processing, and mutual aid. HBI staff want to be further integrated and valued within medical teams. Medical providers should recognize that HBI may already be working with a client on mental health concerns and should consult with HBI as a vital resource before involving the child welfare system.

**Researcher recommendations**: Implicit bias training, and specifically anti-Blackness training, would be beneficial. Healthcare providers should track child welfare involvement of Black people in their systems of care, investigate these trends, and respond to disparities.

*"Your blood pressures high, early child birth, low birth weights, or the mother gains a lot of weight. Because she's stress eating. You know? Not necessarily because she's eating for two, because she can't help but shovel it in because we're taught to keep it to ourselves basically." – HBI client*

*"You felt like I was incapable of taking care of my kids because I was sick. Why would you call DHS? So you trying to take them from me when you already seeing I was going through a struggle. I have a brand-new baby, and then you want to come and add on that stress. To me, you were being judgmental, to me that was being racist." -HBI client who was reported to child welfare*

*"People just stick their nose in your business because they don't know your life, but that's not for you to stick your nose in because unless I come to you and ask for that help or you to butt into my life without knowing what my life is." – HBI client*

**5. Medicalized birth trauma is pervasive and affects both individuals and communities.** Medicalized birth trauma is a pervasive experience for many Black women and Black communities. Vicarious trauma is experienced through poor birth outcomes for individual pregnant people and for other members of their community; Black people experience this vicarious trauma communally. For individual Black women, birth trauma can take many forms including: inadequate information about what might happen or is happening during labor; unanticipated moments in the birthing process; not being listened to by medical professionals; clashes between the desire to bring family into the experience and medical professionals not welcoming family; medical neglect; being alone; and negative feelings about the care they received.

**How does HBI address this?** HBI provides birthing classes in which they discuss key medical issues related to Black women's maternal health. They also discuss how to advocate for oneself to a doctor. HBI can also act directly as an advocate with women and their doctors. HBI provides recommendations and referrals to Black doulas. HBI creates a birth plan with clients and their providers. HBI provides a Black therapist to clients.

**Participant recommendations:** Women need dedicated space and resources for processing birth trauma, including peer support groups. Access to Black doulas should be expanded: women who accessed the services of a Black doula talked about how important this was for them. Providers should ask clients about previous birth trauma and how birth has been experienced within their community.

**Researcher recommendations:** HBI has previously hosted birth trauma and birthing related supports groups, and could do so again. In these groups, HBI could provide a community health worker, doula, or nurse to provide consultation around health-related topics and to counter medical myths and misconceptions.

*"I'm just pissed off at the systems and community as well. It may be just one experience with them, it may be 20 experiences for myself because I hear them all." – HBI staff*

**6. Distrust and disrespect hinder relationships within healthcare settings.**
HBI clients reported being the target of microaggressions and describe feelings of being exploited, lied to, and disbelieved. These experiences contribute to distrust and medical misinformation (including pregnancy-related myths about preventative prenatal care, contraception, and medical procedures). Black people are aware of the history of medical racism, and worry that involvement with medical providers can lead to entanglement with other systems. Women say that their intelligence is automatically questioned when they move into medical spaces. They encounter invasive questioning about the paternity of their pregnancies, their marital status, number of children, and drug use. Participants experienced healthcare providers as sporadic in their care and willingness to provide a full spectrum of options to them as pregnant people. Lack of trust makes it hard to accept medical information and recommendations. HBI staff have to navigate similar dynamics of distrust with medical providers; they feel frustrated and betrayed when members of the medical establishment profess their understanding and partnership with HBI only to fail to respond appropriately to clients.

**How does HBI address this?** HBI is continuously learning from its community, knowing that the Black community is not monolithic. HBI uses its Community Action Network and leadership network to hear from Black parents about what they need and to incorporate their voices in decision making and advocacy. Racial and gender concordance helps develop trust. Clients feel like HBI workers understand them and have their best interest in mind; it allows for a more immediate productive and trusting relationships. Women more readily believe medical information because it comes from providers who share some of their intersectional identities as Black women. Through its birth classes, breastfeeding classes, and prenatal and postpartum visits, HBI talks with pregnant peoples about their prenatal and birth options, how to advocate for these options with healthcare providers, and how to heal during the postpartum period.

**Participant recommendations:** Providers need to address racist assumptions they may hold of Black women and community, and consider how these assumptions appear in healthcare settings at all levels. Positive regard and attentiveness are necessary for relationship building between providers and clients. Learn about Black people as individuals and as a group. Believe in the autonomy and ability of Black clients to thrive. Partner with them to work towards the best possible outcomes.

**Researcher recommendations: I**mplement implicit bias and anti-Blackness training. Evaluate Black people's experiences and interactions with medical staff; track why Black women do or do not continue with services. Structurally address ways of strengthening provider and client collaboration.

*"Even before you're pregnant. You may have had a doctor or some type of medical professional who may have not listened to you. And so, that trauma is carried on throughout your pregnancy as well." – HBI client*

*"They treat us as if we're uneducated." – HBI client*

*"It's not to say that a white person can't come and help a Black person, but the way that they come in trying to help a Black woman is where it goes wrong. I've run into some white people that were very on it. They didn't care what you were, because they was a loving person their self. But if you get someone who has that attitude of, "This is just my job and I don't really care, I make my money whether I help this person or not," then it goes left […] As Black women, we like to feel secure. We like to feel that. We don't want you coming into our life, telling us what we are, who we are. We already know who we are, we just need help or a little understanding." – HBI client*

**7. Black women take a holistic view of pregnancy, birthing, and parenting; these things are embedded in wider familial, community, and societal contexts.**
Physical health during pregnancy and birthing is simply one important aspect of keeping children and families safe. Systemic racism impacts many facets of women's lives beyond the medical domain. Black women talk about worries for their children in the education system, their children experiencing police brutality, the difficulties of housing insecurity, and general concerns about how to keep children safe and healthy in the community. The cumulative effects of these experiences are significant and the pregnancy experience cannot be separated from this. To not recognize these stressors and the long-term, holistic needs of families is itself a threat to safety and well-being. Furthermore, for Black women, pregnancy and parenting supports often go beyond the nuclear family; interventions need to support a variety of actors.

**How does HBI address this?** HBI uses a holistic approach. It directly addresses racism; builds women's ability to advocate for themselves and their families; strengthens community among women through community building events and the deliberate inclusion of children and partners in HBI's work; and connects women to resources to address specific needs like housing and domestic violence care. HBI believes in the Black family and supports people to parent. This challenges the racist assumption that Black people are not fit parents.

**Participant recommendations:** Providers must understand women and their health within larger contexts. Relationship building between providers and clients is a crucial aspect of healthcare. Providers should discuss clients' holistic needs and have information and resources at their disposal to help meet these needs. Women also identified how systemic institutional barriers undermine family cohesion and push Black men away from their families and communities. Transforming policies related to male involvement in the home post incarceration, while the family is using social welfare benefits, and around child support payments is an opportunity for systemic advocacy.

**Researcher recommendations:** Medical providers need to understand and discuss racism, health, and safety from a holistic perspective beyond discrete medical moments and medical contexts. Women's access to long-term, stable resources is a critical component of a holistic view of health and safety; thus, women would benefit from a dedicated resource navigator. Make deliberate outreach efforts to Black communities to let them know you exist and want to work with them. Acknowledge where your processes may exclude other members of the Black family. Invite key members of pregnant people's communities to support pregnancy and postpartum care.

*"For me, I was going to say it's just like there's this heaviness all the time, whether it's just going to the store, or being in the work environment, or even with your home, and your family … I've had this conversation a lot lately with my boys, about I will never as a black woman, black mother, I will never be able to stop worrying about you. And I have a daughter, too, but I don't worry about her in the same way that I worry about the boys, and so it's that all of the time, just that layer." – HBI staff*

**8. Culturally-specific knowledge and services are necessary in healthcare to address racism.**

Black people who can become pregnant need access to culturally-specific services and providers across the healthcare spectrum, but are often dismissed when they ask for this within mainstream institutions. Both HBI staff and clients recognize the unique benefits provided by shared racial identity in work related to pregnancy, birthing, and parenting. Blackness as a shared identity and experience means that Black providers intimately know the racism faced by Black women and their families. Shared experiences of racism facilitate some level of immediate trust; women can assume that Black providers know the threats of system involvement and the need for holistic, long-term supports for children and families. This means clients do not have to fight for this shared knowledge between themselves and their providers; they can get straight to the work at hand.

**How does HBI address this?** HBI is fundamentally a culturally-specific organization that provides Afro-centric services. In HBI's model, Black community health workers and nurses work with Black clients. This racial concordance is a pillar of HBI's direct service delivery and the administrative team. The societal context of anti-Black racism informs HBI's approach to services and guides explicit efforts to help Black women navigate mainstream healthcare institutions. HBI is consciously antiracist in engaging clients in conversation about systemic racism, builds community among Black women and families, and advocates within a variety of systems to increase awareness and responsiveness to the unique needs of Black women.

**Participant recommendations:** HBI clients want to see more Black providers within mainstream healthcare institutions, and they want those institutions to be more culturally aware in general. Furthermore, they want medical providers to take them seriously when they ask for culturally-specific services and providers. Hire and retain more Black medical providers and provide an up-to-date registry of existing Black providers along the healthcare spectrum.

**Researcher recommendations:** Mainstream healthcare institutions need to identify culturally-specific resources that exist so they're ready to refer clients. Healthcare providers must take the onus of responsibility for incorporating culturally-specific care in the medical experience. This should be one of the many options offered to women, rather than women having to advocate for themselves and ask for it.

*"HBI as a whole has given me a whole other understanding of what it is to be a Black woman" – HBI client*

**9. Stronger collaboration between HBI and medical providers is necessary.**
Clients need HBI and medical providers to work closely together. This means deeper relationship building and integration of HBI within medical teams. HBI wants to be recognized as a critical resource. Just as HBI is willing to show up and do the work, HBI expects medical providers to be actively working on their own internal practices as it relates to bias and various institutional and cultural protocols that are purportedly colorblind but in reality are embedded with assumptions of Black inferiority. Staff are exhausted by the experience of advocacy and the ways that medical practitioners fail to maintain commitments to anti-racist behavior with clients.

**How does HBI address this?** HBI conducts trainings with providers across medical systems about Black maternal health and cultural competency. HBI works directly with mothers and provides monthly prenatal and postpartum visits; HBI can also accompany women to appointments and be a resource for postpartum recovery. HBI is flexible in how they can be utilized across the spectrum of birthing and parenting experiences. It intentionally cultivates ongoing relationships with healthcare systems.

**Participant recommendations:** Staff note that some clients work more closely with their HBI worker than with medical providers; those providers need to be aware of this collaboration. Doctors could ask about women's relationship with HBI: "Are you working with HBI? How would you like me to work with them?" HBI staff themselves are directly asking and telling medical providers: "Integrate us! We are most effective when we are on the same team and working together."

**Researcher recommendations:** Healthcare institutions and medical providers should welcome HBI as part of interdisciplinary continuity of care teams and intentionally work to integrate HBI when providing care to pregnant and parenting women.

# Findings Section Three: Lessons for HBI and Multnomah County Public Health

**1. Anti-racism advocacy is critical.**
One of HBI's most powerful interventions is its anti-racism advocacy on behalf of and alongside Black women. HBI models and teaches advocacy skills to clients in terms of navigating interactions with the medical system, recognizing disparate treatment when it occurs, and interrupting this violence. Clients and staff alike shared moving examples of how HBI achieves what we believe is an under-recognized benefit of HBI involvement.

**Researcher recommendations:** Emphasize HBI's advocacy activities as a critical public health intervention in funding proposals and promotional materials. HBI could further strengthen its advocacy component through educating clients about their rights including parental rights, patient rights, and housing rights in pamphlets or other written materials. Because HBI clients often need advocacy in the arenas of housing, job training, mental healthcare, and childcare assistance, HBI could consider dedicating one FTE to a resource navigator to address these needs. Additionally, Multnomah County could support HBI through designated funds that address these issues specifically for HBI clients. Finally, HBI could track client outcomes (e.g., mental health child welfare system involvement) and compare them to the outcomes of programs do not operate from a culturally-specific paradigm. For example, HBI could evaluate how many child welfare-involved HBI clients have reduced contact with the child welfare system after their participation in HBI, which could demonstrate the impact of HBI's culturally-specific approach across multiple systems of care.

*"What's working is just having us as a program, having Black nurses in the home is working. I think that has opened the doors tremendously, because not only are we teaching them how to advocate, but we're giving them almost permission to use their voice, and to know that you can affect change in your own life. This is how you can do it. Clients sometimes feel stuck, for example, with a care provider, and it's like, "If you're not feeling happy about how you're being treated, you know you can change providers, right?" "Oh. Well ... " And it's kind of just having that discussion, I think. Being able to bring education into the home about what's going on." – HBI staff*

**2. HBI's medical partnership-building changes systems.**
Black pregnant people and families will continue to benefit from stronger collaboration between HBI and community partners. HBI staff are well positioned to be vital members of interdisciplinary continuity-of-care teams across local medical systems. HBI has successfully nurtured a relationship with nursing through presenting its model and advocating for cultural and institutional change in nursing schools.

**Researcher recommendations:** Continue to expand the reach of HBI throughout the Portland-metropolitan area and strengthen relationships with community partners, including social work, public health, and community health worker educational programs. Consider expanding community partnerships through increasing outreach to professional Black women. This may be achieved through connecting with local Black women's organizations, as well as through a direct marketing campaign that explains how Black maternal and child health disparities span socioeconomic position and education.

*"I'd also like for us to be in more than just Multnomah County. ... we know we're moving all over Clackamas and Washington" – HBI staff*

**3. HBI is simultaneously part of the Black community and the public healthcare system.** HBI's work requires a delicate balance between two practice frameworks: holistic, community-oriented Reproductive Justice and professionalized medical health services. HBI is a part of both the healthcare system and the Black community. Historically, the healthcare system has contributed to unethical and harmful behavior towards Black people. Thus, HBI is attached to a broader system that has harmed and continues to harm to Black individuals and communities. This connection to the broader healthcare system can impede HBI's mission to positively impact the health and safety of clients and the broader Black community. Shared racial and gender identities, and shared membership in the broader community, helps HBI gain trust and legitimacy with clients - especially compared to traditional medical providers. Yet, the boundaries between HBI staff as part of the community and also a service provider can be challenging for clients. Clients report genuinely enjoying their working relationships with HBI staff, but they also recognize these are healthcare professionals who are part of a larger system. This results in connection and integration alongside distance in these relationships.

**Researcher recommendations:** Emphasize messaging to clients and the broader community about the holistic and community-based nature of Reproductive Justice. Acknowledge that boundaries and roles of Black women serving Black people within the same community might be slippery sometimes, and implement policy where appropriate to manage this complexity.

*"We experience a lot of what our families experiencing. Some of our families are in this program. I have family members in the program, so I hear it, and I see it, and I go through it myself." – HBI staff*

**4. HBI staff are impacted by racism-related stress.**
Being Black women serving distressed Black communities exposes HBI workers to cumulative racism-related stress, as their professional lives are geared towards addressing the systemic issues that impact their personal lives. HBI staff at times note that they are undervalued, and that their intelligence and professional contributions are undermined. These are forms of racism. In addition, HBI must constantly justify the relevance and importance of their work to a variety of stakeholders, including medical providers and the County. HBI staff are passionate about their work, but factors like low quality office space and repeatedly competing for resources within the County can bring down morale. Sometimes HBI staff feel like they face the same uphill battles as clients in the fight against structural racism. All of these dynamics take a toll on HBI staff's physical and mental health.

**Researcher recommendations:** Implement structural changes to support staff such as higher quality office space and KSA designation for HBI staff to recognize that Black women bring a specific and unique skill set in working with other Black people. Offer additional time and resources for staff mental health and wellness; staff deeply appreciate time spent with the on-site mental health therapist and would like additional supports. Finally, to relieve pressure on individual programs to advocate for their existence, the County can better explain and widely communicate its racial equity funding priorities rather than putting the onus on individual programs to justify their existence.

*"Resources. And I say that in a big way. Not just resources for the client, but resources for us as ability for us to have more nurses, ability for us to have better pay. Because we have to leave our own personal stress outside. So when I think about student loans, that's a stress for me. So resources to make culturally-specific community health nursing something that's attractive, because a lot of the time, people don't come here because if you work in a hospital you get paid $10 more per hour than you do here." – HBI staff*

**5. Cultivate community care practices within the HBI community**

Intentional work around issues of conflict resolution, trauma, healing, and the collective protection of privacy will further strengthen the HBI community. As a community and collective endeavor - and one where significant overlap exists between personal and professional lives - extra care must be taken within the HBI community to ensure privacy and healthy boundaries. Clients may know each other inside and outside of HBI settings. Developing confidentiality protocols and community agreements could help address conflict resolution needs within the community. Distinct challenges to privacy also emerge as a result of HBI's current office space configurations.

**Researcher recommendations:** Consider bringing back peer support groups. Develop a conflict resolution protocol and community agreements for engaging with one another, including the identification of healthy boundaries to hold overlapping community memberships and relationships. Such protocols and agreements should emphasize respecting one another's privacy, holding each other's narratives as sacred and important, and recognizing the community-level dynamics of information sharing; this may be especially important for family events. Finally, consider formalizing HBI's Afrocentric trauma-informed care approach for working with Black pregnant people and community.

*"It would be nice if our space was as therapeutic as the county wants us to be." – HBI staff*

*"Whether you're a client or a supervisor, or a home visitor or a staffer, it's the same community inside and out. We're all experiencing the same thing. I'm not the one giving birth, I'm processing birth trauma too because losing the child … it's like what did I do wrong? Did I teach them incorrectly? I experience it the same, not the same. I experience it as well basically." – HBI staff*

*"I love it. I love the people. It's the best work out there, and it's like I do. I enjoy my job. But like what she's saying, it's a lot." - HBI staff*

# Final Takeaways

Reproductive Justice is “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (SisterSong, n.d.). It seeks to address and transform reproductive oppression: the policies, cultural beliefs, and systemic violence that limits individual control over our bodies, threatens our lives, harms our families and undermines communities. Improving Black maternal and child health requires a commitment to the reproductive autonomy of Black people who can become pregnant, and a willingness from individuals, communities, and systems to work alongside us for the health and well-being of ourselves, families, and communities. It requires that health systems shift damaging protocols that both obscure the needs of Black pregnant people, while at the same time magnifies our vulnerabilities and punishes us for experiencing the real impacts of systemic racism. Healthy Birth Initiatives is an asset-based, culturally-specific program that works alongside Black pregnant people to promote our health, well-being, and autonomy. The work of Reproductive Justice is not easy, and it challenges systems to check assumptions and reimagine systems of care. Key takeaways from this study include:

- Racism-related stress is the symptom of chronic, structural racism. Dismantling structural racism must be a public health priority.
- Systemic racism within the healthcare system places HBI stakeholders in binds that make Black people vulnerable to harm and medical neglect.
- Racism-related stress affects health and pregnancy through perpetuating social isolation, mental health stigma, health misinformation, and compounds distrust of health systems.
- Black people who can become pregnant need support to mitigate racism throughout the perinatal system of care.
- Anti-racism advocacy, advocacy skills training, and providing space to process racism are powerful public health strategies.
- Providers who are also members of their client community need structural and mental health support.
- Culturally-specific and trauma-informed approaches should focus on both client populations and staff.

# References


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

Alhusen, J.L., Gross, D., Hayat, M.J., Rose, L., & Sharps, P. (2012). The role of mental health on material-fetal attachment in low-income women. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 41*(6), E71-E81. https://doi.org/10.1111/j.1552-6909.2012.01385.x

Collins, J.W. & David, R.J. (2009). Racial disparity in low birth weight and infant mortality. *Clinics in Perinatology, 36*(1), 63-73. https://doi.org/10.1016/j.clp.2008.09.004

Collins, J.W., David, R.J., Symons, R., Handler, A., Wall, S.N., Dwyer, L. (2000). Low-income African-American mothers' perception of exposure to racial discrimination and infant birth weight. *Epidemiology, 11*(3), 337-339.

Collins, P. (1989). The social construction of Black feminist thought. *Signs: Journal of Women in Culture and Society, 14*(4), 745-773.

Ely, D.M. & Driscoll, A.K. (2019). Infant mortality in the United States, 2017: Data from the period linked birth/infant death file. *National Vital Statistics Reports, 68*(10), 1-20.

Escarne, J.G., Atrash, H.K., de la Cruz, D.S., Baker, B., & Reyes, M. (2017). Introduction to the Special Issue on Health Start. *Maternal and Child Health Journal, 21*(Suppl 1), 1-3. https://doi.org/ 10.1007/s10995-017-2404-y

Gilmore, R.W. (2007). *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* University of California Press.

Jackson, F.M. (2007). *Race, stress, and social support: Addressing the crisis in Black infant mortality*. Joint Center for Political and Economic Studies Health Policy Institute. https://www.faithhealthtransformation.org/wp-content/uploads/2015/11/Courage-to-Love-Report.pdf

Jones, C. P. (2018). Toward the science and practice of anti-racism: Launching a national campaign against racism. *Ethnicity & Disease, 28*(Suppl 1), 231-234. https://doi.org/10.18865/ed.28.S1.231

Jones, C.P. (2020, June 12). *Why racism, not race, is a risk factor for dying of COVID-19.* Scientific American. https://www.scientificamerican.com/article/why-racism-not-race-is-a-risk-factor-for-dying-of-covid-191/

Kleinman, J.C. & Kessel, S.S. (1987). Racial differences in low birth weight. *New England Journal of Medicine, 317*(12), 749-753. https://doi.org/10.1056/NEJM198709173171207

Lu, M.C. & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life course perspective. *Maternal and Child Health Journal, 7*(1), 13-30. https://doi.org/ 10.1023/a:1022537516969

Lu, M., Highsmith, K., Cruz, D., & Atrash, H. (2015). Putting the 'M' back in the Maternal and Child Health Bureau: Reducing maternal mortality and morbidity. *Maternal and Child Health Journal, 19*(7), 1435-1439. https://doi.org/10.1007/s10995-015-1665-6

March of Dimes (2015, Feb. 27). *Racial and ethnic disparities in birth outcomes.* March of Dimes. https://www.marchofdimes.org/March-of-Dimes-Racial-and-Ethnic-Disparities_feb-27-2015.pdf

Matthews, T.J., MacDorman, M.F., & Thoma, M.E. (2015). Infant mortality statistics from the 2013 period linked birth/infant death data set. *National Vital Statistics Reports, 64*(9), 1-30.

Multnomah County (2020). Health Birth Initiatives. https://multco.us/children-and-family-health-services/healthy-birth-initiative

Petersen, E.E., Davis, N.L., Goodman, D., Cox, S., Syverson, C., Seed, K., Shapiro-Mendoza, C., Callaghan, W.M., & Barfield, W. (2019). Racial/ethnic disparities in pregnancy-related deaths -- United States, 2007-2016. *MMWR Morbidity and Mortality Weekly Report, 68*(35), 762-765. https://doi.org/ 10.15585/mmwr.mm6835a3

Roberts, D. (2017). Foreward. In L.J. Ross, L. Roberts, E. Derkas, W. Peoples, and P.B. Toure (Eds.), *Radical Reproductive Justice: Foundation, Theory, Practice, Critique.* Feminist Press.

Ross, L.J. (2017). Introduction. In L.J. Ross, L. Roberts, E. Derkas, W. Peoples, & P.B. Toure (Eds.), *Radical Reproductive Justice: Foundations, Theory, Practice, Critique* (pp. 11-34). Feminist Press.

Rosenberg, L., Palmer, J.R., Wise, L.A., Horton, N.J., & Corwin, M.J. (2002). Perceptions of racial discrimination and the risk of preterm birth. *Epidemiology, 13*(6), 646-652. https://doi.org/10.1097/00001648-200211000-00008

SisterSong (n.d.). Reproductive Justice. https://www.sistersong.net/reproductive-justice

Utsey, S.O., Belvet, B., Hubbard, R.R., Fischer, N.L., Opare-Henaku, A., Gladney, L.L. (2013). Development and validation of the prolonged activation and anticipatory race-related stress scale. *Journal of Black Psychology, 39*(6), 532-559. https://doi.org/10.1177/0095798412461808

Wilkinson, S. (1998). Focus group methodology: A review. *International Journal of Social Research Methodology, 3*(1), 181-203. https://doi.org/10.1080/13645579.1998.10846874