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ENVISIONING MATERNAL HEALTH PRACTICE THROUGH ANTIRACIST FEMINISMS

A Thesis

Presented in

Partial Fulfillment of the

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Master of Arts

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BY

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Abstract

Health care systems in the United States perpetuate disturbing maternal health inequity. Rampant maternal health disparities, including preterm births, low birthweight, maternal and infant mortality, and maternal morbidities, disproportionately affect birthing parents of color, queer parents, and low-income parents in comparison to white, cisgender, heterosexual, financially-privileged parents. My master's thesis examines how hegemonic cultural ideology surrounding motherhood in the United States (rooted in white supremacist, cis-hetero-patriarchal, and classist standards of mothering and birth) affects health care practices and provider biases, as well as directly contributes to maternal health disparities experienced by marginalized birthing parents. Furthermore, my thesis examines how antiracist feminisms, including tenets of reproductive justice, provide foundational, theoretical frameworks for health care practitioners to ground and transform their care practices, directly combat maternal health inequity, and further the work of maternal health care and reproductive justice.

Keywords: maternal, health, disparities, antiracist, feminism

Introduction

The United States is not shy about boasting its power. The nation reigns as a globalizing empire, remaining one of the wealthiest, most technologically-advanced countries in the world. Dominant culture in the United States prioritizes the family as motivation for strenuous work and outperforming competition in order to provide opportunities for improved livelihood and status for one's children. As a society, we deem our children and our families as our greatest accomplishments and our greatest assets. Sloganeering children as our future labels reproduction as an investment in maintaining the nation's superiority in human advancement. It is profoundly disturbing, however, that society in the United States politicizes the futures of our children while actively disenfranchising an essential population: the ones who birth and raise these children.

Despite the wealth of financial and technological resources within the United States medical industry, this nation is among the worst in which to give birth. Rampant maternal health disparities exist among birthing parents, particularly at the intersections of race, class, and gender. Maternal health disparities in the United States, "range from preconception to postpartum and include inequities in access to family planning, prenatal and obstetrical care services, newborn screenings, low birth weight, preterm birth, birth defects, infant mortality, and maternal mortality."¹ Furthermore, addressing these disparities lies in, "the complexity of root causes in [their] production."² When discussing maternal mortality, access to quality reproductive health services, and inequities in maternal and infant health, these discussions cannot occur without addressing the systemic racism, heteropatriarchy, sexism, and classism that perpetuate the existence of these disparities.

¹ Tina Bloom, "The Great Asset: Addressing Maternal-Child Health Disparities in the United States," *Western Journal of Nursing Research* 33, no. 4 (2011): 483-485, pg. 483.

² Bloom, "The Greatest Asset: Addressing Maternal-Child Health Disparities in the United States," pg. 484.

This master's thesis examines racist, sexist, heteropatriarchal, and classist ideology of motherhood and the family in the United States, as well as identifies how such ideas impact maternal health disparities. Analysis of ideology and the root causes of maternal health disparities throughout this thesis is done through antiracist feminist frameworks proposed and studied by predominantly Black, women of color, and queer feminist scholars and activists. Antiracist feminist frameworks actively challenge the institutionalization of whiteness, heteropatriarchy, and classism within United States society. Antiracist feminisms also serve as a contextualizing lens when observing U.S. macrosystems and the corresponding effects on the individuals within those macrosystems, particularly those existing on the margins of society. Antiracist feminisms, including tenets of reproductive justice, challenge and dismantle white, cis-heterosexual, classist standards of giving birth and parenting, which cause extensive harm to parents who are not white, cisgender women, as well as their children. Moreover, understanding and utilizing antiracist feminisms, particularly through the lens of reproductive justice, furthers the reproductive justice principle that, "all people [should] have the economic, social, and political power and resources to make healthy decisions about their lives. [This] includes the right to have or not have children and focuses on personal bodily autonomy and living in safe and sustainable communities."³

The purpose of this research is for all health care workers, yet particularly those who hold racially- and gender-privileged identities, to strengthen understanding on why parents who are not white, cisgender women experience disturbing maternal health disparities. Moreover, this understanding may influence the necessary micro and macro level transformations within health care practice and culture to reduce maternal health disparities. Transformations in everyday

³ Dána-Ain Davis, *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*, (New York: New York University Press, 2019), pg. 15.

practices, such as how providers interact with and understand the needs of marginalized patients, to macro level policies, like how providers advocate for improved patient care, are vital components in reducing maternal health disparities. Health care practitioners and health service workers encounter, and even experience, these health disparities in different capacities depending upon one's positionalities. In other words, health care workers and patients interact with the United States health care system quite differently, depending on their racial, gender, sexual, and class identities. While we all experience the inequities of a for-profit, capitalist health care system, my purpose in conducting this research is to highlight the disproportionate inequities experienced by marginalized communities. Furthermore, as a white, cisgender, economically- and educationally-privileged, able-bodied woman, I call upon other white, privileged health care workers to examine their own privileges and identities, recognize how their identities inherently influence their health care practice, and consider what transformations we may make within ourselves and our practice to combat these inequities.

Health care providers and health service workers are impacted by the prevalence of systemic oppression within the health care system. This research is important for all health care practitioners and health service workers who work with marginalized patient populations, yet particularly so for those with privileged identities. Moreover, this thesis addresses the following questions:

- 1.) How does hegemonic cultural ideology around motherhood in the United States directly impact maternal health disparities seen among birthing parents of various races, classes, and genders?

2.) How do antiracist feminisms, including reproductive justice frameworks, examine maternal health disparities in the United States and what do feminist scholars suggest for eliminating such disparities?

3.) How can white, privileged people in health care and social service fields mindfully apply antiracist feminist frameworks in their everyday practices, in order to address maternal health disparities and advocate alongside patients for improved care?

I conduct this research to emphasize and highlight established theoretical knowledge on maternal health disparities. Scholars and activists, particularly within movements for reproductive justice, already provide ample material for understanding what ideas reinforce oppressive attitudes about birthing parents and their families, as well as how antiracist feminist-based practices may reframe these ideas and provide theoretical grounding for transforming maternal health practice. I utilize and apply this scholarship to ground four primary implications for health care practice, which are discussed in the last section of this thesis.

As a white woman, it is important to me that I properly credit the feminist and reproductive justice theories from which I draw knowledge (largely those from Black feminists), so as to not appropriate these ideas as my own when discussing implications for health care practice. I ground my practice implications in the established ideas and theories of predominantly women of color and queer feminists. Through my research, I stress the importance of mindful care for birthing parents, as well as the future of feminist and social justice practice in transforming patient interactions and advocacy while working within the United States' inherently oppressive health care system.

Significance of Thesis

My motivation for creating this thesis is deeply personal. I connect with birthing parents and mothers every day, personally and from a distance; and their struggles impact me. I see new mothers conflicted on how to raise their babies by their wishes versus societal expectations. I listen to experienced mothers reminisce how they resisted personal insecurities and cultural pressures to still raise well-rounded children. I see mothers experience painful, isolating childbirths. I witness mothers experiencing the stigmatization of not being able to conceive, as well as people being shamed for not conceiving. I read of mothers whom this country refuses to care for socially and economically, yet their dedication to and love for their children remains unparalleled. Within each story, I see injustice; but I also see beautiful resilience and power. Furthermore, it is important that I recognize mothers and birthing parents who are not cisgender women, including transgender and nonbinary folks. A mother, or birthing parent, does not equate a cisgender woman; a birthing parent does not encompass a single identity or definition, nor does a family.

As a white, cisgender woman of child-bearing age, this research prompts me to ponder my future familial status. As a graduate student, this research motivates me to advocate for birthing parents by emphasizing the feminist frameworks that have not only dismantled and restructured my knowledge of racism, patriarchy, and reproductive justice, but have also founded and led social and cultural movements that influence justice for birthing parents, particularly Black, brown, queer, and low-income parents. Everything I currently know and everything I continue to learn about reproductive and maternal health justice comes predominantly from the work and lived experiences of Black, brown, and queer feminists, which in turn influences how I exist as a white person in society and as a future social worker. I must credit and acknowledge

the scholars, professionals, clinicians, activists, and everyday people who, whether intentionally or not, educate my practice as a social worker and student of feminist theories. Black and brown people in the United States have been protecting themselves and their communities, as well as struggling for reproductive and maternal health justice since the founding of this country, and it is long overdue that practitioners of privilege join as co-strugglers in this movement for dignity, equity, and liberation. The often-fatal injustice experienced by birthing parents in this country is disturbing and inhumane. We must do better as practitioners and as people because birthing parents deserve and have always deserved better.

The gender, class, and racial injustices experienced by birthing parents are stark. In the United States, “infants of [Black] mothers die of causes associated with low birth weight at a rate four times the rate for white infants.”⁴ Furthermore, “Black non-Hispanic women die [more than three times] more often due to direct or indirect obstetric causes than white non-Hispanic women.”⁵ The weight of this injustice rests on human lives, particularly those whose lives are already marginalized and disrespected within every facet of society. Black birthing parents experience the most significant impact of these injustices, with other parents of color and parents of lower socioeconomic status also experiencing harm at highly disproportionate rates. Health care institutions are powerful systems in U.S. society, directly influencing the physical and mental health of people birthing and raising new generations of citizens. Systemic racism, misogyny, heterosexism, and classism within health care institutions contribute to maternal health disparities across races, classes, and genders. Therefore, transforming the practices and

⁴ Jonathan B. Kotch, “Chapter 6: Mother and Infants,” in *Maternal and Child Health: Programs, Problems, and Policy in Public Health*, (Burlington, MA: Jones & Bartlett Learning, LLC, 2012), pg. 6.

⁵ Kotch, “Ch. 6: Mothers and Infants,” pg. 9.

cultural socialization of health care and social service professionals is a main goal of my thesis and a key component to resisting oppression and minimizing health care disparities.

Birthing parents experiencing often fatal mistreatment at drastic rates is fundamentally wrong and inhumane, yet this proclamation is not unique to me as the author of this thesis. Reproductive justice scholars and activists have, for decades, been calling attention to and leading movements toward reproductive health liberation, as well as the end of systemic racism and oppression within reproductive and maternal health care. Here I emphasize the work of reproductive justice activist and professor Dána-Ain Davis, a prominent voice in reproductive justice scholarship. Her book, *Reproductive Injustice*, “explores how medical racism...influences medical encounters in the United States, particularly as it relates to Black women’s reproduction.”⁶ Davis also heavily discusses the conceptual framework of obstetric racism, which, “sits at the intersections of obstetric violence and medical racism. [Obstetric racism] is the mechanisms and practices of subordination to which Black women and people’s reproduction are subjected that track along histories of anti-Black racism.”⁷ Frameworks such as obstetric racism and the work of academics like Davis are scholarly precedents that inspire the work of this thesis.

Furthermore, Davis proclaims that, “to move closer to reproductive justice, we must address medical racism”⁸ as well as intersecting sexism, heteropatriarchy, and classism that continually oppress marginalized birthing parents. One’s race, gender, class, sexual identity, citizenship status, etc. should not influence whether a parent welcomes their child safely and

⁶ Davis, *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*, pg. 8.

⁷ Gwendolyn Wallace and Roberto Sirvent, “Health Justice and Black Liberation: Dána-Ain Davis,” Published by PopularResistance.org, October 18, 2020, Accessed June 25, 2021, <https://popularresistance.org/health-justice-and-black-liberation-dana-ain-davis/>

⁸ Davis, pg. 206.

with dignity. As a society and as institutions of medicine and care, we must do better as practitioners, clinicians, and human beings because birthing parents deserve better than the treatment they are currently receiving. Reproductive and maternal health justice is not a privilege for the powerful: It is a human right. My research upholds this ideal, as well as emphasizes reproductive justice scholarship that has advocated for this ideal throughout the past three decades.

The significance of this thesis is that it draws concepts and strategies from antiracist feminist theoretical frameworks, including tenets of reproductive justice, that practitioners may apply in transforming their maternal health practice and in resisting whiteness, racism, classism, and heteropatriarchy within health care and social service institutions. Author Leela Fernandes provides a reframing for health care work that is instrumental in producing the ideals of this thesis: Health care professionals must recognize the powerful positionalities their careers provide them, and rethink their professions, “as more appropriately a form of labor and service than in terms of achievement.”⁹ Reframing health care work as social justice work through antiracist feminisms provides opportunities for health care professionals of both physical and social realms of health to transform their work into compassionate, culturally-humble, equitable, and mindful practice. Additionally, incorporating principles of reproductive justice into maternal health practice reinforces this reframing of health care work as social justice work, for a key principle of reproductive justice is, “reproductive rights embedded in a human rights and social justice framework.”¹⁰ As practitioners working within a for-profit health care system, health care

⁹ Leela Fernandes, *Transforming Feminist Practice: Non-violence, Social Justice, and the Possibilities of a Spiritualized Feminism*, (San Francisco: Aunt Lute Books, 2003), pg. 57.

¹⁰ Lorretta Ross, “The Color of Choice: White Supremacy and Reproductive Justice,” Retrieved from https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=2K2QA27B, Accessed June 23, 2021, pg. 1.

workers are implicitly and explicitly impacted by systems, policies, and medical culture designed to limit patient-centered care and prioritize the efficiency of churning profits from medical care.¹¹ Therefore, addressing systemic oppression with those who experience its impacts, and benefits, as care providers is significant not only for the advocacy of patients, but also for the progression of health care within greater society.

Feminist scholars support the notion of grounding clinical health and social service practice in social justice and anti-oppression frameworks; this notion is central to my research and its implications for health care practice. According to Bartoli et al.:

“Feminists of color have written extensively about moving from an additive model of [racial and multicultural knowledge] to one of intersectionality, which ‘emphasizes the interlocking effects of race, class, gender, and sexuality, highlighting the ways in which categories of identity and structures of inequality are mutually constituted and defy separation into discrete categories of analysis.’”¹²

Diversity and multicultural education within societal institutions, like health care, often fails to move beyond the focus on interpersonal incidents of racial and gender oppression to the systems and structures within our society that perpetuate white supremacy, heterosexism, and other forms of oppression. In other words, “the dialogue about race within [clinical health and social service] programs must extend beyond basic multicultural knowledge and ask [practitioners] to become change agents and social justice advocates combating racism on individual and systemic levels.”¹³ My research enters this conversation as a tool for health care practitioners to educate

¹¹ Louise Marie Roth and Megan M. Henley, “Unequal Motherhood: Racial-Ethnic and Socioeconomic Disparities in Cesarean Sections in the United States,” *Social Problems* 59, no. 2 (2012): 207-227.

¹² Eleonora Bartoli, Keisha L. Bentley-Edwards, Ana Maria Garcia, Ali Michael, and Audrey Ervin, “What Do White Counselors and Psychotherapists Need to Know About Race? White Racial Socialization in Counseling and Psychotherapy Training Programs,” *Women & Therapy* 38, no. 3-4 (2015): 246-262, pg. 248.

¹³ Bartoli et al., “What Do White Counselors and Psychotherapists Need to Know About Race...,” pg. 252.

themselves, through antiracist feminisms, on systemic oppression within maternal health care practice, as well as deeply reflect on how they present themselves in their practice and what biases they may be perpetuating in their work with marginalized patients.

Most importantly, my work asks that practitioners utilize knowledge on privilege and oppression to dismantle and restructure their perspectives on practice and actively do the work of being change agents in their field. All practitioners within the health care system must build and utilize a critical consciousness of the ongoing history of racism, sexism, and classism within maternal health practice that, “perpetuates the status quo and furthers racial marginalization, and recognize the ways in which White privileges are actually perpetuated within their settings.”¹⁴ My research, moreover, provides specific practice implications for white, privileged practitioners to interrogate how they internalize whiteness and white supremacy, as well as how they navigate systemic oppression as practitioners and as people.

Interrogating whiteness as well as gender and class privilege in spaces of service is non-negotiable for health care workers. As Bartoli et al. remind, “being White in a racist society holds meaning and implications whether we acknowledge it or not...it is essential that White [practitioners] learn about their ancestors’ roles in perpetuating an unjust system as well as the role of anti-racist Whites in joining with people of color and forming meaningful and effective alliances.”¹⁵ Critical reflections and examinations of how privileged practitioners occupy space and provide services to patients and clients are essential in order to identify whether practitioners are perpetuating systemic oppressions or resisting them; whether practitioners are identifying white privilege and actually “giving [privilege] up.”¹⁶ As Magnet summarizes:

¹⁴ Bartoli et al., pg. 252.

¹⁵ Bartoli et al., pg. 254-255.

¹⁶ Shoshana Magnet, “Protesting Privilege: An Autoethnographic Look at Whiteness,” *Qualitative Inquiry* 12, no. 4 (2006): 736-749, pg. 746.

“To participate in this struggle...we must think about our place within it. We have to not only move beyond ‘white ignorance, white denial, white fear, white apathy, white lies, white power’...Resistance work is possible only when we consider our own impulse to ‘race to innocence’ and acknowledge our contested places within these hierarchies.”¹⁷

Practitioners who understand and utilize antiracist feminist frameworks in their professional practice and in their everyday lives actively resist the oppressive status quo of societal institutions like health care.

While activist and organizing work is being done toward dismantling and eliminating white supremacy and systemic oppression, individual practitioners must continually reflect on what they may do to support these movements, as well as decolonize and dismantle their own oppressive practices on a daily basis. Practitioners must also understand that partaking in social justice work is not time-limited. Developing critical consciousness does not happen within the course of several years; for white, cis-heterosexual people especially, this is a lifelong process. Practitioners must understand social justice work and social justice education, as Paulo Freire defines, as “the practice of freedom” and liberation rather than contributing to and utilizing education that practices domination and oppression.¹⁸ The current systems and policies designated for maternal health care practice too often result in trauma and death. There must be a better system of care for birthing parents, one that consists of antiracist, social justice-oriented, patient-centered care provided by educated, culturally-humble practitioners.

¹⁷ Magnet, “Protesting Privilege...,” pg. 747.

¹⁸ Paulo Freire, *Pedagogy of the Oppressed: 30th Anniversary Edition*, (New York: Bloombury Academic and Professional, 2014), pg. 81.

Pertinence of the Problem

In order to contextualize the importance of transforming health care practice, it is necessary to understand the scope of maternal health disparities. Maternal health disparities in the United States are not a new phenomenon. Data collected since the late 1980s demonstrate an upward trend in maternal health disparities experienced by birthing parents, particularly those of marginalized populations. My research utilizes data collected and analyzed by several sources to comprehensively outline the progressing nature of maternal health disparities across the intersections of race, class, and gender. Data utilized in this section include that collected by the Center for Disease Control (CDC), the Chicago Health Atlas, as well as independent research collaboratives that investigate public health trends. After highlighting data figures that demonstrate maternal health disparities across several decades, the remaining sections of this thesis will include my engagement with literature that support the connection between hegemonic ideology around motherhood and health disparities, as well as my engagement with antiracist feminisms and reproductive justice as the central frameworks grounding my implications for maternal health practice.

As recent as 2018, “there were 17 maternal deaths for every 100,000 live births in the U.S. – a ratio more than double that of most other high-income countries...Women in the U.S. are the most likely to die from complications related to pregnancy or childbirth.”¹⁹ Additionally, it is significant to understand the timing of maternal mortality. Data show that 17% of maternal deaths occur on the day of delivery, while 52% of deaths occur after delivery or postpartum. Tikkanen et al. found that, “in the first week postpartum, severe bleeding, high blood pressure,

¹⁹ Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald, and Laurie Zephyrin, “Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries,” Published by The Commonwealth Fund, November 18, 2020, Accessed April 24, 2021, <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>

and infection are the most common contributors to maternal deaths...Previous research indicates that U.S. women experience more late maternal deaths than women in other high-income countries.”²⁰ This data suggest the high importance of postpartum care for birthing parents, since a majority of maternal deaths occur in the postpartum period. Not receiving postpartum care is especially exacerbated for low-income and uninsured birthing parents. As Tikkanen et al. also discovered, “all countries, apart from the U.S., guarantee at least one [postpartum nurse] visit within one week postpartum, although some U.S. states provide these for Medicaid beneficiaries...[Furthermore] the U.S. is the only high-income country that does not guarantee paid leave to mothers after childbirth.”²¹ These findings speak to the broader relationship between maternal health and paid maternity leave, as well as managing postpartum care within the United States’ for-profit health care system. While the table below highlights that some Medicaid programs and health care plans in the United States cover postpartum care, it is worth

Exhibit 4
Postpartum Home Visits

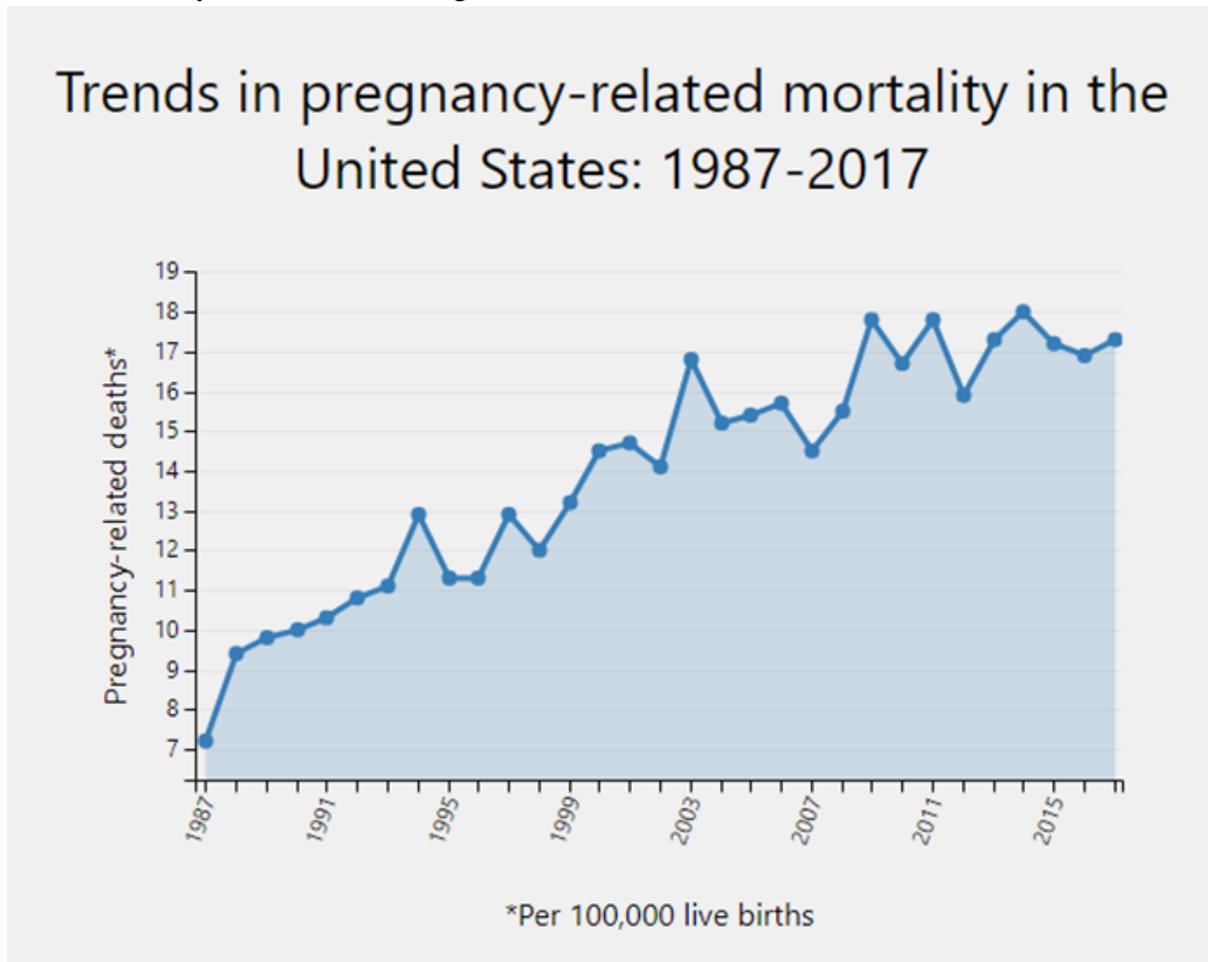
	Covered by national insurance?	Timing and number of covered visits	Provider
Australia	Yes	Within week 1, typically one to three visits	Midwife
Canada	Yes	Contacted or visited within 24 to 48 hours after going home	Public health nurse
France	Yes	Starting within 24 hours after discharge, one to three visits	Midwife
Germany	Yes	Daily if needed until day 10, plus 16 visits as needed until eight weeks postpartum	Midwife
Netherlands	Yes	Daily, starting immediately after birth and up to 10 days postpartum, staying at a minimum 4 hours per day	Maternity nurse
New Zealand	Yes	At least five visits over six weeks, starting within 48 hours postpartum	Midwife
Norway	Yes	Midwife: Starting at 24 to 48 hours, or three days (for low-risk multiparous women) after going home Nurse: First visit on days 7 to 10 postpartum; second visit on days 14 to 21	Midwife, nurse
Sweden	Yes	First visit during week 1; visits thereafter every one to two weeks until week 8	Midwife, nurse
Switzerland	Yes	Daily, up to 10 days postpartum	Midwife
United Kingdom	Yes	At least until 10 days postpartum	Midwife, nurse
United States	Covered by some state Medicaid programs and certain health plans	Varies by state Medicaid program and by individual insurer	Nurse, physician, community health worker, doula, home health worker

²⁰ Tikkanen et al., “Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries,” Accessed April 24, 2021.

²¹ Tikkanen et al., Accessed April 24, 2021.

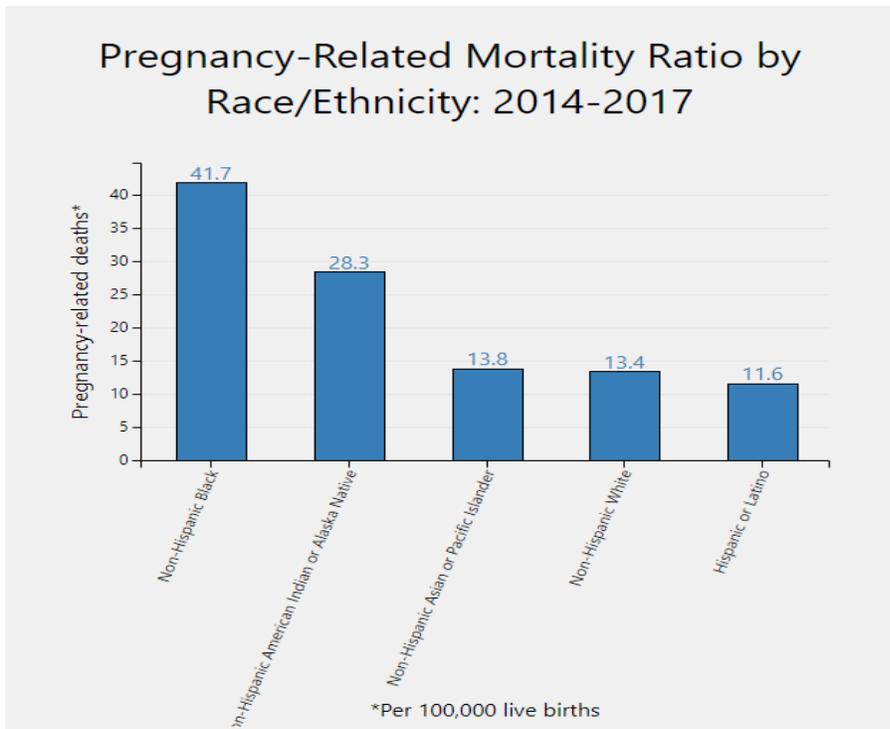
noting the significance of care coverage in countries that have a universal, national health insurance model.²² Birthing parents in the United States should not have to worry whether the state they live in will provide for their birth and postpartum costs. These data figures are important tools for health care professionals to engage with and advocate for a system of health care that recognizes health care as a human right and guarantees health care for all people within the United States. I will further discuss these advocacy possibilities when discussing implications for practice.

According to data collected by the CDC, as emphasized in the graph below, pregnancy-related mortality has been increasing in the United States since the late 1980s.²³



²² “Exhibit 4: Postpartum Home Visits.” Image Credit: The Commonwealth Fund.

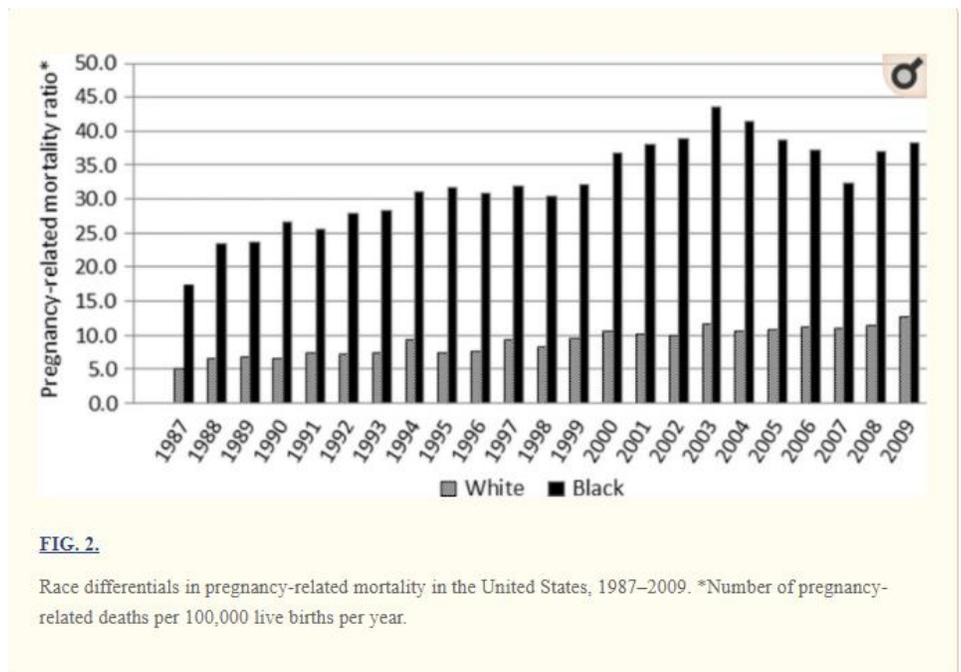
²³ “Trends in pregnancy-related mortality in the United States: 1987-2017.” Image Credit: Center for Disease Control.



It is important to note that maternal health care disparities and maternal mortality did not begin in 1987; rather, my research utilizes the most readily available and current data. Furthermore, the Division of Reproductive

Health at the CDC confirms that Black birthing parents, as well as other parents of color, experience higher rates of pregnancy-related mortality than white parents. The first chart above entitled “Pregnancy-Related Mortality Ratio by Race/Ethnicity: 2014-2017” highlights racial disparities in mortality

rates within the latter half of the last decade.²⁴ The second chart, to the right, labeled “Figure 2” comes from research conducted by Creanga et al. that emphasizes, arguably, the



²⁴ “Pregnancy-Related Mortality Ratio by Race/Ethnicity: 2014-2017.” Image Credit: Center for Disease Control.

starkest racial disparity in maternal mortality, which is between white and Black birthing parents.²⁵

According to Creanga et al., their research confirms that “pregnancy-related mortality ratios are 3-4 times higher among Black than white women, and for the specific mortality causes (e.g., ectopic pregnancy), this gap appears to be even greater.”²⁶ Furthermore, the authors conclude that, “except for foreign-born white women, all other race, ethnicity, and nativity groups were at higher risk of dying from pregnancy-related causes than U.S.-born white women.”²⁷ These findings also compliment data collected right here in Chicago, Illinois, which provides a localized, contextual lens for Chicagoland health care professionals to understand the impact of maternal health disparities.

Most recent data collected by the Chicago Health Atlas in 2017 demonstrate health disparities such as preterm births, low infant birthweight, and cesarean deliveries. Parents of color had higher rates of preterm births than non-Hispanic white birthing parents, with non-Hispanic Black birthing parents having nearly double the rate of preterm births than white parents. Additionally, parents with high economic hardships (such as low-income or unemployed parents) had higher rates of preterm births than parents with low economic hardships.²⁸ Similarly, rates of low infant birthweight were higher for parents of color than white parents with, once again, Black parents having more than double the rates of low birthweight than white

²⁵ “Fig. 2” Image Credit: Andreea A. Creanga et al. (2014).

²⁶ Andreea A. Creanga, Cynthia J. Berg, Jean Y. Ko, Sherry L. Farr, Van T. Tong, F. Carol Bruce, and William M. Callaghan, “Maternal Mortality and Morbidity in the United States: Where Are We Now?” *Journal of Women’s Health* 23, no.1(2014), 3-9, pg. 4.

²⁷ Creanga et al., “Maternal Mortality and Morbidity in the United States...”, pg. 4-5.

²⁸ Chicago Health Atlas, “Preterm Births”, Published by Chicago Health Atlas, April 9, 2019, Accessed April 24, 2021, <https://www.chicagohealthatlas.org/indicators/preterm-births>

parents. Additionally, parents with high economic hardships had higher rates of low infant birthweight than parents with low economic hardships.²⁹

Finally, data show that Black birthing parents had higher rates of cesarean deliveries than white parents. Data for this disparity is a bit different in terms of economic hardship, with parents with low economic hardships having higher rates of cesarean deliveries than parents with high economic hardships. However, if the data is contextualized by neighborhood, areas that are statistically more affluent boast lower rates of cesarean deliveries. Overall, the near north side of Chicago has lower rates of cesareans than the near south side. South and west side neighborhoods, such as Roseland, Pullman, Austin, and West Garfield Park, have historically been affected by high rates of unemployment, poverty, and economic hardship compared to neighborhoods on the north side like Lincoln Park and North Center.³⁰ While rates of cesarean deliveries across the city are in double-digits, there remains a disparity between the historically racially and economically segregated north and south sides of the city. Below are data charts

published by the Chicago Health Atlas that outline these maternal health disparities.³¹

Preterm Births

Year 2017	Number	Rate
▼ Economic Hardship		
Low	1,017	8.6
Medium	1,266	11.0
High	1,533	11.9
▼ Race-Ethnicity		
Chicago	3,817	10.5
Hispanic or Latino	1,089	9.9
Non-Hispanic African American or Black	1,585	14.2
Non-Hispanic Asian or Pacific Islander	228	8.3
Non-Hispanic White	854	7.9

²⁹ Chicago Health Atlas, “Low Birthweight”, Published by Chicago Health Atlas, March 28, 2019, Accessed April 24, 2021, <https://www.chicagohealthatlas.org/indicators/low-birthweight>

³⁰ Chicago Health Atlas, “Cesarean Delivery”, Published by Chicago Health Atlas, March 28, 2019, Accessed April 24, 2021, <https://www.chicagohealthatlas.org/indicators/cesarean-delivery>.

³¹ “Preterm Births”, “Low Birthweight”, “Cesarean Deliveries.” Image credits: Chicago Health Atlas.

Low Birthweight

Year 2017	Number	Rate
▼ Economic Hardship		
Low	867	7.3
Medium	1,136	9.9
High	1,405	10.9
▼ Race-Ethnicity		
Chicago	3,409	9.4
Hispanic or Latino	794	7.2
Non-Hispanic African American or Black	1,640	14.7
Non-Hispanic Asian or Pacific Islander	242	8.8
Non-Hispanic White	686	6.3

Cesarean Delivery

Year 2017	Number	Rate
▼ Economic Hardship		
Low	1,478	16.5
Medium	1,368	16.3
High	1,371	14.7
▼ Race-Ethnicity		
Chicago	4,221	15.8
Hispanic or Latino	1,184	14.5
Non-Hispanic African American or Black	1,345	17.2
Non-Hispanic Asian or Pacific Islander	372	17.6
Non-Hispanic White	1,265	15.3

While these figures represent the last several years, maternal mortality and maternal health disparities continue impacting birthing parents in the present day. The data collected for this section emphasize the public health crisis of maternal health disparities and maternal mortality that disproportionately affect parents of color, low-income parents, and the intersections between these populations. The following sections delve deeper into the historical and cultural contexts of marginalized populations experiencing higher rates of maternal health injustice, including through perspectives of antiracist feminisms and reproductive justice. Moreover, the data highlighted in this section contextualize my research questions:

- 1.) How does hegemonic cultural ideology around motherhood in the United States directly impact maternal health disparities seen among birthing parents of various races, classes, and genders?
- 2.) How do antiracist feminisms, including reproductive justice frameworks, examine maternal health disparities in the United States and what do feminist scholars suggest for eliminating such disparities?
- 3.) How can white, privileged people in health care and social service fields mindfully apply antiracist feminist frameworks in their everyday practices, in order to address maternal health disparities and advocate alongside patients for improved care?

Systemic and institutional racism, patriarchy, heterosexism, and classism drastically influence the experiences of marginalized birthing parents, as well as the biases of health care professionals that directly impact the care received by parents. Antiracist feminisms, as well as reproductive justice frameworks, provide theories and perspectives that center the experiences of marginalized communities and directly address the racial, gender, and class hierarchies inherent within United States society.

In *Reproductive Injustice*, Dána-Ain Davis also cites concrete statistics of maternal and reproductive inequity yet invites readers to engage with the impact of this inequity through the literature and testimonies of people who experience it. She states that, “the statistics show starkly that Black [people’s and other marginalized bodies] and babies are profoundly at risk. Thus, it is Black [people’s] words that we must hear if we are to understand the meaning and impact of that risk... [People’s] words are a legitimate source for knowledge production.” I will expand on this point by Davis when discussing the pertinence of antiracist feminisms and reproductive justice to health care practice. Utilizing the data, literature, and feminist frameworks reviewed within this research provides health care professionals of all positionalities (particularly those with multiple privileges) opportunities for education, reflection, and accountability. Furthermore, my hope in writing this thesis is that practitioners will invest in the life-long pursuit of holding themselves accountable for the harm they have perpetuated, as well as actively resisting institutional policies and culture that contribute to the structural harm committed against marginalized populations.

Pertinence of Hegemonic Ideology of Motherhood

I begin this section with reference to Evelyn Nakano Glenn, a prominent scholar in feminist theorizing of motherhood, who provides an important definition of ideology construction surrounding motherhood. Nakano Glenn writes that, “ideology is a powerful tool for keeping people in their place...Ideology is the conceptual system by which a group makes sense of and thinks about the world... [Furthermore,] a dominant ideology represents the view of a dominant group; it attempts to justify the domination over other groups, often by making the existing order seem inevitable.”³² It is crucial to recognize the dominant groups in United States

³² Evelyn Nakano Glenn, “Social Constructions of Mothering: A Thematic Overview,” in *Mothering: Ideology, Experience, and Agency*, eds. Evelyn Nakano Glenn, Grace Chang, and Linda Rennie Forcey, (New York: Routledge, 1994), pg. 9-10.

society, including those with power, privilege, and influence over cultural ideology. Hegemonic mothering ideology is reflective of dominant, oppressive ideologies in our society including white supremacy, patriarchy, misogyny, heteronormativity, and classism. As a student of feminist theory, I, as well as other feminist scholars, continually see these ideologies enacted every day. However, Nakano Glenn emphasizes the pushback by marginalized communities of birthing people that directly challenges this oppression and spotlights the social construction of motherhood. Nakano Glenn states that:

“As Third World women, women of color, lesbians, and working-class women began to challenge dominant European and American conceptions of womanhood, and to insist that differences among women were as important as commonalities, they have brought alternative constructions of mothering into the spotlight. The existence of such historical and social variation confirms that mothering, like other relationships and institutions, is socially constructed, not biologically inscribed.”³³

I now reference additional scholars and theorists whose contribute to the discussion of hegemonic constructions of motherhood, how these constructions privilege white, cis-heterosexual motherhood, as well as how these constructions oppress and invalidate the experiences of marginalized birthing parents.

Author Jonathan B. Kotch writes that, “if women are not socially valued, they are likely to face limitations in reproductive decision making and hazards to their general and reproductive health status.”³⁴ Furthermore, Paolo Freire writes that, “the interests of the oppressors lie in ‘changing the consciousness of the oppressed, not the situation which oppresses them’... for the

³³ Nakano Glenn, “Social Constructions of Motherhood: A Thematic Overview,” pg. 3.

³⁴ Jonathan B. Kotch, “Ch.11: Women’s Health – A Life Cycle,” in *Maternal and Child Health: Programs, Problems, and Policy in Public Health*, (Burlington, MA: Jones & Bartlett Learning, LLC, 2012), pg. 2.

more the oppressed can be led to adapt to that situation, the more easily they can be dominated.”³⁵ These two writers provide contextual lenses on the hegemonic views of birthing people, motherhood, and parenting in the United States. Women are, largely, not as socially valued as men in United States society, which has been an ongoing struggle throughout the country’s history. This is evidenced by the historical social movements for women’s liberation in areas including, but not limited to, voting, labor, equal pay, reproductive and maternal rights, and sexual and intimate partner violence. It is also important to note that movements for women’s liberation and equality overwhelmingly center middle-class white cisgender women. Women and femmes of color, queer and transgender folks, and low-income, working-class people fight additional interpersonal and systemic struggles than middle-class white cisgender women due to their intersecting racial, sexual, and class identities. The pervasive racism, cis-heterosexism, and classism experienced by marginalized populations influence hegemony around motherhood and, in turn, maternal health disparities.

Birthing parents whose identities exist outside white, heteropatriarchal, middle-class standards of parenting experience rampant maternal and reproductive health inequities. Black birthing parents and other parents of color have experienced horrendous, and often lethal, acts of maternal health malpractice since enslavement and the beginning of colonization. Low-income parents struggle with accessing critical maternal health care from conception to post-partum care. Queer parents consistently experience discrimination and difficulty accessing reproductive health services due to the cis-heterosexual ideals of “proper” parenting. These ideological concepts are engrained within United States society and culture, which create deep, harmful biases within societal institutions like health care. While Kotch and Freire provide important contextual lens

³⁵ Freire, *Pedagogy of the Oppressed: 30th Anniversary Edition*, pg. 74.

for hegemony around motherhood, scholars like Dána-Ain Davis, through a reproductive justice framework, provide critical context to hegemonic ideology surrounding mothering and birth that centers the experiences of Black birthing parents and critically interrogates whiteness in mothering.

Davis states that, “mothering has been viewed on a continuum, which ranges from the ideal to the unruly. The ideal mother is a type that is fetishized and exists in perfect unity with her child. Alternatively, there is the notion of ‘monstrous mothers,’ whose class and race often indict them as being dangerous for all manners of reasons...Black women, in particular, have not been respected as mothers.”³⁶ These words by Davis provide an important introduction and grounding to the following literature I cite regarding the United States’ cultural obsession with “proper”, “ideal” motherhood and its roots in white womanhood. As author Katie Arosteguy elaborates, “this country is obsessed with motherhood—with what it should, or should not, look like...Mothers are being put under the microscope; popular images abound and influence our perceptions of what makes a good mom.”³⁷ Motherhood theorist Andrea O’Reilly elaborates on this point stating that, “the ‘good’, [respectable] mother is white, heterosexual, able-bodied, married, and in a nuclear family.”³⁸ This woman is a, “professional working...in an urban space who can seamlessly incorporate a baby into her independent lifestyle...This relationship is all made possible, of course, by money, access to resources, and a disavowal of deviant desires.”³⁹

This trope of the “good mother” is widely projected within media, including television and literature, which has been so for centuries. Davis writes that, “one way Black women’s

³⁶ Davis, pg. 77.

³⁷ Katie Arosteguy, “The Politics of Race, Class, and Sexuality in Contemporary American Mommy Lit”, *Women’s Studies* 39, (2010): 409-429, pg. 410.

³⁸ Heather Hewett, “‘Talkin’ Bout a Revolution’: Building a Mother’s Movement in the Third Wave,” in “The Politics of Race, Class and Sexuality in Contemporary American Mommy Lit”, *Women’s Studies* 39, (2010): 409-429, pg. 413.

³⁹ Arosteguy, “The Politics of Race, Class, and Sexuality...”, pg. 413.

prenatal experiences, pregnancy, and birthing can be understood is an extension of tropes, practices, and beliefs that can be traced back to antebellum and postbellum periods...All aspects of reproduction idealize whiteness...From breastfeeding to the fragility of uteruses, the pretense of perfection and importance has been legitimized through white womanhood.”⁴⁰ Furthermore, as Arosteguy discusses about the representation of white motherhood in mothering and parenting literature, “conformity to white, wealthy styles of motherhood is useful for current structures of patriarchal power to maintain control...the Mommy Lit sub-genre can be seen broadly as a hegemonic tool for encouraging complicity with these fantastical representation of motherhood.”⁴¹

These ideas and constructions of motherhood, however, largely “alienate many women of color who find parenting one of the few interpersonal relationships where they are affirmed and appreciated...Black feminists do not feel the same kind of isolation and antipathy for staying at home because Black women have always worked and, as a result, have often found home to be a space of comfort.”⁴² I ask my readers to reflect on this trope of the “good mother” and how our perceptions of parents existing outside of this trope are influenced. Particularly for my white readers, how do your parents, or even your own experiences with parenting, reflect ideas of parenting rooted in white motherhood? Furthermore, I examine the work of other Black scholars who delve deeper into women of color being alienated by white constructions of motherhood. This history is crucial for maternal health care providers to understand, especially since Black parents, and other parents of color, have historically been denied their right to reproduce and parent freely.

⁴⁰ Davis, pgs. 14-15.

⁴¹ Arosteguy, pg. 418.

⁴² Arosteguy, pg. 417.

As scholar Dorothy Roberts writes, “reproductive politics in America inevitably involves racial politics...White childbearing is generally thought to be a beneficial activity; it brings personal joy and allows the nation to flourish. Black reproduction, on the other hand, is treated as a form of degeneracy...Black mothers, it is believed, transmit inferior physical traits to the product of conception through their genes.”⁴³ These beliefs have reigned since the time of slavery. Enslaved Black women were forced to procreate in order to maintain the workforce of the enslavers, particularly after the ban on importing enslaved Africans.⁴⁴ This was often done through enslavers raping Black women or enslavers forcing procreation between those enslaved. Once enslaved children were conceived, they were automatically the property of the enslaver. Often times, enslavers continued to overwork enslaved Black women who were pregnant, “in order to maximize [the woman’s] capacities as both producers and reproducers...with labor considerations often taking precedence.”⁴⁵ Enslaved children were often forcibly separated from their families and traded, thus denying the Black woman’s ability to raise her child and reinforcing the dehumanization of enslaved Black women as people, let alone mothers. As Roberts states, “slavery could only exist by nullifying Black parents’ moral claim to their children.”⁴⁶

The abolition of slavery did not result in the improved social value of Black birthing people. I, as a student of feminism and a new social worker, notice throughout my personal and professional spheres that many of my fellow white folk view our society as post-racial or view themselves as uninvolved in race conversations. Despite the abolition of slavery, the outlawing

⁴³ Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, (New York: Pantheon Books, 1997), pg. 9.

⁴⁴ Roberts, *Killing the Black Body...*, pg. 24.

⁴⁵ Roberts, pg. 25.

⁴⁶ Roberts, pg. 39.

of Jim Crow, and the civil rights movements that persist throughout our contemporary society, Black people and other people of color are not liberated from systemic oppression. I implore white people, including white health care practitioners, to understand that white supremacy still controls the systems of our country. More importantly, recognize that my voice is simply echoing what Black people have been telling us for decades. I speak to my white readers saying we are white people existing within a white supremacist society; and it is our responsibility to combat and dismantle these evils in every aspect of our lives, especially our care practices.

The legacy of slavery continues into the twentieth and twenty-first century with Black people being mistreated and dehumanized in maternal health care practice. Dána-Ain Davis writes extensively in *Reproductive Injustice* on the lived experiences of Black birthing parents, of various ages and classes, in the “afterlife of slavery...exploring how Black women’s prenatal care, labor, birth, and treatment in medical environments, are extensions of eighteenth-, nineteenth-, and twentieth-century racial thinking.”⁴⁷ I further support Davis’ notion with the work of Dr. David Ansell, a former physician at Chicago’s Cook County Hospital, who provides historical accounts regarding the treatment of Black mothers, particularly with low socioeconomic status and without health insurance, in the late 1970s into the 1980s. As a doctor serving primarily low-income communities of color, Ansell recounts the testimony of a former patient who describes Black women’s experiences giving birth:

“If a white woman came in [doctors] would have to serve her first. Even if there were

⁴⁷ Davis, pg. 2.

Black women before her. They'd leave you on the table with your legs raised up, until they was through with the white woman...We didn't know no better...It was what was expected.”⁴⁸

Dr. Ansell also highlights the intersections of race and class for mothers of color who hold low socioeconomic status or are uninsured. He recounts that patients frequently waited for hours or even days to receive treatment. People in labor received no fairer treatment. Often women would lie on gurneys in hallways waiting to receive maternal care, if these were even available. He describes the experience of another former patient:

“She stood outside in the hallway for hours having contractions while she waited for a stretcher to open up in the labor room...The room was wall to wall gurneys. Twenty to thirty women, sometimes more. No privacy. Sweat-drenched women, in various stages of labor, screamed in pain. No medications.”⁴⁹

Unfortunately, birthing conditions have not improved much for Black women and other women of color throughout the millennium.

It is my intention to include the accounts of scholars and health care providers who witness the pervasive racism and biases against Black birthing parents as evidence that this phenomenon is alive and well; and health care providers are not immune to its impacts. Black people living in the United States too often have their humanity ignored and their lives devalued, which results in dire, and often fatal, consequences. I ask health care providers to pay particular attention to the systemic dehumanizing of Black birthing people and recognize how health care practices are not exempt from the effects of racism. As recent as 2016, researchers report that,

⁴⁸ David A. Ansell, *County: Life, Death, and Politics at Chicago's Public Hospital*, (Chicago: Academy Chicago Publishers, 2011), pg. 166-168.

⁴⁹ Ansell, *County: Life, Death, and Politics at Chicago's Public Hospital*, pg. 167.

“Black women in the United States...were more than three times as likely to die a pregnancy-related death than white and Hispanic women...Black infants die at more than two times the rates of white infants...[Additionally] Black women have a higher preterm birth rate...Finally, Black women are at least twice as likely to experience severe maternal morbidities [including cesarean deliveries].”⁵⁰ These disparities are largely in part to the racial discrimination birthing parents experience inside and outside of the hospital.

For example, researchers found that, “Black women who experienced discrimination were [1.4 times] more likely to deliver preterm than white women...Prenatal maternal stress is increasingly being considered as an explanation for racial disparities in birth outcomes.”⁵¹ Furthermore, stress is compounded by the physician caring for the birthing parent. According to the American Medical Association, “among obstetrician-gynecologists in office-based practice, 75% are white men and only 2% are Black women...Black women are unlikely to be cared for by a physician of the same race and gender, resulting in a variety of consequences for decision-making and communication.”⁵² This may include a lack of trust and cultural understanding between the physician and the patient, which may lead the patient to feel intimidated, invalidated, or uninvolved in decision-making with the physician. I contribute to this point by encouraging white, privileged practitioners to consider this statistic. If you are working in a densely-populated, multicultural area, are you internalizing and considering how your patients feel by your presence on their medical team? How are you supporting your patients in feeling safe in your care? If they do not, what steps are you taking in order to support their comfort,

⁵⁰ Kacey Y. Eichelberger, Kemi Doll, Geraldine E. Ekpo, and Matthew L. Zerden, “Black Lives Matter: Claiming a Space for Evidence-Based Outrage in Obstetrics and Gynecology,” *American Journal of Public Health* 106, no. 10 (2016): 1771-1772, pg. 1771.

⁵¹ Lisa Rosenthal and Marci Lobel, “Explaining Racial Disparities in Adverse Birth Outcomes: Unique Sources of Stress for Black American Women,” *Social Science & Medicine* 72, (2011): 977-983, pg. 978.

⁵² Rosenthal and Lobel, “Explaining Racial Disparities in Adverse Birth Outcomes...,” pg. 979.

including referring them to another provider that better meets their needs? These are some questions that will be revisited in my section on practice implications.

Roth and Henley further support this conclusion in their research findings regarding unequal rates of cesarean delivery between white, affluent mothers and low-income mothers of color. The authors write that, “it is likely that highly educated women and non-Hispanic white women have more opportunities to realize their preferences than less educated women and women of color because they tend to have better access to quality prenatal care, more continuity of care, *better communication with care providers, and stronger provider-patient relationships.*”⁵³ Findings such as these speak to the importance of maternal health providers understanding how racism, classism, and the trope of the respectable white mother permeate within health care practices and patient-provider relationships. These are dynamics I implore health care providers to evaluate as they consider how their care practices may perpetuate maternal health disparities. Furthermore, Roth’s and Henley’s research also speaks to the harm that the medicalization of childbirth causes to many birthing parents, but particularly parents of color and low-income parents.

As mentioned previously, “dramatic rises in cesarean rates have coincided with increasing maternal deaths [specially for Black women], a significant portion of which are connected to unnecessary cesareans.” Roth and Henley state that:

“Disparities in cesarean delivery rates in the United States represent an important social problem because cesareans are related to...the high cost of American health care...Lower socioeconomic status and racial-ethnic minority women are more likely to receive the type of standard obstetrical care that encourages cesarean deliveries without a strong

⁵³ Roth and Henley, “Unequal Motherhood: Racial-Ethnic and Socioeconomic Disparities in Cesarean Sections in the United States,” pg. 207.

clinical rationale, which may serve *institutional profit and scheduling needs*, but which poorly serves these women and their families.”⁵⁴

Research findings like Roth’s and Henley’s exacerbates concerns, including my own, that birthing parents’ autonomous decisions to follow their bodies’ natural deliveries minimizes capitalist profits, prompting hospitals to prioritize surgical procedures and medically-induced births. The authors even state that, “high cesarean rates have negative implications for maternity care quality: Evidence-based ‘best practices’ for optimal management of birth include low rates of medical intervention, doula support, freedom of movement, physiologic positions, and a midwifery model of care.”⁵⁵ Author Barbara Katz Rothman echoes these sentiments in her research. She discovered that between mothers who chose home births and those who chose medical interventions, “both of these groups are in agreement that hospitals are not safe places to give birth. Both groups of women are struggling for control: How do you maintain control over your body and yourself at a vulnerable moment? Not by subjecting yourself to medically controlled hospital management.”⁵⁶

While identifying the dangers and inequities of giving birth within the medical-industrial complex, it is important to recognize there is privilege in being able to dictate where one gives birth. Since people of color and low-income folks already have less access to quality health care, a local hospital or clinic may be the only viable option for giving birth; as Roth and Henley state, “women with racial and socioeconomic advantages use them to avoid medically unnecessary cesarean deliveries...These women are more likely to receive quality health care and to be able to

⁵⁴ Roth and Henley, pgs. 207, 223.

⁵⁵ Roth and Henley, pg. 223.

⁵⁶ Barbara Katz Rothman, “Pregnancy, Birth, and Risk: An Introduction,” *Health, Risk, & Society* 16, no.1 (2014): 1-6, pg. 4.

advocate for their own interests and preferences...”⁵⁷ This opens up and contributes to conversations regarding the importance of community-based care run by and for people within disenfranchised communities that resists systemic oppression embedded within the medical-industrial complex. Navigating and advocating for these conversations as health care providers will also be further discussed within implications for practice.

It is important to note that while Black birthing parents experience the highest rates of maternal mortality and maternal morbidities, like cesarean deliveries, other women of color also experience these injustices at disproportionate rates. As Roth and Henley note, “c-sections with weak clinical indications represent a negative health outcome that is more common among Latina...and Native American mothers.”⁵⁸ Similarly, Bromley, Nunes, and Phipps discovered that, “Hispanic [and Latina] women were more likely to experience inadequate prenatal care and have no one-week born visit, as well as no well-baby care.”⁵⁹ Nevertheless, it is also important to note that maternal mortality and morbidities are also experienced by white women, especially low-income women, “who tend to have less prenatal care, more discontinuity of care, and more risk factors.”⁶⁰ While it is crucial to recognize and understand why Black women and other women of color experience higher rates of maternal health disparities, maternal mortality and health issues remain a higher-than-average problem for all birthing parents in the United States.

Here I restate my point, however, that parents existing outside of the white, heterosexual, financially-affluent trope of motherhood may be disproportionately affected by maternal health disparities, since their reproduction is labeled as deviant or less than respectable by society. Not

⁵⁷ Roth and Henley, pg. 223.

⁵⁸ Roth and Henley, pg. 222.

⁵⁹ Erica Bromley, Anthony Nunes, and Maureen G. Phipps, “Disparities in Pregnancy Healthcare Utilization Between Hispanic and Non-Hispanic White Women in Rhode Island,” *Maternal and Child Health Journal* 16, (2012): 1576-1582, pg. 1580.

⁶⁰ Roth and Henley, pg. 208.

only do birthing parents outside this trope experience disproportionate maternal health disparities while pregnant and giving birth, but they also experience health care disparities and oppression surrounding conception. Walden writes that, “mothering rhetoric [impacts] the ways we think about women...the policies put in place to protect and support them, and the institutionalized forms of discrimination against all women, particularly women of color and low-income women whose experiences largely exist outside of white, middle-class, professional, and maternal ideals.”⁶¹ These policies referenced by Walden include access, or lack thereof, to contraceptives and birth control, a continuously stigmatized form of health care.

Grindlay and Grossman report that, “one-third of American women who ever tried to obtain hormonal contraception reported difficulties with prescription or refill access... [Furthermore the authors conclude that] expanded insurance coverage and the removal of the prescription requirement for oral contraceptives may reduce access barriers and facilitate consistent contraceptive use.”⁶² Governmental and institutional restrictions on contraceptives reinforce the ideology that individuals capable of reproducing are expected to do so, instead of having access to medications and health care that allow them control over their reproduction. Furthermore, government control of contraceptives allows for government and institutional control of people’s reproduction, particularly the reproduction of individuals who are not white, cisgender women; this is especially relevant for Black women in the United States. Reproductive control tactics are embedded within institutions like health care. Weaponized racist, classist, homophobic rhetoric prevents new and prospective parents from accessing quality maternal

⁶¹ Sarah W. Walden, “Professional Instincts: Professional Mothering Rhetoric and the Revision of Maternal Labor,” *Women’s Studies in Communication* 41, no. 3(2018): 205-223, pg. 207-208.

⁶² Kate Grindlay and Daniel Grossman, “Prescription Birth Control Access Among U.S. Women at Risk of Unintended Pregnancy,” *Journal of Women’s Health* 25, no. 3(2016): 249-254, pg. 252-253.

health services and deters parents, particularly parents of color and LGBTQIA+ parents, from growing their families in the first place.

In the years following the abolition of slavery, “more recent policies have sought to reduce Black women’s fertility. [These policies, as well as those of enslavers,] share a common theme – that Black women’s childbearing should be regulated to achieve social objectives.”⁶³ Thus began a decades-long history of eugenics policies, including forced sterilization and contraception that largely targeted low-income Black women and other women of color. As Roberts reports, “the federal government pays for sterilization services under the Medicaid program while it does not make available information about and access to certain other contraceptives techniques and abortion. In effect, sterilization was for decades the only publicly funded birth control method readily available to poor women of color.”⁶⁴

The justification for these policies largely stems from the creation of racist stereotypes that paint the picture of largely low-income Black mothers as deviants who, beginning in their teenage years, carelessly birth children for a government check (i.e., “the welfare queen”). This perception is significantly skewed from reality, however. Most welfare recipients are not Black, and most teen mothers are not Black.⁶⁵ Nevertheless, “the media and politicians have shown pictures of Black mothers when they discuss public assistance. Now the link between race and welfare is firmly implanted in Americans’ minds.”⁶⁶ Once again, I emphasize that health care practitioners, as human beings in American society, are not immune to these stereotypes and biases. It is essential to reflect upon how stereotypes of marginalized people influence our perspectives that, in turn, influence the quality of our practice. Decades of policies in the

⁶³ Roberts, pg. 56.

⁶⁴ Robert, pg. 97.

⁶⁵ Roberts, pgs. 111, 113.

⁶⁶ Roberts, pg. 111.

twentieth century that subjugated Black women to forced sterilization and contraceptive use (often times as a requirement for receiving government benefits) have left a legacy of not only racially biased perceptions of Black birthing people, but also of a severe distrust by Black people in a medical system that has dehumanized and harmed them through deceptive, coercive tactics that serve the interests of anti-Blackness and white supremacy.

While this problem exists across the intersections of race and class, parents who are not cis-heterosexual also experience maternal and reproductive health inequities at alarming rates. Walden elaborates by describing that, “institutionalized motherhood is so intertwined with gender that it elides the distinction between ‘woman’ and ‘mother’ or between a woman’s gender identity and a potential role she performs.”⁶⁷ This concept not only co-opts a woman’s individual identity as a person, but also wildly invalidates and isolates birthing parents who are not cisgender women. Queer parents who are expanding their families through biological reproduction experience frequent barriers to maternal health coverage during and after conception. Researchers found that, “barriers to conception often take the form of provider heteronormativity, health insurance policies that do not include fertility coverage for same-sex partners, or a lack of education for medical providers about LBQ (lesbian, bisexual, queer) women’s needs.”⁶⁸ Furthermore, queer parents of color also experience the racialized history of insemination that still remains prevalent in reproduction. Karpman, Ruppel, and Torres discovered that sperm banks often utilized by queer parents, “practice a form of positive eugenics, which works in concert with efforts to suppress reproduction in populations of color to achieve its social aims. Today, banks sell sperm from predominantly white donors; Black and

⁶⁷ Walden, “Professional Instincts: Professional Mothering Rhetoric and the Revision of Maternal Labor,” pg. 207.

⁶⁸ Hannah E. Karpman, Emily H. Ruppel, and Maria Torres, “‘It Wasn’t Feasible for Us’: Queer Women of Color Navigating Family Formation,” *Family Relations* 67 (2018): 118-131, pg. 120.

Latino donors are substantially underrepresented.”⁶⁹ This connects back with Dorothy Roberts’ exploration of the intersections of race and gender oppression and the control of Black reproduction as a tool of white supremacy.

Parents whose gender and sexual identities exist within the LGBTQIA+ spectrum must consistently navigate the conditions of conceiving and rearing children in a dominantly cis-heteronormative, patriarchal society. Motherhood and reproduction remain intrinsically linked to womanhood, with cisgender women labeled as the sole “natural” providers of human life. As Lynn M. Stearney cites:

“Cultural constructions of motherhood exert rhetorical power as they create an ideational standard...The maternal archetype functions persuasively...through its ability to 1) construct an analogy between women’s role in biological reproduction and the cycles of nature as a premise of women’s greater attunement to the environment; and 2) reinforce the socially created contract that it is women who have the requisite psychological characteristics to ‘mother’, biologically, emotionally, and environmentally.”⁷⁰

Furthermore, powerful cultural influence from institutions like the Christian church proclaims, “God and the human body intertwine to create a trusted and comforting knowledge base about God’s natural order for the world, and women’s place in it as the physical vessel for bearing children.”⁷¹ Moreover, it is notable that sociocultural pressure on capable individuals to have children are disproportionately on those who reflect institutionalized characteristics of “respectable” members of society.

⁶⁹ Karpman, Ruppel, and Torres, “‘It Wasn’t Feasible for Us’...,” pg. 121.

⁷⁰ Lynn M. Stearney, “Feminism, Ecofeminism, and the Maternal Archetype: Motherhood as a Feminine Universal,” *Communication Quarterly* 42, no. 2(1994): 145-159, pg. 151-152.

⁷¹ Cynthia Woodson, Michele Shedlin, and Helen Koo, “The ‘Natural’ Body, God, and Contraceptive Use in the Southeastern United States,” *Culture, Health, & Sexuality* 6, no. 1 (2004): 61-78, pg. 65-67.

These characteristics, again, include white, heterosexual, cisgender, able-bodied parents from financially stable, educated households. As evidenced by the literature in this section, people of color, people experiencing poverty, queer folks, and other marginalized individuals are continuously condemned and punished for reproducing outside of white supremacist, nuclear family standards. Therefore, it is incumbent upon health care providers to recognize and interrogate these racist, queerphobic, classist ideologies that often prevent these parents from receiving quality, patient-centered health services. This is necessary for influencing how non-heteropatriarchal families receive human and social services, like health care. According to research by Stephen Sugarman:

“Programs aimed primarily at middle-class and richer families advantage the traditionally ‘ideal’ nuclear family in which the husband goes to work, and the wife stays home to care for the children...Even today, as a matter of social norms, low-income, single motherhood is not viewed as an equally desirable family type as the [nuclear] family. Rather, the mainstream view regards this as an unfortunate family structure that will be tolerated and financially helped for the sake of the children (at least so long as the mother properly behaves).”⁷²

The systemic and interpersonal oppression experienced by racially, economically, and gender marginalized populations must be recognized, understood, and resisted through health care practitioners and social service workers reevaluating and transforming their daily practices in maternal health care.

It is futile to work toward reforming and decolonizing an institution like health care that is inherently constructed as a tool of white supremacy, patriarchy, and capitalism. However, as

⁷² Stephen Sugarman, “What is a ‘Family’? Conflicting Messages from Our Public Programs,” *Family Law Quarterly* 42, no. 2 (2008): 231-261, pgs. 232, 247.

long as these institutions remain operating, practitioners may construct their practices to actively and intentionally resist the oppression perpetuated by the system in which they work. This is a challenging feat; however, health care practitioners and social service workers must remember that they work in service of their clients and patients. Health care is a human right and all necessary actions to protect this right must be taken at all levels of advocacy. This may include the paradoxical action of advocating for the abolition of the medical-industrial complex, in favor of community-centered and patient-controlled health care. It is understandable that workers want to protect their livelihoods, yet we must remember the ethical call of this profession. Our health care systems are harming and killing our patients, and we must act in every manner necessary to eliminate these injustices.

Pertinence of Antiracist Feminisms

My work contributes to the conversation of transforming maternal health practice by utilizing antiracist feminisms as foundational frameworks for practice implications. As I previously highlighted, antiracist feminisms directly challenge the institutionalization of whiteness, cis-heteropatriarchy, and classism within hegemonic cultural ideology, as well as social systems where this ideology exists. Understanding foundations of antiracist feminisms provides opportunities for health care practitioners to dismantle biases and build knowledge and practices that are anti-oppressive. While I cannot encapsulate the entire history of antiracist feminisms into this research, it is my hope that health care practitioners utilize foundations of antiracist feminisms to continue strengthening their understanding of antiracist, anti-oppressive practices throughout their careers and their individual lives.

Antiracist feminisms, particularly Black feminist politics and women of color feminisms are largely grounded in “the historical reality of Afro-American women’s continuous life-and-

death struggle for survival and liberation. Black women's extremely negative relationship to the American political system (a system of white male rule) has always been determined by our membership in two oppressed racial and sexual castes."⁷³ These are the words of the Combahee River Collective, a revolutionary collective of Black, lesbian feminists whose activism and politics "struggled against racial, sexual, heterosexual, and class oppression"⁷⁴ predominantly during the second wave of the United States women's movement of the late 1960s and 1970s. As the Collective clarifies, the work of Black women activists, abolitionists, and revolutionaries pervades colonial United States history; however, the writers note that "a Black feminist presence evolved most obviously"⁷⁵ throughout the second wave of American feminism.

Before Kimberlé Crenshaw coined the term "intersectionality", Black feminists of the Combahee River Collective frequently highlighted the interlocking oppressions they experience as Black lesbian women. This led the Collective to "develop a politics that was antiracist, unlike those of white women, and antisexist, unlike those of Black and white men...Sexual politics under patriarchy is as pervasive in Black women's lives as are the politics of class and race. [They also found] it difficult to separate race from class from sex oppression because in [their] lives they are most often experienced simultaneously."⁷⁶ These interlocking, simultaneously experienced oppressions are what Crenshaw later defined as intersectionality. Crenshaw writes that, "because of their intersectional identity as both women *and* of color within discourses that are shaped to respond to one *or* the other, women of color are marginalized by both...My focus on the intersections of race and gender only highlights the need to account for multiple ground of

⁷³ Combahee River Collective, "A Black Feminist Statement," in *This Bridge Called My Back: Writing by Radical Women of Color*, eds. Cherrie Moraga and Gloria Anzaldua, Watertown, MA: Persephone Press, 1981, pg. 234.

⁷⁴ Combahee River Collective, "A Black Feminist Statement," pg. 234.

⁷⁵ Combahee River Collective, pg. 235.

⁷⁶ Combahee River Collective pg. 253, 237.

identity when considering how the social world is constructed.”⁷⁷ A main point of my research is viewing referenced data and literature with consistent intersectional analysis of how birthing parents with intersecting oppressed identities experience maternal health inequity at disproportionate rates than birthing parents with multiple privileged identities.

The Combahee River Collective declared decades ago that, “there is a very low value placed upon Black women’s psyches in this society, which is both racist and sexist...We are disposed psychologically and on every other level, and yet we feel the necessity to struggle to change the conditions of all Black women.”⁷⁸ Furthermore, I intentionally connect this declaration back to Kitch’s previous statement: If women are not socially valued, the conditions of their reproductive and general health suffer. Black feminist politics have been utilized by movements for justice and liberation of Black people and all people of color; as the Collective proclaimed, “we realize that the liberation of all oppressed peoples necessitates the destruction of the political-economic systems of capitalism and imperialism, as well as patriarchy.”⁷⁹ The United States health care system is an inherently capitalist institution, systemically infiltrated by patriarchy, racism, heterosexism, and colonization. Grounding health care practice in antiracist feminisms requires continued action against systems of oppression that directly harm people. As the Collective described, “we are particularly committed to working on those struggles in which race, sex, and class are simultaneous factors in oppression. We might, for example, become involved in workplace organizing...or picket a hospital that is cutting back on already inadequate health care...the work to be done and the countless issues that this work represents merely reflect

⁷⁷ Kimberlé Crenshaw, “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color,” *Stanford Law Review* 43, no. 6 (July 1991): 1241- 1299, pg. 1244, 1245.

⁷⁸ Combahee River Collective, pg. 239.

⁷⁹ Combahee River Collective, pg. 237.

the pervasiveness of our oppression.”⁸⁰ Health care professionals who practice through antiracist feminist methodologies must continually interrogate how their practices observe intersectionality in order to comprehend the complexity and entirety of patient experiences.

Here I also incorporate the importance of reproductive justice tenets into antiracist feminist practice, as reproductive justice frameworks also account for the intersectionality of birthing people’s experiences, as well as utilize a Black feminist approach to birth and reproduction. In 1994, the term “reproductive justice” originated here in Chicago Illinois, coined by a group of Black women, more specifically the Black Women’s Caucus of the Illinois Pro-Choice Alliance.⁸¹ Lorretta Ross, a feminist reproductive justice scholar and co-founder of SisterSong Women of Color Reproductive Justice Collective, emphasizes the reproductive justice framework as, “the right to have children, not have children, and to parent the children we have in a safe and healthy environment.”⁸² However, what too many feminists and reproductive rights advocates overlook is how intrinsically linked reproductive justice is to Black birthing people’s lives. Reproductive justice frameworks cannot be utilized without understanding and centering Black feminisms and Black birthing people’s lived experiences.

Black feminist scholars like Lorretta Ross and Dána-Ain Davis are critical voices to uphold when understanding the intersectionality and depth to reproductive justice, beyond the pro-choice movement and abortion rights. Ross writes that, “a reproductive justice analysis addresses the fact that progressive issues are divided, isolating advocacy for abortion from other social justice issues relevant to the lives of every woman.”⁸³ This connects to Davis’

⁸⁰ Combahee River Collective, pg. 242, 243.

⁸¹ EverThrive Illinois, “Reproductive Justice Framework,” Retrieved from <https://everthriveil.org/our-work/contraceptive-justice/>, Accessed June 24, 2021.

⁸² Lorretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction*, in *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*, author Dána-Ain Davis, (New York: New York University Press, 2019), pg. 175.

⁸³ Ross, “The Color of Choice: White Supremacy and Reproductive Justice,” pg. 1.

ethnographic work on the lives of Black birthing parents navigating birth and reproduction in the afterlife of slavery. Davis quotes Saidiya Hartman who writes that, “Black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery – skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment.”⁸⁴ Reproductive justice frameworks account for the intersecting social justice issues that Black birthing people, as well as other marginalized birthing people, experience, for systemic oppression is directly linked to reproductive injustice. Just as both antiracist feminisms and reproductive justice frameworks cannot exist without Black and women of color feminisms, antiracist feminisms and reproductive justice must intersect with each other, especially in the context of maternal health practice. Both reproductive justice frameworks and antiracist feminisms emphasize the importance of intersectionality, which captures the totality and complexity of lived experiences of marginalized and oppressed populations.

Kimberlé Crenshaw clearly states in her research on intersectionality that, “[she] considers how the experiences of women of color are frequently the product of intersecting patterns of racism and sexism, and how these experiences tend not to be represented within the discourses of either feminism or antiracism.”⁸⁵ She elaborates that, “the failure of feminism to interrogate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of antiracism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women.”⁸⁶ I highlight this quote to demonstrate the importance of intersectional antiracist feminisms through its resistance to and

⁸⁴ Davis, pg. 13.

⁸⁵ Crenshaw, “Mapping the Margins...,” pg. 1243, 1244.

⁸⁶ Crenshaw, pg. 1252.

critique of mainstream white feminism and patriarchal antiracism. Furthermore, the concepts of intersectionality are not only crucial for health care providers to understand in terms of equitable patient care, but also for providers to demand accountability from the institutions and organizations in which they serve. One idea is for health care practitioners to engage with how, and if, their colleagues and institutions participate in conversations and trainings surrounding the incorporation of antiracist and intersectional feminist concepts into everyday practice.

As antiracism and feminism become stronger concepts within mainstream United States society, societal institutions like physical and mental health care are increasing diversity and inclusion trainings, as well as seminars on antiracism and “transforming” practice with marginalized communities. However, it is important for practitioners to keenly identify how their organizations are engaging with antiracism, feminism, and other ideologies that combat systemic oppression. I advise practitioners to ask this question: Is my healthcare organization truly invested in transformation or is the engagement with these ideologies performative? I also elaborate on the implications of this question in the following section on implications for practice. Moreover, this work of demanding accountability and justice for healthcare patients involves the continued development of individual and systemic critical consciousness of privilege and oppression, which should be particularly expected of white practitioners and other practitioners with significant privilege.

Building critical consciousness is an essential component of antiracist feminist practice, as well as any anti-oppression work. Yvette P. Franklin neatly defines critical consciousness as, “awareness and knowledge of hegemony, marginalization, and one’s own privileges, in themselves. [Furthermore, critical consciousness is understanding that] race, class, gender, and sexuality come together in particular contexts to affect who we are, and that we need to see what

is happening systemically and personally to be able to extend our understanding.”⁸⁷ I utilize Franklin’s definition, further emphasizing that critical consciousness is also the continued awareness of how specifically white, privileged people embody power and privilege, how we perpetuate and benefit from systems of oppression in our everyday existence, and how our privileges are intrinsically linked to the oppression and marginalization of others. In terms of maternal health disparities, critical consciousness also involves questioning the policies and protocols that create disproportionate barriers for birthing parents, as well as dissuade resisting the status quo to better care for birthing parents. Perhaps most importantly, critical consciousness involves reflecting and unpacking the instances where practitioners unintentionally, or intentionally, caused harm to their patients and fractured relationships by perpetuating oppressive biases and hegemonic, stereotyped knowledge of birthing parents.

Feminist ideologies bolster the development of critical consciousness, particularly for privileged individuals, in order to strengthen self-reflexivity, as well as critical awareness and understanding for how systemic and institutional oppressions affect human beings at micro, meso, and macro levels of society. Consciousness-raising stems largely from feminist consciousness-raising groups during the second wave of American feminism. Cricket Keating discovered in their research of consciousness-raising and coalition building that, “feminist-consciousness-raising had a tremendous impact on U.S. society. It is through the practice of consciousness-raising...that the notion of the ‘personal is political’ began to take root as women in the groups began to ‘unpack the moment-to-moment meaning of being a woman in a society that men dominate...[and look] at how women see their everyday lives.’”⁸⁸ While feminist-consciousness raising groups were spaces for women of similar lived experiences to theorize,

⁸⁷ Yvette P. Franklin, “A Journey into Critical Consciousness,” *Encounter* 24, no. 4 (2011): 46-49, pgs. 46, 47.

⁸⁸ Cricket Keating, “Building Coalitional Consciousness,” *NWSA Journal* 17, no.2 (2005): 86-103, pg. 89.

share stories, and develop action, they provide an excellent model for coalition-building spaces for folks to understand how their identities and lived experiences are political and how they are affected, similarly and differently, by the societal systems within which they live, work, and have relationships with each other.

As Bartoli et al. elaborate, “feminists have long used self-reflexivity as a ‘minimum requirement’ to carefully scrutinize what we bring to our relationships...Reflexivity is a particular approach to antiracist work that helps us manage what is perhaps most difficult, i.e. the dysphoria of guilt and anxiety, as well as a tool for cultural self-awareness. Here feminism is an especially useful framework as it pairs self-knowledge with social action.”⁸⁹ Furthermore, I repeat and emphasize the authors’ statement that, “clinicians and students with heightened critical consciousness must be able to negotiate with systems that perpetuate the racial status quo and further racial marginalization and recognize the ways in which white privileges are actually perpetuated within their settings.”⁹⁰ Developing and strengthening critical consciousness largely occurs when practitioners are able to engage in conversations regarding whiteness, systemic oppression, and what responsible allyship and antiracism mean within the contexts of health care settings. Participating in and unpacking diversity and multicultural seminars within their organizations, as well as building community with each other through affinity groups may assist practitioners in embodying and engaging with antiracism in their practices. I dissect and further unpack these ideas in the following paragraphs, as well as in the implications for practice section.

As mentioned previously, engaging with multicultural education within health care settings requires practitioners to pay keen attention to how conversations surrounding

⁸⁹ Bartoli et al., pg. 256.

⁹⁰ Bartoli et al., pg. 252.

multiculturalism and antiracism are framed. Bartoli et al. highlight that, “multicultural trainings in [mental health care, for example,] have focused primarily on the impact of particular identities, especially racial identity, on the therapeutic relationship...the field for the most part has studied how ‘minorities’ experience the world, how mental health or illness are shaped by such experience, or how racial difference impacts the power dynamic within the therapeutic relationship.”⁹¹ The authors continue by emphasizing what is neglected by utilizing this approach to multicultural education:

“While such an approach does begin to acknowledge the privilege of whiteness, it does not problematize the very method of inquiry that places whiteness as *the standard from which viewpoint we study those who are ‘other’ or different*...Programs operating within and from a mostly white lens embrace approaches that are geared toward teaching white students how to work with racial and ethnic minorities, thus perpetuating othering, marginalization, microaggressions, and systemic silence about the ways in which one participates or benefits from institutional racism.”⁹²

The maternal health data referenced in the “Pertinence of the Problem” section of this research may very well be utilized in multicultural and diversity education to highlight racial disparities. It is through antiracist and feminist critical consciousness, however, that health care practitioners are able to critically analyze this data and what actually contributes to such disparities. Questions to consider when unpacking the influences on maternal health disparities are provided in the following section on implications for practice.

Health care professionals invested in antiracist feminist health care practice can expect this work to be difficult and, for white folks especially, deeply discomforting. As Sleeter states,

⁹¹ Bartoli et al., pg. 247.

⁹² Bartoli et al., pg. 247, 251, 252.

“working against racism is messy and frequently uncomfortable, even when you can’t imagine yourself doing anything else. The often tacitly assumed explanation of comfort needs to be questioned, particularly since white people never stop benefiting from racist systems in ways that are not always visible to us. In other words, we need to learn not to avoid discomfort but to grow through it.”⁹³ Bartoli et al. adds to Sleeter’s point by stating:

“[Practitioners] must be able to acknowledge the ‘both/and’ possibility of being racist and antiracist at the same time...Acknowledging this seemingly contradictory state of being can be critical to breaking down the binary in which people are always either ‘racist’ or ‘not racist.’ This expanded perspective creates the space to receive important critical feedback that may challenge one’s self-image as anti-racist, while it also offers the possibility of growing in one’s anti-racism.”⁹⁴

White practitioners, as well as practitioners with other interlocking privileges, cannot consider themselves “outside” of race or apart from racism because they work with a diverse medical team, or they are kind and attentive to marginalized patients.

Critical consciousness involves interrogating how and why privileged practitioners are in unearned positions of power and hierarchy within their profession due to the privileges that are inherent within their identities. Critical consciousness involves understanding the power dynamics and potential barriers between white, cisgender, heterosexual practitioners and birthing parents of color, uninsured parents, immigrant parents, LGBTQ+ parents, and parents of other marginalized backgrounds. There is deep, individual, transformational work necessary for responsibly and righteously building critical consciousness and practicing through an antiracist

⁹³ Christine E. Sleeter, “Learning to Become an Antiracist Racist,” in *Everyday White People Confront Racial and Social Injustice*, eds. Eddie Moore Jr., Marguerite W. Penick-Parks, and Ali Michael, Sterling, VA: Stylus Publishing, LLC, 2015, pg. 85.

⁹⁴ Bartoli et al., pg. 258.

feminist lens. For practitioners beginning to unpack and relearn much of how they were socialized, this individual and systemic work may feel overwhelming and isolating. However, it is powerful and comforting to know that antiracist feminist-based practices are often done in community with others who are also advocating for individual and systemic change, as well as personal accountability.

Ann Russo writes in her book, *Feminist Accountability: Disrupting Violence and Transforming Power*, that, “a communal approach to accountability means that we build relationships and communities that can hold the inevitable conflict, oppression, and difficulty that we will inevitably experience given the ongoing work of interlocking systemic oppression. This puts us in a better position to work collectively to engage, understand, process, and transform these systems and their impact.”⁹⁵ Similarly, Bartoli et al. write that, “the development of an anti-racist community in all of one’s spheres is essential in empowering individuals to sustain both the vision and process needed for systemic change.”⁹⁶ Working within an organization where other practitioners and colleagues are invested in radically transforming practice and resisting the oppressive structures of the medical system is critical to building community and sustaining individual work in antiracism.

It is beneficial to create spaces where practitioners may process the difficulties and inequities of working within the health care system, as well as affinity spaces for practitioners of privilege, as well as those of marginalized backgrounds, to have community with each other to discuss their unique experiences working within health care and to continuously demand self-accountability. If one’s workplace is not invested in creating these spaces or this “political” work

⁹⁵ Ann Russo, *Feminist Accountability: Disrupting Violence and Transforming Power*, New York: New York University Press, 2019, pg. 21.

⁹⁶ Bartoli et al., pg. 256-257.

is prohibited within the workplace, it is incumbent upon practitioners to ask why and consider the possibilities available to create such spaces within or outside of their organization.

Perhaps the most impactful message regarding the radical possibilities of antiracist feminist-based practice and building critical consciousness comes from renowned feminist scholar Audre Lorde. Building self-awareness, self-reflexivity, and critical consciousness all reflect what Lorde refers to as, “this process of identifying and confronting the oppressor in us. This level of continuous interrogation is necessary on both individual and social levels.”⁹⁷ Furthermore, she writes in her acclaimed work, *Sister Outsider*:

“For we have, built into all of us, old blueprints of expectation and response, old structures of oppression, and these must be altered at the same time as we alter the living conditions which are a result of those structures. For the master’s tools will never dismantle the master’s house. As Paulo Freire shows, ‘the true focus of revolutionary change is never merely the oppressive situations which we seek to escape, but that piece of the oppressor which is planted deep within each of us, and which knows only the oppressors’ tactics, the oppressors’ relationships.’ Change means growth, and growth can be painful. But we sharpen self-definition by exposing the self in work and struggle together with those whom we define as different from ourselves, although sharing the same goals.”⁹⁸

It is possible to live in a society without exacerbated maternal and infant death. It is possible to live in a society where Black, brown, queer, immigrant, and low-income people do not have to fear for their lives and their families when delivering their babies. We unfortunately live in a

⁹⁷ Bartoli et al., pg. 256.

⁹⁸ Audre Lorde, “Age, Race, Class, and Sex: Women Redefining Difference”, in *Sister Outsider: Essays and Speeches*, Freedom, CA: Crossing Press, 1984, pg. 123.

current society where our medical and health care systems are designed to prevent these possibilities. The social and health care systems of the United States are not plagued by systemic oppression, they are agents of systemic oppression. It is likely that institutional reform will not attain the desired outcomes of antiracist feminisms; health care practitioners must be prepared to engage in conversations and activism surrounding the abolition of the medical-industrial complex and our current health care systems. In the meantime, the foundations of antiracist feminist-based practices provide grounding for how practitioners may transform their practice and continue to resist the harm perpetuated by health care systems. This is the work that is needed; this is the work that matters.

Implications for Practice

For health care workers to transform their professional practices, they must radically transform themselves through engagement with social justice, antiracist feminisms, reproductive justice, and anti-oppression work. As stated previously, health care workers must reframe their practices as service and social justice work that may largely be grounded in antiracist feminist frameworks. For social workers specifically, our code of ethics is rooted in furthering social justice and equity for all people. Medical professionals and other health care workers also take oaths to care for and protect their patients from further harm to the fullest extent of their abilities. In order to responsibly honor these oaths and ethics, health care practitioners must recognize how systemic oppression perpetuated within health care systems harms their patients, as well as strategize how their individual and institutional practices may directly combat oppressive policies, procedures, and patient stereotypes. I utilize the data, literature, and frameworks collected for this thesis to distinguish four distinct implications for practice, which I will discuss individually:

1.) Health care practitioners must consistently do the individual work of recognizing and understanding their privileges, identities, and biases in order to prevent perpetuating harmful stereotypes and biased knowledge against maternal health patients.

I echo the words of scholars like Dána-Ain Davis who have long called for health care practitioners to identify and restructure their perceptions and biases of health care patients. Davis proclaims that, “it is fundamentally important that medical and health care professionals who have been trained and work in that system be willing to take responsibility for their own behaviors and biases. They must look racism in the face and question the ways that the system within which they work might contribute to racist outcomes, draw from racist discourse, or perpetuate racist ideas.”⁹⁹ Furthermore, to repeat Audre Lorde, we have all internalized oppressive ideas and behaviors that maintain the supremacy of whiteness, patriarchy, cis-heterosexism, and capitalism by living within the United States. This is especially true for white, privileged people who are, inherently, the oppressors within a white supremacist society. Therefore, it is the sole responsibility of white, privileged folks to do the individual and collective work of dismantling the oppressor within us by educating ourselves on the colonized, oppressive history of this country, as well as the current systems within society that maintain oppression and marginalization, especially within health care.

This work may include continuous engagement with books, documentaries, art, social media and other work by people of color and queer folks who are scholars, revolutionaries, activists, and everyday people. Additionally, I encourage white, privileged folks to start at home and consider their personal relationships with people of color, queer folks, and other marginalized communities. Start with asking yourself these questions: How are you presenting

⁹⁹ Davis, pg. 206.

yourselves in your relationships with your friends, family, and colleagues who experience oppression? Are you perpetuating racist, homophobic, classist stereotypes through your words and behaviors? Can the people of color and queer folks in your life rely on you to support them and empathize with struggles that you do not experience as a white, cisgender or cis-heterosexual person? Do you feel attacked and defensive when you are asked to hold yourself accountable and do better? If you feel uncomfortable by these questions or have difficulty holding yourself accountable for your loved ones, consider how you are presenting yourself to your patients and your clients.

I recognize that growing in self-awareness and self-reflexivity may feel overwhelming and abstract. I often times do not have many concrete suggestions for this work, as it is a deeply personal journey. I often rely on the experiences and insight of others who have long dedicated themselves to antiracist feminist practice to guide me in this personal work, and I still often times find myself making mistakes or failing to hold myself accountable. It is important to have self-compassion when relearning much of how we are socialized as white, privileged people. This is a tumultuous process; nevertheless, self-compassion must not become self-pity nor justification for our lack of knowledge or harmful behavior. While we are undertaking a massive personal transformation, we do not deserve any praise from anyone, especially marginalized communities. If we listen to the calls of Black people and other marginalized folks, this is the transformational work that white, privileged people should have been doing all along; unfortunately, many of us are only now paying attention, as people and as health care providers.

Furthermore, I revisit some previous considerations for health care practitioners highlighted by Roth's and Henley's research. As a practitioner with privileged identities and positionalities, are you actively internalizing and considering how marginalized patients feel by your presence

on their medical team? How are you working toward supporting your patients and prioritizing their physical and emotional safety? Most importantly, if your patients have doubts about your practices and they vocalize their concerns, are you prioritizing your ego or are you changing your behaviors to support your patients feeling safe and validated during their medical treatments? These are questions that all health care practitioners must ask themselves, yet particularly practitioners with privilege. These are some, yet not all, individual considerations that may assist in developing critical consciousness and humility as anti-oppressive practitioners, as well as advocating for equitable, patient-centered health care. The second practice implication further discusses developing critical consciousness and advocating for accountability within health care institutions.

2.) Health care practitioners must continuously engage with and critique antiracism and anti-oppression education and training within their professional settings in order to demand accountability for themselves and their institutions for responsibly utilizing antiracist feminist-based practices.

Antiracism and anti-oppression education is increasingly in demand following social and political movements for racial justice over the last couple of years. Diversity and multiculturalism trainings, as well as seminars on racial equity are becoming more prevalent in workplaces across the nation, including health care institutions. While it is important for health care practitioners to participate in these conversations, it is also important for practitioners, utilizing antiracist feminisms in practice, to engage with and critique education and trainings that do not center the lived experiences of marginalized people; are predominantly taught by and center the voices of white people; or are one-time occurrences and do not emphasize the necessity of continued antiracism work. Some reflection questions I posed earlier in this thesis

include: Are conversations and explanations surrounding racial, gender, and class disparities in health care centering the lived experiences and testimonies of marginalized communities? Who are these trainings taught by and do they perpetuate the othering of marginalized people through a lens of whiteness? Is your organization inviting people who are doing the work of antiracist feminist practice or reproductive justice in health care to hold trainings and engage in conversation with your workplace? Is this education an integrated part of practice or a one-time occurrence to meet a diversity quota? Are racial health care disparities attributed to people being Black or explained as a consequence of racism and white supremacy? These are some necessary critiques to consider if individual practitioners, as well as health care institutions, are truly invested in responsibly and honorably applying antiracist feminist frameworks in their work.

A major component of antiracist feminist practice is consistent awareness and critiquing of the status quo, as well as critiquing of powerful, oppressive institutions that claim to prioritize antiracism and equity, yet their policies and practices are contradictory. Critical consciousness is, in essence, a state of mind that consistently questions, resists complacency with an oppressive status quo, and demands self-improvement and self-accountability. Strengthening critical consciousness, dismantling the internalized oppressor, and demanding accountability from others is not only an individual responsibility, but also a collective one. The third practice implication stresses the importance of community-building and collective accountability for practitioners engaging with antiracist feminist work.

3.) Health care practitioners must hold themselves accountable for continuing their antiracism and anti-oppression work by engaging with co-workers and colleagues and form community with each other in order to process and improve their antiracist feminist practices.

As Ann Russo stated earlier, doing collective work toward accountability and transformation helps practitioners maintain engagement with antiracist feminist practices, since they have a community to unpack, process, and dialogue about the challenging, unsettling nature of accountability work. It is important for white, privileged practitioners to be in community with and work in solidarity with practitioners and patients who experience oppression. However, it is also important for practitioners who experience oppression and marginalization to have communal spaces with each other that are free of whiteness and where their experiences working with health care are centered.

Similarly, I believe it is necessary for white, privileged practitioners to have communal spaces with each other, in order to share and process what we are learning through antiracist feminist practices, what we do not understand, and what we might be struggling with as we work to relearn and dismantle much of how we were socialized as white people. Most importantly, communal spaces for white practitioners provide opportunities for practitioners to ask for and demand accountability from each other if we notice our colleagues are continuing to perpetuate harm or if our colleagues are violating their professional and personal ethics. To echo the calls of many activists and people of color, it is not the responsibility of people of color to consistently educate and demand accountability from their white counterparts.

Engaging with antiracist, feminist, anti-oppression education will introduce practitioners to new concepts, ideas, and terminology that practitioners need to deeply process, understand, and then apply to practice. I believe attending an anti-oppression training without having space afterward to discuss how these concepts will be applied to practice, or having space to ask questions, is futile. For example, let us imagine that a group of predominantly white, cisgender care providers are attending a training on birthing care for transgender parents of color, based off

a recent article by Rheana Murray discussing perinatal health inequity and violence experienced by transgender birthing parents. The article captures the harmful experiences of several transgender parents, including Kayden Coleman, a transgender man who experienced extensive trauma during his birthing experiences. Coleman states that, “there was a lot of trauma...Most of that came from inside the birthing world, with medical professionals. There was a lot of questioning about my identity, a lot of misgendering. Being told I shouldn’t be in spaces I was seeking care from because they were considered women’s spaces. I was offered an abortion a ridiculous amount of times.”¹⁰⁰ Not only do transgender birthing parents experience misgendering, the invalidation of their identities, and the harmful stigma against transgender parents, care providers discover that the language we as practitioners use is often not reflective of transgender and genderqueer parents.

Murray writes that, “the female-oriented language around pregnancy and childbirth can be hurtful and triggering to someone who doesn’t identify as a woman. [Some folks] suggest people consider saying perinatal care instead of maternity care, chestfeeding instead of breastfeeding, birthing people instead of mothers.”¹⁰¹ Finally, after previously highlighting research by Roth and Henley on the overuse of caesarean deliveries, practitioners also need to hold space in their practice for the nuances of the medicalization of childbirth. Murray quotes a perinatal health practitioner who states that, “people have scheduled c-sections all the time. I support them for a huge variety of reasons and gender is as valid a reason as any other...the decision on how to give

¹⁰⁰ Rheana Murray, “A lot of trauma: Trans parents say medical systems isn’t set up for their pregnancies,” Published by Today, June 2, 2021, Accessed June 25, 2021, <https://www.today.com/health/trans-parents-say-medical-system-isn-t-set-their-pregnancies-t218691>

¹⁰¹ Murray, “A lot of trauma: Trans parents say medical system isn’t set up for their pregnancies,”, Accessed June 25, 2021.

birth may depend on multiple factors: whether the patient has had bottom surgery, or whether a vaginal delivery would create extreme gender dysphoria for the patient.”¹⁰²

Transgender birthing parents are not anomalies; they are people who are harmed by perinatal health systems every day. Therefore, holding a training on transgender birth experiences and hearing the testimonies of parents like Kayden Coleman is a prime example of how white, cisgender health care practitioners must delve deeper into these concepts, with each other, outside of the training space. Holding formal debriefing spaces, talking circles, or follow-up conversations may provide practitioners opportunities to further understand concepts like misgendering, gender dysphoria, language and terminology alteration, and others that may be applied to and transformed into more affirming, collaborative interactions with birthing patients.

White, cis-heterosexual, privileged practitioners must consistently develop their own critical consciousness and converse with their peers in order to be responsible, ever-growing accomplices in the struggle for racial, gender, and class liberation. As I stated earlier, racially- and gender-privileged people can expect this work to be deeply uncomfortable and a life-long dedication, which may often times deter people from continuing antiracist feminist practices. However, I ask my privileged peers and colleagues to consider how exhausting it must feel to experience daily and continued oppression, marginalization, and injustice. Would you rather remain complacent and comfortable or honor what is right and just in our professions? This is an accountability question I will reflect on throughout my career as a social worker; I ask you to do the same as you continue your health care practice. Furthermore, recognize that our antiracist feminist work is not limited to individual patient interactions and daily practice. We also have responsibility to contribute to macro-level advocacy in order to remain dedicated to the

¹⁰² Murray, Accessed June 25, 2021.

transformation of society. The final practice implication further discusses our contributions to broader system and societal changes.

4.) Health care practitioners must consistently engage with macro-level implications for health care practice, including engaging with conversations surrounding health care policy in the United States, as well as abolition of oppressive systems, including the medical-industrial complex.

Previous sections of this thesis emphasize the detrimental health care policies of a for-profit health care system. Health care disparities are largely exacerbated by institutional and governmental policies that too often prioritize profits over people. For example, research by the Commonwealth Fund, highlighted in the “Pertinence of the Problem” section, demonstrated that in other high-income countries, universal health care models correlate with decreased maternal health care complications. As stated previously, the United States is the only high-income country in the world that does not guarantee some form of postpartum care to *all* birthing parents. Additionally, the United States is the only high-income country that does not guarantee paid leave to parents after childbirth. Health care justice intersects and correlates with economic, racial, and reproductive justice, and we cannot advocate for one without the others. Health care practitioners who dedicate themselves to pursuing the equity of all patients, as well as improved patient care, must engage with how they and their institutions are advocating for health care for all. As a growing social worker and health care practitioner, I believe that all health care professionals must advocate, personally and systemically, for a universal model of health care that guarantees coverage to all people within the United States, as well eliminates hierarchies within quality of coverage, particularly for people with economic privilege.

Additionally, providers must consider how the medicalization and capitalization of childbirth has, largely, negatively affected patient care in favor of institutional profit. As discovered through Roth's and Henley's research, marginalized birthing parents often experience higher rates of medically-induced births and surgical health procedures that serve institutional profit and capacity, yet poorly serve birthing parents and their families. Roth and Henley also highlighted how birthing practices should emphasize reduced medical intervention, doula support, and a midwifery model of care. Therefore, this creates opportunities for health care workers and providers to advocate for minimally-invasive, community-centered models of care through community-based care providers. Specifically if health care practitioners work for large hospitals or clinics, they may consider how to build connections with community-based care providers who largely reflect the demographics of those they serve. Health care providers may also consider how to advocate for patient-centered and collaborative models of care that include midwifery and doula support, especially if a birthing patient feels supported and empowered by these practices.

Current health care practitioners should consider the community-centered, collaborative care work that is already being done by predominantly Black women and reproductive justice advocates, including right here in Chicago. For instance, EverThrive Illinois is a collective of individuals whose approach, “weaves together advocacy, community engagement, and strategic partnerships to collectively fight for necessary, high-quality health care on behalf of all women, children, and families.”¹⁰³ Their focus areas of work include health reform, maternal and infant mortality, and reproductive and contraceptive justice. Additionally, Chicago Birthworks Collective are a group of radical birth workers, healers, and wellness practitioners, “committed to

¹⁰³ EverThrive Illinois, “Our Work,” Accessed June 25, 2021, <https://everthriveil.org/our-work/>.

centering Black mamas and birthing people in their own reproductive experiences through radical attention, culturally affirming and centered education, and a village centered model of care.”¹⁰⁴ Chicago Birthworks Collective is founded and run by predominantly Black women who strive toward an “empowered birth and postpartum experience”¹⁰⁵ for families. Also, the Chicago Abortion Fund is a localized organization providing “financial, logistical, and emotional support to people seeking abortion services”¹⁰⁶, as well as other reproductive health resources. The mission of Chicago Abortion Fund is to “advance reproductive autonomy and justice for everyone...[to] envision a world where everyone has the freedom and autonomy to create lives, families, and communities that are healthy, safe, and thriving.”¹⁰⁷ These three organizations are just few of the many communities striving toward health care justice and radical transformation of our society. Health care practitioners advocating for more community-centered models of care should consider their engagement with individuals and communities who are already doing exceptional work in these areas.

Personal and institutional advocacy for health care providers is not limited to these examples. Working within an inherently oppressive and flawed health care system requires continued diligence on where and how health care practices may be improved and transformed. However, I, as a social worker and student of feminism, also strongly encourage health care practitioners to consider and engage with conversations and advocacy surrounding abolition and the abolition of the medical-industrial complex, which I briefly mentioned earlier in this thesis. As the Combahee River Collective stated, the liberation of all oppressed people necessitates the

¹⁰⁴ Chicago Birthworks Collective, “Meet the Collective – About Us,” Accessed June 25, 2021, <https://www.chicagobirthworks.com/about-us>.

¹⁰⁵ Chicago Birthworks Collective, “Meet the Collective – About Us,” Accessed June 25, 2021.

¹⁰⁶ Chicago Abortion Fund, “Our Mission,” Accessed June 25, 2021, <https://www.chicagoabortionfund.org/mission>.

¹⁰⁷ Chicago Abortion Fund, “Our Mission,” Accessed June 25, 2021.

destruction of the political-economic systems of capitalism, imperialism, patriarchy, and white supremacy. Societal systems within the United States are engrained with and are agents of racism, patriarchy, and capitalism. Ideas of reforming foundationally oppressive systems are increasingly being replaced with ideas of abolition; for an institution that inherently oppresses and marginalizes cannot be reformed.

Abolitionist and educator Mariame Kaba grounds the idea of abolition through prison-industrial complex abolition. She writes:

“Abolition is a political vision, a structural analysis of oppression, and a practical organizing strategy...Abolition is a vision of a restructured society in a world where we have everything we need: food, shelter, education, health, art, beauty, clean water, and more... [Furthermore,] abolition is a positive project that focuses, in part, on building a society where it is possible to address harm without relying on structural forms of oppression or the violent systems that increase it.”¹⁰⁸

Kaba writes extensively on the abolition of policing and prisons, as these are systems that do not prevent nor address harm within society, but rather perpetuate violence against individuals and communities. Furthermore, writer Gwendolyn Wallace states that, “like prisons, health care systems are part of the way that empire reproduces itself...anti-Blackness has not distorted medical relationships and institutions, so much as built them”¹⁰⁹; the same may be said for policing and prisons. Wallace further explains the medical-industrial complex and how our

¹⁰⁸ Mariame Kaba, “So You’re Thinking About Becoming an Abolitionist,” Published by Level, October 30, 2020, Accessed May 30, 2021, <https://level.medium.com/so-youre-thinking-about-becoming-an-abolitionist-a436f8e31894>.

¹⁰⁹ Gwendolyn Wallace, “To Abolish the Medical Industrial Complex,” Published by Black Agenda Report, July 8, 2020, Accessed May 30, 2021, <https://www.blackagendareport.com/abolish-medical-industrial-complex>.

current systems of health care will always be detrimental to the well-being of marginalized communities:

“Though medical institutions portray themselves as benevolent and objective, the structural reality is that biomedicine was forged in the political and social terrain of colonialism. Commonly known as the medical industrial complex, we are all affected by a huge system that provides ‘healthcare’ services for profit...Along with its foundations in anti-Blackness, the medical industrial complex is also inherently gendered and contoured by ableism, fatphobia, and anti-transness...the medical industrial complex is so deeply deleterious to Black people that reforms like increasing the number of Black doctors or unconscious bias training for health care professionals are not enough to ensure Black people’s lives. The values of the medical industrial complex run in contradiction to the well-being of all Black people.”¹¹⁰

A component of engaging with antiracist feminisms may also be engaging with abolitionist frameworks, as many antiracist feminist scholars and activists are also abolitionists. Furthermore, reproductive justice advocates also discuss the effects of state violence on health care and reproductive justice, thus calling for a radical restructuring of health care practices to be largely disseminated by and for communities. As Dána-Ain Davis explains:

“State violence bleeds into particular public health issues, specifically reproductive health issues...At the level of the collective, healing looks like the provision of radical care where biomedical technological complexes do not control care capitalism. It looks like community nursing, community-led sustainability, participatory governance, and the abolition of systems that do not possess accounting for human need.”¹¹¹

¹¹⁰ Wallace, “To Abolish the Medical Industrial Complex,” Accessed on May 30, 2021.

¹¹¹ Wallace and Sirvent, “Health Justice and Black Liberation: Dána-Ain Davis,” Accessed on June 25, 2021.

Antiracist feminist and reproductive justice frameworks for the betterment of society involve the dismantling and abolition of oppressive systems like capitalism, patriarchy, white supremacy, and imperialism. A critical component of accomplishing these visions are abolishing the institutions and systems that uphold oppression, including the medical-industrial complex. Health care practitioners and workers should sustain the personal and professional value of envisioning a society where everyone has resources to heal, grow, and thrive, without relying on punitive institutions to address harm. As mentioned earlier by Lorretta Ross, reproductive justice goes beyond abortion rights. Reproductive justice includes the resolution and abolition of social injustices like housing and food insecurity, incarceration, and inaccessibility to education that prevent people and families from living and growing in the way that they deserve. Harm may be addressed and resolved within communities, as individual communities know best what they need in order to heal and provide for their people. In order for revolutionary transformation of health care practices to occur, abolitionist frameworks of care and justice must be prevalent within individual and institutional conversations on transforming health care practices.

Conclusions

While the previous four implications for practice should not limit health care practitioners in how they restructure their practices, I firmly believe these implications are essential and transformative for not only privileged practitioners, but also all practitioners contributing to the field of maternal health care. As a student of feminism and women's studies, I have personally experienced profound personal and professional transformations engaging with antiracist feminisms in my practices; it is my sincerest hope that other providers engaging with this thesis experience similar growth as people and as maternal health professionals.

Maternal health practice is a beautiful and honored field. Supporting new parents as they grow their families and welcome new life into the world is precious and rewarding. Birthing parents deserve the right to welcome their children with safety, dignity, and celebration. Unfortunately, maternal health practice in the United States consistently fails birthing parents and disproportionately fails parents existing on the margins of society. The United States is a colonized territory with a legacy of upholding white supremacy, patriarchy, and cis-heterosexism. Throughout its history, and particularly in this current day, people have called rigorous attention to the injustices that people in power perpetuate and people who are oppressed experience. White supremacy, anti-Black racism, cis hetero-patriarchy, and capitalism maintain systemic oppression that impacts the culture of motherhood, parenting, and giving birth in this country. These systemic oppressions are embedded within societal institutions like health care, creating the individual and institutional conditions under which marginalized parents experience harm and injustice by the health care system, as well as individual providers. While it is questionable whether the roots of these injustices can be transformed, health care practice as we know it may be transformed in order to support birthing parents responsibly and rightfully, as well as actively resist systemic injustice.

Antiracist feminist frameworks directly challenge harmful and oppressive health care practices. Feminist scholars and activists have long utilized their work to combat the societal and cultural conditions of systemic oppression, as well as combat the internalized oppression, and oppressor, that operates within the individual. Antiracist feminisms, intersecting with reproductive justice principles, provide liberatory frameworks that health care providers and health service workers may integrate into their everyday practices with patients, as well as advocate for marginalized birthing parents who are directly targeted by discriminatory, unjust

policies and procedures of medical institutions. Antiracist feminisms also provide frameworks for community-building and organizing among health care workers, in order for practitioners to build community with one another as they navigate working within an inherently oppressive system. I also remain rooted in the necessity for health care workers to engage in conversations regarding social justice and systemic oppression from abolitionist frameworks as well, for the abolition of the medical-industrial complex is key for health care justice. While I myself am only beginning my education and engagement with abolitionist frameworks, as I stated earlier I guide my education and practice through the work and words of others conducting antiracist feminist activism; and these folks are largely participating in abolitionist practices and conversations. Moreover, I believe the transformation of maternal health practice is a necessary component along the path toward abolishing oppressive systems within United States society.

Further research and conversations into the oppressive nature of whiteness, racism, patriarchy, heterosexism, classism, and ableism on maternal health remains necessary for the radical transformation of health care practice. Specifically, I call for continued research into how queer and transgender parents experience homophobia and transphobia within maternal and reproductive health care, in order to decenter cisgender women as the sole bearers of children, as well as understand motherhood, birth experiences, and maternal health injustice within the vast spectrum of gender. Additionally, further research and conversation into the remaining question of how to achieve health care justice within unjust systems, including the path of abolition, are necessary in order to increase conversations within health care and academic communities on how to obtain true health equity for all communities of birthing parents.

As I approach the end of my graduate education, I consider my own path of entering the health care field as a social service provider and a student of feminist theory. As a post-graduate,

I am currently exploring therapeutic pursuits within the field of reproductive and perinatal mental health, as well as trauma; and antiracist feminisms will be at the forefront of my practice. The frameworks and practices of antiracist feminisms have demonstrated throughout history to be revolutionary for social justice and the equity of all human beings. I remain dedicated to these teachings and ground myself in these practices as I leave academia and enter society as a working professional and continuous learner. I also think of my own mother and all the birthing parents I have encountered throughout my life that inspired me to conduct this research. Birthing parents are extraordinary, resilient, and they deserve every ounce of care. Birthing parents, no matter if they identify as mothers or another label, deserve the human right of reproductive and maternal health care. Birthing parents deserve better; and I hope to see these changes throughout my career and lifetime.

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