Title

Perspectives of Certified Nurse-Midwives and Physicians on Structural and Institutional Barriers that Contribute to the Reproductive Inequities of Black Birthing People in San Francisco

Author

Nelson, Tamara J

Publication Date

2021

Peer reviewed|Thesis/dissertation

Perspectives of Certified Nurse-Midwives and Physicians on Structural and Institutional Barriers that Contribute to the Reproductive Inequities of Black Birthing People in San Francisco

by

Tamara Juel Nelson

THESIS

Submitted in partial satisfaction of the requirements for degree of

MASTER OF SCIENCE

in

Nursing

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Approved:

DocuSigned by:

McLemore, Monica

0B300BA1DCDC43C...

McLemore, Monica

Chair

DocuSigned by:

Brittany Chambers

DocuSigned by:

Ana Delgado

B25A501157E1473...

Ana Delgado

Committee Members

Dedication and Acknowledgements

I am grateful for the many generations of shoulders who I humbly stand upon to do this work. For the participants who took the time to talk with me and the other research assistants of the CREATE study. To my family, Eric, Mariah and Shiloh who have been there through it all and supported me to no end. To my mother, Julie, for being my greatest inspiration of reimagining and becoming. To my sister, Jess, who has always been my biggest fan & a great editor. To my mentors: Dr. Monica McLemore, Dr. Brittany Chambers, and Ana Delgado, thank you for believing in me and my ideas, for pushing me to think bigger, for always keeping me on track, and who inspire me with your work, your play, & your unwavering commitment to justice. It is truly an honor to work with you. To my advisor Cynthia Belew and program director Kim Dau, who have offered constant support since those admission interviews back in early 2018. To my friends and colleagues, specifically Arielle Bell, Christy Camp, Frank Molina & my midwifery cohort who have helped me grow, held me accountable, taught me so much and learned alongside me. Finally, thank you to Cindy Bacon, a community midwife who I apprenticed with, who caught my baby 21 years ago, & who showed me the possibility of beautiful, healing perinatal and reproductive health care.

Perspectives of Certified Nurse-Midwives and Physicians on the Structural and Institutional Barriers that Contribute to the Reproductive Inequities of Black Birthing People in San Francisco, Tamara Juel Nelson

Abstract

Background: Black birthing people in the United States disproportionately endure adverse experiences and outcomes during pregnancy and childbirth compared to those of any other racial or ethnic groups. Research confirms that structural and interpersonal racism rather than race are the underlying root causes responsible for the inequities in perinatal and reproductive health outcomes facing Black birthing people and families.

Purpose: The purpose of this study was to determine how care model informs and affect how racism is perpetuated in institutional perinatal and reproductive health care through a case study analysis focused on physicians and certified nurse midwives' perspectives of how racism affects their Black birthing patients' experiences and outcomes.

Objectives: To determine provider perspectives of structural- (e.g., transportation, housing) and institutional (e.g., policies, practices) barriers contributing to reproductive health inequities among Black birthing people and families in San Francisco. To determine if and how models of care inform providers and how these perspectives vary among provider types (e.g., midwife, physician).

Setting: Two hospitals (one public community hospital in academic partnership and one University hospital) in San Francisco, California.

Participants: Twenty-four Perinatal Providers (Certified Nurse Midwives [n=7] and Physicians [n=17]) recruited by "Dear Clinician" letters and voluntarily participated in interviews.

Methods: Critical Race Theory, Reproductive Justice and the Midwifery theory were combined to conduct a secondary thematic analysis of existing qualitative data from Community Racial Equity and Training Interventions and Evaluation of Current and Future Healthcare Clinicians Study. Audio files, transcripts, and field notes provide the data for this analysis. An iterative process was used to determine

the influence of professional identity, model of care, and other factors that contribute to provider perceptions about health equity.

Results: Thematic analysis resulted in the identification of five themes, namely: racism as a co-morbidity; healthcare systems inability to address the needs of Black birthing people; healthcare systems prioritizing providers over patients is a failed system; patients are the experts in the optimal healthcare model; and benefits of interdisciplinary teams grounded in Reproductive Justice. One finding from this study is that both physicians and midwives expressed a need for a new care model and a new system of care delivery.

Implications: With these findings, our team proposes a modification of the midwifery model for application by all provider types that could radically shift perinatal reproductive health care. Using a human rights approach to perinatal care, critical race theory, Reproductive Justice-informed midwifery theory may be operationalized by all perinatal and reproductive health care providers, not only midwives, to move racial health and justice forward in a way that serves and honors all birthing people. The clinical implications of this work are wide and may range from but are not limited to the creation of algorithms of how to address racism in the healthcare environment, to patient satisfaction tools built into electronic medical records that trigger provider accountability, to doulas available to all and covered by all insurance types, to patient navigators dedicated to the safety and experience of patient, to community tools like participant-led perinatal reproductive health support groups, community advisory participants in research, and apps such as the Irth© app to report which providers are considered safe for Black birthing people (https://irthapp.com/).

Table of Contents

List of Figure

List of Tables

Introduction

Black birthing people in the United States (U.S.) disproportionately endure adverse experiences and outcomes during pregnancy and childbirth compared to those of any other racial or ethnic groups (Collier & Molina, 2019). Black birthing people are 3 to 4 times more likely to die during or related to childbirth when adjusted for all other factors such as socioeconomic status, education level, pre-existing health conditions and complications, compared to white birthing people (Chambers et al., 2019; Collier & Molina, 2019). Leading professional organizations in midwifery and obstetrics and gynecology have put forth statements that affirm these disparities are a reflection of racial inequities present in maternal healthcare (*ACOG*, 2020.; Likis, 2018). This thesis aims to fill the gap in racial disparity and inequity research to explore how models of care affects perspectives on intervention strategies.

In order to discuss the racial inequities that Black birthing people currently experience, the legacy of Black and Indigenous midwifery and the historic mistreatment of Black birthing people in the formation of modern medicine must be addressed (Owens & Fett, 2019). The current harm caused by racism in healthcare, specifically obstetric racism (Bonaparte, 2015; Davis, 2019; Davis, 2019), and the explicit link of structural racism to perinatal and reproductive health (PRH) inequities (Julian et al., 2020; Scott et al., 2019) must be brought forth. Structural racism has been defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, cash, media, healthcare, and criminal justice" (Bailey et al., 2017, p1453). These historic and current conditions inform the adverse experiences and outcomes endured by Black birthing people and call for urgent need for preventative and reparative measures.

Throughout this thesis the research team will use gender neutral language by using "birthing people" while speaking generally. The phrase birthing people recognizes that not all childbearing people identify as women. However, when quoting previously published research findings, the language of those authors will be used.

The research team recognizes that Indigenous and First Nation people as well as other people of color (POC) suffer inequities related to racism in PRH care. However, this study specifically examines

the PRH inequities facing Black birthing people. This work intentionally focuses where the greatest inequities in PRH lie, between Black and white birthing people, while acknowledging the experiences of others who suffer inequities.

Statement of the Problem

Institutional- (e.g., healthcare maltreatment and institutionally identified and managed complications of pregnancy) and structural- (e.g., housing and transportation) determinants of health affect the physical and mental health of birthing people and their children throughout the lifetime (Chambers et al., 2020; Owens & Fett, 2019; Scott et al., 2019; Wallace et al., 2017). Previous research has shown that racism and racial bias negatively affect individual and population health, patient-provider relationships, and the culture of wellbeing at the institutional (e.g., clinic, hospital) level (Owens & Fett, 2019; Scott et al., 2019; Wallace et al., 2017).

Research has shown that structural and interpersonal racism not race are the underlying root cause responsible for the inequities in reproductive health facing Black birthing people and families (Scott et al., 2019; Wallace et al., 2017). White supremacist systems of structural racism and systemic inequities have unfairly disadvantaged communities of color by withholding wealth and causing stress, which both lead to poorer health outcomes. Additionally, Chambers et al (2021) created a novel definition of structural racism and effects on the reproductive lifespan directly from the perspective of Black women's experiences as "a system that distributed unequal access to resources and opportunity" (Chambers et al., 2021, p405). Concurrently, white communities have been unfairly privileged with greater wealth, more access to resources and opportunity, and thus achieve better health outcomes (Scott et al., 2019; Williams & Cooper, 2019). Bonds and Inwood (2016) state that white supremacy "more precisely describes and locates white racial domination by underscoring the material production and violence of racial structures and the hegemony of whiteness in settler societies" (Bonds & Inwood, 2016, p716).

Furthermore, modern healthcare was created within a white supremacist and paternalistic framework which centers clinicians, who historically have been disproportionately white and male as expert and the patient as recipient of healthcare (Frye et al., 2020). The history of obstetrics and modern

midwifery has been appropriated and systematically stripped from Black and Indigenous midwifery practices which were forced underground and then delegitimatized (Guerra-Reyes & Hamilton, 2017; Owens & Fett, 2019). In addition, the history of modern obstetric and gynecologic procedural advances was developed using unethical medical experimentation on Black enslaved women (Owens, 2017; Owens & Fett, 2019). This history, including human rights violations and the continued healthcare mistreatment, neglect, disproportionate practices of oversurveillance, stripping of reproductive autonomy of patients who identify as Black, Indigenous and People of Color (BIPOC) is what Dr. Dána-Ain Davis has named obstetric violence. One byproduct of obstetric violence is the fostering of a culture of rightful mistrust among patients towards their providers and the healthcare system at large (Davis, 2019). In order to disrupt the current inequities in healthcare, it is imperative to acknowledge this history, build community trust by repairing damages, and reimagine with community partners new systems that support the comprehensive health of Black birthing people (Yancy, 2020).

Aims and Objectives

To begin the work of reimaging new systems to support Black birthing people, the purpose of this study was to explore providers' perspectives of structural and institutional barriers that contribute to the PRH inequities among Black birthing people and families in San Francisco. The research team used a qualitative case study approach to explore midwife and physician providers perspectives on both model and provision of care. The research questions for this study were: To determine what are providers' perspectives of structural- (e.g., transportation, housing) and institutional (e.g., policies, practices) barriers contributing to PRH inequities among Black birthing people and families in San Francisco? To determine if and how these perspectives vary among provider types (e.g., midwife, physician)? To determine if and how does the model of care inform providers? This work determines the necessity of using the frameworks of Critical Race Theory, Reproductive Justice and core components of the Midwifery Model to better equip perinatal care providers with tools to support the autonomy and sacredness of Black birthing people and their perinatal experiences and outcomes.

Literature Review

Maternal and Infant Health

With the consistent rising rates of maternal and infant mortality in the U.S. and the disproportionate impact on Black birthing people (Collier & Molina, 2019; Davis, 2019; Kramer et al., 2019), there must be an acknowledgment that current practices are not sufficiently narrowing outcome gaps (Collier & Molina, 2019). For example, in 1850 the Black infant mortality rate for enslaved persons was 1.6 times the rate for white infants, which was 340 vs 217 per 1000 live births. According to data from 2016, the U.S. Black infant mortality rate has nearly doubled at 2.3 times that of white infants (Owens & Fett, 2019). These statistics supports the narrative that dominant culture deemed Black infant lives more worthy of saving when considered property.

The worldwide maternal mortality rate (MMR) has declined among most high-resourced nations. However, in the U.S., MMR has risen 23% from 2000 to 2014 making it the highest of any well-resourced nation and the only where it is rising and research shows that more than 60% of these deaths could have been prevented (Collier & Molina, 2019; Riggan et al., 2020). In addition to the U.S. being the most dangerous of all well-resourced nations to give birth, it is also the most expensive. The burden of these deaths in the U.S. are carried among Black birthing people, who are estimated to be 3 to 4 times more likely to die during or related to childbirth than white birthing people (Collier & Molina, 2019).

Prior research has posited that living in a systemically racist society causes chronic stress on all systems of the body (Riggan et al., 2020). This particular type of chronic stress is described as weathering (Geronimus, 1992). Weathering is defined as the measurable disproportionate allostatic load caused by carrying stress (Geronimus, 1992; Geronimus et al., 2006) from enduring racism over the life span, which negatively impacts the physiologic processes (e.g., systolic and diastolic reactivity, amount of cortisol and other stress hormones present in the blood) necessary for a healthy pregnancy, which then results in poorer outcomes for both the birthing person and their infant (Geronimus, 1992; Chambers et al., 2020; Geronimus et al., 2006; Riggan et al., 2020).

Clinical and Social Determinants of Health

Individual factors such as co-morbidities, advanced age, and lack of access to healthcare/insurance are often named as the culprits of why people are entering pregnancy with more complicated health issues and thus have worse outcomes (Scott et al., 2019). Physiologic co-morbidities include obesity, diabetes, hypertension, cardiovascular disease, kidney disease, and the weathering effects of racism (Scott et al., 2019). The social determinants of health framework contextualize previously determined co-morbidities by elucidating how resource allocation as well as other barriers to healthcare and resources can manifest negative health effects. Key determinants highlighted by the social determinants of health framework that disproportionately impact Black birthing people includes: poverty, lack of access to health insurance, health education including reproductive and sex education, contraception and family building choices, prenatal care, disrespectful healthcare (e.g., micro and macroaggressions), parental or other advocate support for teens, healthy fresh food, safe neighborhoods (e.g. safe from violence and environmental hazards) (Julian et al., 2020; Kramer et al., 2019).

Research supports that racism influences Black birthing peoples' access to clinical and social determinants of health. Research has shown that Black birthing people are provided less information (Altman et al., 2019), less comprehensive care (Davis, 2019), less respect of privacy, autonomy, and less agency from health care providers based on racism (Vedam et al., 2019).

Racism and Health

Racism is built into the paternalistic, institutional delivery of healthcare exacerbating the harm against Black people and exerts pressure on existing power differentials between Black birthing persons and disproportionately white providers of their care (Riggan et al., 2020). Race is the "social classification of people based on phenotype" whereas racism "is a system of structuring opportunity and assigning value based on phenotype (race) that: unfairly disadvantages BIPOC individuals and communities while unfairly advantaging white individuals and communities" (Jones, 2002, p9).

Based on public health research by epidemiologist Dr. Camara Jones (2002), there are three levels of racism, namely internalized or individual racism; institutional racism; and structural racism.

Internalized racism is as an individual holding negative bias or stereotype about self or another based on race (Jones, 2002). Institutional racism constitutes the ways in which specific institutions and policies favor some over others (e.g., white over Black and BIPOC communities and individuals) in representation, differential access, and privilege (Cobbinah & Lewis, 2018). Structural racism constitutes the culmination of systems, structures, and histories built upon white supremacist ideologies to concentrate and siphon power, wealth, health, safety, and security to whites and away from BIPOC individuals and communities based on race (Hardeman et al., 2016). The impact of structural racism and discrimination are evidenced by reported differential treatment experienced by Black birthing people and adverse maternal and infant outcomes (Chambers et al., 2020).

Healthcare is deeply steeped in racism and supports white supremacy and white culture (Castillo et al., 2020; Owens & Fett, 2019). White culture is defined as "dominant, unquestioned standards of behavior and ways of functioning embodied by the vast majority of institutions in the U.S." (Gulati-Partee & Potapchuk, 2014, p27). Modern healthcare is rooted in racism and white supremacy stemming from of the history of chattel slavery when medical establishments served as quality control for the industry of human enslavement, treating Black bodies as valuable property to be protected, verified, and assessed for value for enslavers. Additionally, racism persisted through the surgical experimentation without anesthesia on Black enslaved women for the advancement of surgical techniques such as cesarean section birth and the repair of obstetric fistula; to the need to control Black women's reproduction (e.g., reproduction as means to create more enslaved individuals, abortion rights and access, coercion of contraception, forced sterilization); to the continued push of the false claim of race as risk factor to disease which is still printed in healthcare textbooks today (Castillo et al., 2020; Owens, 2017; Owens & Fett, 2019).

As previously mentioned, obstetric racism is a concept expressed by scholar Dána-Ain Davis to describe the intersection of obstetric violence and medical racism (Davis, 2019). Davis centers obstetric racism on the particular experience of Black women who may suffer from both obstetric violence – a gender-based violence that can be experienced by some who are dehumanized or made to feel powerless

due to being an obstetric patient, and medical racism which is racism experienced (both historically and currently) in the context of healthcare (Davis, 2019).

Finally, in healthcare and public health, the phrase "race as a risk factor" falsely ascribes biological difference based on race and is a concept intentionally carried over from medical and pseudoscientific studies during chattel slavery and into the Jim Crow era which aimed at proving white superiority and justifying racial segregation (Wailoo, 2018). There is a growing body of research which evidences the correct use of "racism as risk factor" rather than "race" in racial disparity and health equity research. Racism causes detrimental health effects associated with stress placed on the body due to the weathering effect on Black people who are subjected to a lifetime of experiencing all levels of racism (Chambers et al., 2020; Geronimus et al., 2006; Riggan et al., 2020). Our team posits that racism and its effects on health be defined as a structural co-morbidity for which most institutions do not account for or attempt to repair (Scott et al., 2019).

Understanding the Impact of Racism in Healthcare

Research supports that Black birthing people carry mistrust of institutional healthcare based on experiences of racial discrimination and mistreatment (Vedam et al., 2019). First, the oversurveillance including disproportionate urine toxicology testing of Black patients and involvement of child protective services (CPS) and other agents of the state (e.g., security, hospital sheriffs) (Roberts & Nuru-Jeter, 2010). Next, the lack of concordant representation in the healthcare workforce and leadership roles (Bailey et al., 2021; Owoseni, 2020). Third, the countless historic human rights violations in healthcare settings such as removal without consent and the continued use of Henrietta Lacks' cervical tissues (Kemet, 2019; Skloot, 2011) the torturous gynecological experiments on enslaved Black women by Dr. J. Marion Sims (Owens, 2017); and the egregious Tuskegee Syphilis Studies that occurred through the 1970s (Washington, H. 2006 p 157; (Collier & Molina, 2019). Finally, the false belief that Black people experience less pain because of thicker skin, and the everyday assaults of neglect and mistreatment in clinical settings (Owens & Fett, 2019; Wailoo, 2018).

Furthermore, the provider supremacy culture that places the provider as expert focused on individual level risk factors further replicates the very same systems of oppression where modern medicine and healthcare are rooted, in white supremacy (Julian et al., 2020). Data from a study conducted in 2019, found that women of color experiences in the perinatal period were greatly influenced by how they were given information, invited (or not) to participate in their care decisions and overall, how they were treated by their care providers (Altman et al., 2019).

Additionally, in a large (n = 2138) study, Giving Voice to Mothers (GVtM-U.S.), conducted in 2016, seven domains of perinatal mistreatment were identified by birthing individuals (Vedam et al., 2019). These domains were: physical abuse, verbal abuse, neglect and abandonment, poor rapport between women and providers, loss of confidentiality, and lack of supportive care (Vedam et al., 2019). The GVtM study found that one in six participants (17.6%) experienced one or more of the above types of mistreatment during their care (Vedam et al., 2019). The most common type of mistreatment was being yelled at, neglected by healthcare personnel, and threatened that their baby would have a poor outcome if they didn't comply with provider recommendations (Vedam et al., 2019). Finally, the GVtM study found that women of color experienced individual instances of mistreatment at disproportionate levels compared to white women that were statistically significant (Vedam et al., 2019). Racism and provider-centered culture provides fertile ground for maltreatment and implicit bias to flourish.

Implicit bias research has shown that Black patients receive fewer diagnoses, procedures, patient education, and lesser quality healthcare than do white patients (Nelson, 2002; Williams & Wyatt, 2015). Explicit bias represents conscious self-reportable thoughts and attitudes, whereas implicit bias represents unconscious thoughts and attitudes (Maina et al., 2018). In a systematic review of implicit bias research in healthcare settings, Maina et al (2018), found that 31 out of 37 studies evidenced a strong unconscious favoring of providers towards white or light-skin and anti-Black or other POC bias. Implicit bias has been recognized by the State of California through both Senate Bill #464 (*Bill Text - SB-464 California Dignity in Pregnancy and Childbirth Act.*, 2020.) and Assembly Bill #241 (*Bill Text - AB-241 Implicit Bias: Continuing Education: Requirements.*, 2020.) as a key driver of "unequal treatment of people based on

race, ethnicity, gender identity, sexual orientation, age, disability, and other characteristics" and "key driver that drives health disparities in communities of color." Thus, beginning January 1, 2022, implicit bias training must be included in all nursing and physician continuing education training as per AB241 (*Bill Text - AB-241 Implicit Bias: Continuing Education: Requirements.*, 2020). SB464 would bring about better data collection regarding maternal mortality records and impose stricter guidelines on provider perinatal anti-racism and implicit bias trainings (*Bill Text - SB-464 California Dignity in Pregnancy and Childbirth Act.*, 2020.).

Defining Health Equity

Macro-Level Definition of Health equity

The World Health Organization (WHO) defines health "as complete physical, mental and social well-being, not merely as the absence of disease or infirmity"(Grad, 2002, p981). In order for this description of health to be optimized, health must be put into context with individual, social, and structural determinants of health in order to achieve health equity (*WHO | Prevention and Elimination of Disrespect and Abuse during Childbirth*, 2005). The social ecological theory (see Figure 1) recognizes that each individual lives within an ecosystem comprised of their individual experiences, their interpersonal relationships, the social institutions and environment they interact with regularly, the outer community, and finally with the overarching systems of influence such as public policies and the political climate (Golden & Earp, 2012).

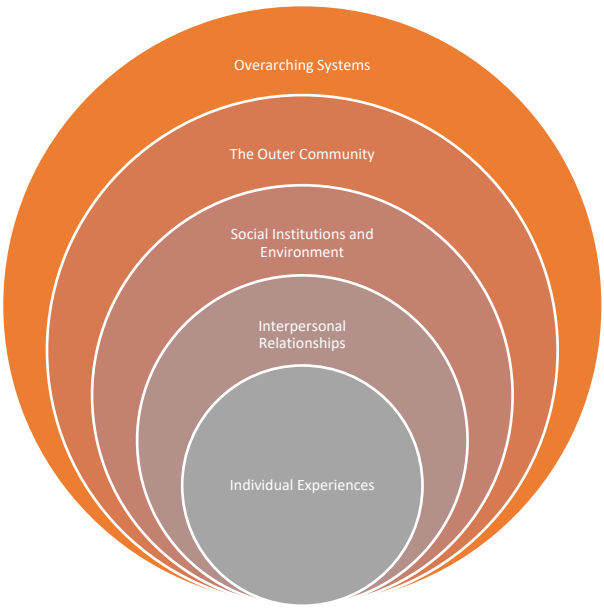

Figure 1: The Social Ecological Theory.

Health equity has been put forward as an optimal concept where every human has the same opportunities and access to health regardless of their starting point and is built upon the assumption that individuals will need different resources and varying levels of support for equal prospects to optimal health (Castillo et al., 2019; Hogan et al., 2018; Levesque et al., 2013). To move toward health equity, there must be a reimagining of health care that includes an integration of all levels of the social ecological theory in order to center the patient within the broader view of their particular strengths, needs and barriers to health (Castillo et al., 2019; Hogan et al., 2018).

Patient-centered care has become a standard in health care delivery and is identified by the National Quality Forum (NQF) as one of the key drivers to achieve health equity and reduce racial disparities (*NQF*, 2018.; Vedam et al., 2019). Patient-centered care requires centering the patient and their specific health goals in the treatment plan (Epstein & Street, 2011). According to Epstein and Street (2011), those previously in support of evidence-based care were opposed to patient-centered care arguing that patient beliefs should not interfere with the best clinical outcomes. However, more recent and robust research proves that patient-centered care produces more favorable outcomes in both health biomarkers and in individual patient experience (Epstein & Street, 2011; Julian et al., 2020; Levesque et al., 2013).

Meso-Level Definition of Birth Equity

Birth equity is health equity as it is applied to pregnancy, labor, birth and the postpartum period. Dr. Joia Crear-Perry, MD, founder of The National Birth Equity Collaborative defines birth equity as "the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities in a sustained effort" (NBEC, 2020). Racism and its effect on Black individuals and particularly in the context of reproduction is a public health crisis in need of urgent intervention and sustained effort. Research supports that providers and other healthcare personnel describe their care of patients to be equal regardless of race or socioeconomic status (Hardeman et al., 2016). However, research on implicit bias concludes that regardless of intent, providers treat patients differently and equal treatment is not the same as equitable treatment (Maina et al., 2018). Furthermore, research directly reporting findings in the voices of Black women and their experiences reflect inequitable treatment as evidenced by: dismissal and ignoring concerns or signs of deterioration (Chan et al., 2021); the conflation of social and structural determinants of health as individual-level factors (Riggan et al., 2020); and in patients' reporting of microaggressions such as receiving rude or insensitive comments from providers and other staff (Franck et al., 2020; McLemore et al., 2020; Vedam et al., 2017).

Micro-Level Definition of Equity by Model of Care

Models of PRH care outline how patient care, roles and responsibilities of patient and provider, and how interventions and outcomes are both conceptualized and delivered. The majority of births in the U.S. (98.4%) occur in hospitals (MacDorman & Declercq, 2019). In contrast to other high-resourced countries, births in the U.S. are primarily attended by physicians rather than midwives (Souter et al, 2019). Midwives attend 9.8% of all births in the U.S. while physicians attend 89.2% (MacDorman & Declercq, 2019). Though midwives and physicians are trained both didactically and clinically in different models of care, they are both governed by professional licensing which includes a code of ethics committing providers to uphold the safety, autonomy, and basic human rights of patients (ACNM, 2012; ACOG, 2016). However, data from the GVtM study shows that much of the mistreatment that women experience during their perinatal care constitute human rights violations, as described in the 2014 WHO

statement on maltreatment in perinatal care as human rights violations (Khosla et al., 2016; Vedam et al., 2019; WHO, 2014). Logically, for clinicians to operate in alignment with their professional code of ethics, they would be obliged to reject any institutional constraints of policies and practices which were created and continue to be informed by systems of oppression and perpetuate human rights violations, yet evidence shows the contrary (Khosla et al., 2016; Vedam et al., 2019). There are important distinctions in models of care between physicians and midwives that have implications for achieving health equity for Black birthing people.

Medicine and Midwifery Models of Care

Physicians are trained in the medical model of care. The medical model is synonymous with the disease model which identifies malfunctions in the human body and then applies trained observation and testing to differentiate disease processes to perform appropriate treatment (Swaine, 2011). For example, a physician who is presented with a broken leg is trained to differentiate the type of break, set and cast the abnormality, and return functionality to the limb. This model of care is centered on the provider as expert and approaches patients with problem-solving methods. The potential impact that the medical model can have on patient experiences in the PRH realm can range from lifesaving to detrimental depending on the disease process, lack thereof, and the individual health goals of the patient.

The medical model of obstetrics thrives on and greatly benefits birthing people when complications arise which can only be solved by procedural intervention. For example, maternal and infant mortality were greatly reduced when obstetric interventions (e.g. forceps assisted delivery) became available in the 19th century (Owens & Fett, 2019). However, the medical model is at direct odds with normal physiological birth without physical complications because there is no disease process which to treat. It is essential to recognize that all models of care are framed by history. The downward trend in maternal and infant mortality seen in the 19th century has now shifted into an upward arc over the past 50 years in the U.S., with this uptick found to be more closely related to maternal race (and therefore the impact of racism) and zip code than other causation (Chambers et al., 2019; Wallace et al., 2017). Critiques of the medical model include that the model reinforces paternalistic relationships already

present in healthcare, almost exclusively focuses on ailments rather than the assets and strengths of the patient, and the overmedicalization of childbirth gives rise to many unnecessary interventions that carry with them additional risk (Shaw, 2013; Swaine, 2011).

Alternatively, midwives are trained in the midwifery model of care. Midwifery is a continuity model which centers on the patient and holistically views the social, emotional, cultural and physiological aspects of reproductive health, pregnancy and birth as natural rather than pathologic processes (Hunter et al., 2017; Perriman et al., 2018). Eighty percent of the births worldwide are attended by midwives, contrasted by less than 10% of births in the U.S.(Souter et al., 2019). Research supports that there were greater levels of satisfaction in the birth of those using midwifery care stating the reported reason was in the continuity model which supported a trusting relationship with their provider (Perriman et al., 2018; Souter et al., 2019). One feature of the midwifery model of care is community building with other birthing individuals whose pregnancies are of similar gestational ages through group prenatal care; the most studied model is called Centering® (Chen et al., 2017). In Centering® or group prenatal care, patients are encouraged to assess their own vital signs, meet with providers (i.e., midwife, nurse practitioner, nutritionist, physician and/or social worker) and share experiences and resources with other participants (Chen et al., 2017). Group prenatal care is an example of a way to dismantle hierarchy typically present in patient-provider relationships (Chen et al., 2017). In addition, with the midwifery model rooted in relationship-centered care, arguably midwives are better equipped to support people with more socially complex lives, particularly pregnant people who experience the co-morbidity of racism as a risk factor in addition to other social determinants of health (Berg, 2005; Wren Serbin & Donnelly, 2016).

However, similar to medicine, the history of midwifery in the U.S. is rooted in slavery and continues to harm birthing people of color, but most disproportionately Black women and birthing people (Owens & Fett, 2019; Wren Serbin & Donnelly, 2016). Birth and birthing practices have many roots and origins. In the U.S., midwifery began with indigenous birthing practices, native to this land. Additionally, immigrants - both voluntary and forced, who came to the U.S. brought with them their birthing traditions,

and most notably with Black enslaved nurses and midwives who supported the majority of uncomplicated plantation births (Guerra-Reyes & Hamilton, 2017; Owens & Fett, 2019).

As is such with colonialism throughout history, traditional birthing practices were stolen by colonizers, co-opted into standardized practices and then systematically delegitimatized for the originators of the practices (Owens & Fett, 2019). The effects of colonization on midwifery persists today in the U.S., as evidenced by 90% of midwives in the U.S. being white despite 60% of the U.S. population identifying as white (US census, 2019), much research on the benefit of workforce diversification (Guerra-Reyes & Hamilton, 2017; Julian et al., 2020) and vocalized support among the nurse midwifery community regarding the evidence-based benefit of diversity in midwifery care (Wren Serbin & Donnelly, 2016). This persisting lack of diversity in midwifery is also rooted in history. By using their societal position of power and by stealing the practices of Grand midwives and Black nurses and then discrediting them, white male physicians in the 1920s became the dominant providers of obstetric care.

The Sheppard-Towner Maternity and Infancy Protection Act of 1921 simultaneously with physicians participated in the creation of a new model of midwifery centered on whiteness led by white public health nurses (Goode, 2014; Ladd-Taylor, 1988). The aim of the Sheppard-Towner Act was to reduce maternal and infant mortality by professionalizing midwifery by inspections of practices and by public health nurses and the requirement of standardized training for anyone who wished to retain the right to attend births (Goode, 2014). However, the impact of the Sheppard-Towner Act was disrespectful to the generations of passed down knowledge by demonizing practices that were foreign to the medical establishment and reduction of PRH care access for many (Goode, 2014). Then in the 1940s, a white woman, Mary Breckinridge established the first formal midwifery association which intentionally excluded all but white midwives (Dawley & Burst, 2005). Mary Breckinridge and countless other white midwives in the 1940s exemplified a problematic practice that persists today in white feminism when she aligned with the disproportionate white male led field of obstetrics to benefit themselves in proximity to power rather than globally expanding access to the entirety of the midwifery community regardless of race, educational preparation, and professional affiliation. Some 15 years after Breckinridge opened her

school, the American College of Nurse-Midwives (ACNM) formed to create a space for midwives of all races and ethnicities (Dawley & Burst, 2005), although this vision is still partially unfulfilled.

Similarities and Distinctions in Models of Care

Both the midwifery and medical models of obstetrical care aim to provide PRH care. Differences and similarities in patient experiences and outcome by provider type are influenced by the social determinants affecting the patient, the status of patient health, the model of care of the provider, the relationship between patient and provider, and the providers ability to listen to prioritize the patient (Wren Serbin & Donnelly, 2016). Physicians may be more appropriately trained to manage medically complex conditions (e.g., premature birth, blood clotting disorders, and surgical deliveries), during pregnancy, birth and postpartum. Whereas midwives are experts in normal, physiologic pregnancy and birth where they provide educational, nutritional, and emotional support and allow the progression of birth to occur while also being trained to recognize the need to intervene. Additionally, midwives are trained to co-manage complex clinical conditions (e.g., hypertensive disorders, diabetes, cardiovascular disease, and assisting in cesarean birth) with physicians. Interdisciplinary care models that include both physicians and midwives may allow patients with more complex clinical and social histories to receive the high-level obstetric care they need, while also benefitting from the holistic approach of the midwifery model.

Though physicians and midwives operate from different models of care, both are subject to the hierarchy of their professional identities which places physicians at the top as expert, then midwives, and then others. Additionally, in hospitals both models operate in the same environment and under the same institutional constraints, which have been established in a white supremacist society and uphold racism and racial inequities (Castillo et al., 2020; Frye et al., 2020). For example, even though midwives may be trained to center the patient, establish relationships, identify patient goals and values, and review the social determinants that may impact patients – the structural constraints of visits based on billing and hospital policy severely limits time, connection, and thus limits the scope of care.

Theoretical Frameworks

This study combines Critical Race Theory, Public Health Critical Race Praxis, Reproductive Justice, and Midwifery Theory to situate and explore the inequities facing Black birthing people and the perspectives of perinatal providers. Each theory is explained below and how they will be used in this study is described.

Critical Race Theory and Public Health Critical Race Praxis

Critical race theory (CRT) was developed using building block concepts of public health, race consciousness, and acknowledging the social construction of race (Ford & Airhihenbuwa, 2010) CRT offers a way of conducting research based on racial equity and social justice principles and applies that research to clinical practice and policy (Ford & Airhihenbuwa, 2010). Use of CRT, allows healthcare providers to better serve patients by identifying and confronting their own implicit biases, directly advocating for and listening to patients who are most affected by structural and historic racism in healthcare, pushing for increased numbers of Black clinicians and leadership and by challenging research and practices based on racists ideas and racist science.

The application of CRT into research that focuses on policy and institutional level public health interventions, is aligned using Public Health Critical Race Praxis (PHCRP). PHCRP is rooted in the concepts of CRT and how racism is a co-morbidity and cause of racial health disparities and inequities (Ford & Airhihenbuwa, 2016). PHCRP also develops novel research methods to account for bias and racially informs ways the research is conducted (Ford & Airhihenbuwa, 2010).

In the parent study to this secondary analysis, Community Racial Equity And Training Interventions and Evaluation of current and future healthcare clinicians (CREATE), the research was designed using four foci of PHCRP: Contemporary race relations, knowledge production, conceptualization & measurement, and action. These foci are important because they acknowledge the pervasiveness of racism, account for the intersectionality present in research about racism, maternal disparities, racial inequities, and grounds the work in the social construction of knowledge while creating

interventions. The direct application of this framework is inherited from the parent study, since the data presented in this secondary analysis come from the CREATE study.

Reproductive Justice

The Reproductive Justice (RJ) framework uses a human rights approach to achieve bodily autonomy (Ross, 2017). RJ is rooted in Black feminism and social justice in support of the human right whether to become a parent or not and emphasizes that everyone deserves an equitable and optimal experience free from forces of oppression and in supportive conditions (Ross, 2017). RJ, conceived by 12 Black women in 1994, is situated at the intersection of gender, race, and class, and is focused on reproductive autonomy and equity (Luna & Luker, 2013). Research supports that RJ is necessary to any intervention plan aimed at reducing the inequitable disparities facing the Black birthing community in the U.S. (Julian et al., 2020).

The RJ framework is essential for providers serving Black birthing people because the pervasive colorblindness of providers who report to treat all patients equally despite their documented implicit bias not only causes harm on the individual level but perpetuates a culture of harmful obstetric racism (Davis, 2019; Julian et al., 2020). The human rights approach of RJ, specific to birth equity is used in this study to explore providers perspectives on racial equity to examine privilege and power that contribute to the unequal relationship between patient and provider. Using these lenses, the research team will specifically name methodological decisions for data analysis in the methods section.

Midwifery Theory

The Midwifery Model of Care is both a system of care delivery as well as a theoretical framework that supports the “normal, psychological, social, and cultural processes of reproduction and early life” rooted with the birthing person’s individual experience, strengths, barriers and desires centered (ACNM, 2012). The midwifery model is built upon competencies in sexual and reproductive healthcare anchored in the relationship between patient and provider, and a deep belief that the patient is the expert in their experience. Trust is essential and takes skill, time, and care to build. Continuity of care is a core element to midwifery care, and essential in strengthening the trusting relationship between patient and

provider. Continuity of care includes prioritizing a patient meeting with the same provider throughout their pregnancy and interpregnancy to establish a deeper knowing of one's bio health markers, social histories, values, and reproductive health goals. Continuity of care is a critical element in midwifery theory. Midwifery theory is rooted in viewing the patient as expert in their body and experiences while also addressing the social and structural determinants of health that contribute as both strengths and barriers. Additionally, midwifery theory places the midwife as part of the ecosystem of the patient's health care team along with their community and other equally important members such as family members, doulas, nurse, social workers, and spiritual leaders (in some cases). A key distinction between midwifery and the disease model is that traditional midwifery theory views pregnancy and childbirth as normal and routine part of life, with an element of a spiritual or religious ritual (Ladd-Taylor, 1988). Whereas, the disease model focuses more on the potential pathologies and intervention rather than trust and observation (Ladd-Taylor, 1988).

While midwifery theory acknowledges the many racial inequities in PRH care, without grounding it within the broader RJ frame, colorblindness and subsequent harm and inequities will persist. As with all evidence-based science, when new knowledge is generated, treatment, clinical care and interventions evolve. Arguably, the structure that threatens PRH more than any other single factor is racism. Nelson et al (2015) states that not only does racism threaten health, but when providers lack education and training on the health effects of racism, racial inequities are upheld and heightened (Nelson et al., 2015). The relationship of racism and PRH indicates that addressing institutional and structural levels (rather than solely focusing on individual levels) of social determinants of health are essential to reducing MMR and racial inequities specifically facing Black birthing people (Julian et al., 2020; Prather et al., 2016). Research scholars substantiate "RJ-rooted models of PRH directly dismantle structural and obstetric racism in service provision and improve patient-centered access toward equity" (Julian et al., 2020 p4). Given these realities, the team will combine all of these theories to operationalize a CRT informed, RJ praxis applied to midwifery theory as part of the data analysis to be described in the methods.

Methods

This research thesis is a secondary analysis of existing qualitative data from the CREATE study. The CREATE study aims to build foundational data to produce a provider- and patient- informed, racial equity training for perinatal providers to improve experiences and outcomes of Black birthing people. The CREATE study was an exploratory qualitative research study that recruited a convenience sample of 25 perinatal care clinicians. The focus of this secondary analysis is grounded in the perspectives of midwives and physicians who participated in the parent study. A qualitative, case study design using a thematic analytic approach was used to explore the data.

Setting and Sample

Eligibility criteria for participation included clinicians who were at the time of the study providing perinatal care and serving birthing people at two medical facilities in the San Francisco Bay Area. Participants were recruited by *dear clinician letters* and participated voluntarily. Providers were invited to participate in an interview for up to 60 minutes. Confidentiality was ensured by de-identifying participant information and reporting across themes. Transcripts, fieldnotes, and audio recordings were available to the research team. The Institutional Review Board (IRB) of the University of California, San Francisco granted approval of the study and participants provided written informed consent.

Data Sources

Data for the CREATE study were collected through semi-structured interviews of perinatal care providers. All interviews were conducted in private office spaces separate from clinical space, by culturally concordant research assistants who were trained in qualitative data collection. Self-identified racial demographics of participating providers were: Black [n=4, 16%], other POC (Latinx, Middle Eastern, South Asian, and biracial) [n=5, 20%], and white [n=16, 64%]. The author of this thesis was one of the white-identified research assistants and conducted interviews with half of the white-identifying providers. The data were collected between January and March of 2019.

Data Analysis

For this secondary analysis, all transcripts, fieldnotes, and audio recordings from the 25 perinatal providers (midwives [n=8, 32%] and physicians [n=17, 68%]) who participated in the CREATE study, were available. Only one transcript was removed from analysis related to conflict of interest because that clinician is part of the thesis committee. A total of 24 transcripts were analyzed. See Figure 2 and Figure 3 for provider type and self-identified race/ethnicity data of participants in this study. A case study approach was chosen to provide opportunity to compare and contrast models of care, descriptions of health equity from varying perspectives of providers, namely, midwives and physicians. This method allows for the exploration of facilitators and barriers from the perspective of the people providing care. Transcripts were separated into two groups, those from midwives and then physicians. Next, consistent with CRT, RJ and Midwifery Theory, transcripts from Black providers were read first, then those from other POC providers and then white providers from both groups were analyzed respectively.

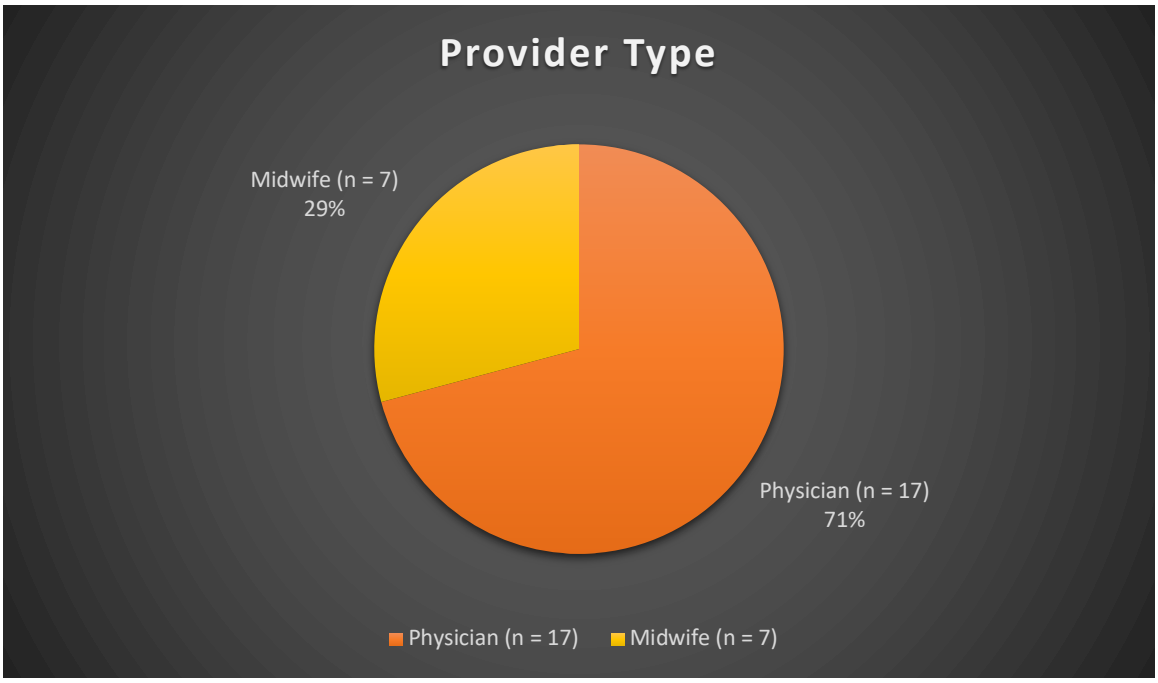

Figure 2:. Self-Identified Provider Type.

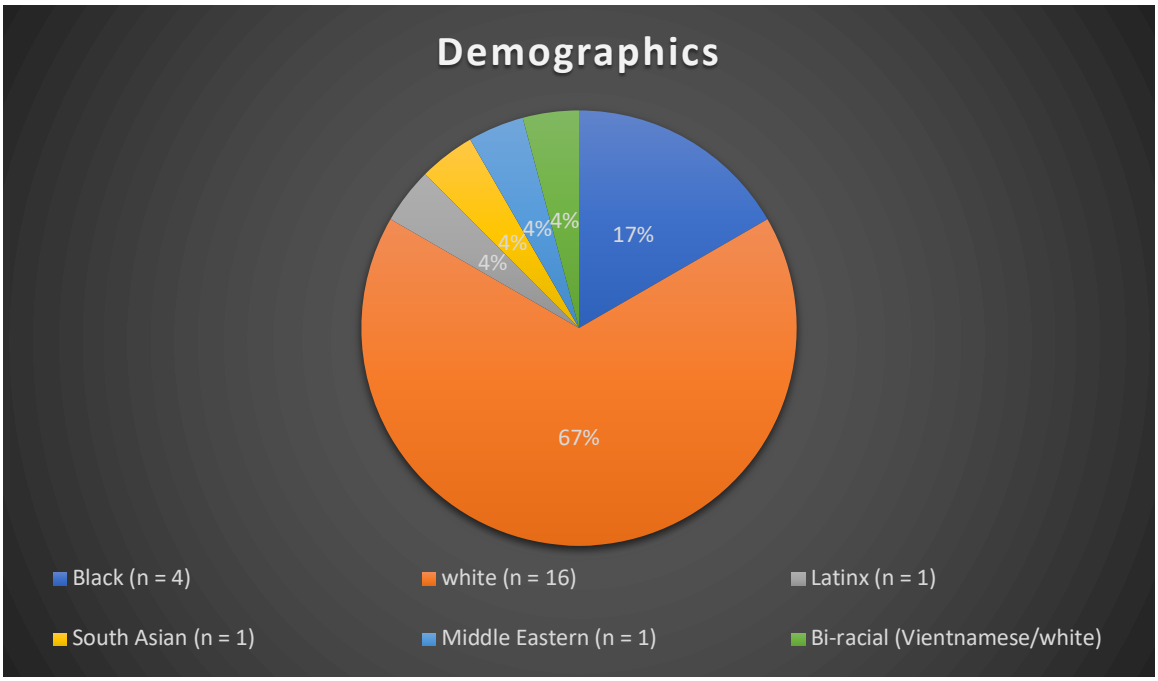

Figure 3. Self-Identified Race/Ethnicity Demographics of Provider Participants.

Thematic analysis (Braun & Clarke, 2006) was used to explore these data. Braun and Clarke's (2006) thematic analysis involve six steps that may be used in an iterative fashion (Braun & Clarke, 2006). The basic steps of thematic analysis are 1) familiarizing oneself with the data; 2) generating initial codes; 3) searching for themes among codes; 4) reviewing themes; 5) defining and naming themes which were identified within each transcript and across the dataset related to the research questions; and finally 6) producing the report by writing out results through the lens of the identified theoretical frameworks (Braun & Clarke, 2006).

We began by refamiliarizing ourselves with the data by listening to the audio recordings and creating memos of initial findings (themes and codes related to research questions). We continued by listening to audio recordings while reading through transcripts to identify additional themes and codes (phase 2 and 3). After creating initial codes across all transcripts, we stratified by themes and again separated the transcripts into two categories of midwives and physicians to see which themes were most salient in each. Specific overlapping codes from the parent study were grouped by topic and description and removed from this analysis. Our team then used a priori groupings based on frameworks, specific to

provider type (nurse midwife and physician), and model of care (midwifery model of care and medicine) to examine the barriers and facilitators to Black birthing people's reproductive healthcare specific to these perspectives. As themes were identified, we looked for marked similarities and differences which generated themes (phases 3,4,5). Once overarching themes were chosen based on meaning and content, we made decisions to exclude less prevalent themes. When all codes and themes were generated, we produced the results using the lens of theoretical frameworks RJ, CRT, and midwifery theory (phase 6).

Positionality of Researcher

This thesis is mentored work that has been conceptualized by a midwifery trainee who identifies as a cisgender white woman with doctoral prepared research mentors who identify as Black. The thesis committee is comprised of expert mentors who are clinicians (i.e., nurse, nurse midwives), community health scientist, multiple research scholars and leaders in the field of racial equity who identify as Black and women of color. In order to ethically conduct this analysis, the research team used PHCRP-informed practices including a layer of bracketing to acknowledge positionality as well as active engagement with anti-racist literature and training.

Bracketing in research offers methods to identify preconceived ideas the researchers may have related to individual characteristics and lived experiences that may bias their efforts, and interaction with the data throughout the study (Tufford & Newman, 2012). Bracketing is important at various points: at outset of data collection the researcher conducted a self-study into positionality and bias: throughout the data analysis and results evaluation stages the researcher continued to bracket through memo writing; and finally, through the mentorship of the research team (Tufford & Newman, 2012).

Application of Theoretical Frameworks in the Methods

This work adds to the body of knowledge aimed at filling a gap in racism-related research by moving beyond documenting racial disparities and inequities. Exploring clinicians and institutional healthcare deficiencies that contribute to barriers in care for Black birthing people illuminates root causes of harm in the context of PRH care. This approach makes space for RJ and CRT to expand midwifery theory by acknowledging what is and what is not working in PRH settings to capture the experiences,

strengths, barriers, and recommendations of those on the frontlines providing care. Achieving health and birth equity is contingent on the combination of these three frameworks (e.g., RJ, CRT, and the midwifery theory) to acknowledge and correct for racism as it shows up in data analyses. Consistent with PHCRP, study findings are identified using in vivo codes, where appropriate. Additionally, after axial coding a meta-synthesis was conducted to determine if the themes were cross cutting regardless of race (Black versus white) and or professional category (midwife versus physician). An additional use of CRT was to determine if the analyses by concept made more sense to organize themes versus the a priori case study determined by midwife versus physician. The use of multiple analytic pathways was consistent with CRT and PHCRP.

This analysis operationalized RJ theory by assuming that data have the potential to differently frame the celebratory and transformational time of pregnancy and birth by restoring focus and power back to the patient. By honestly acknowledging the role of white supremacy and its detrimental effects on health and health services provision, we are able to construct an analytic frame that does not begin from a traditional medical model of algorithmically determining solutions to a clinical problem. This approach begins with examining where clinicians are complicit in oppressing or supporting the reproductive autonomy of pregnant people.

Results

Thematic analysis resulted in the identification of five themes, namely: racism as a co-morbidity; healthcare systems inability to address the needs of Black birthing people; healthcare systems prioritizing providers over patients is a failed system; patients are the experts in the optimal healthcare model; and benefits of interdisciplinary teams grounded in Reproductive Justice. Themes are described and presented with exemplar quotes from participants denoting whether the participant was physician or midwife. We have used historically important Black people in medicine, midwifery and public health to provide pseudonyms for our participant quotes rather than participate in the dehumanization of using subject numbers. See Table 1. We also use this opportunity to celebrate these crucial contributors to the field of racial justice in medicine, midwifery, public health, and research. For without their work, we would not be able to conduct this study. One unexpected finding in using the case study approach is the establishment of a modified midwifery theory that is presented in the discussion section.

Table 1. Pseudonym Descriptions for Verbatim Quotes that Exemplify Themes.

Name used as pseudonym	Study participant represented	Description of historic person
Mary Eliza Mahoney	02_006	(1845-1926) Nurse. First Black nurse licensed in the U.S, director of a Black orphanage in New York, and first Black RN member of American Nurses Association (ANA). Her efforts on reducing racial inequities in nursing education and leadership (the number of Black nurses doubled during her time working with ANA).
Mary Coley	02_002	(1900-1966) Midwife. Cared for thousands of families in Georgia. Her work was documented in the film *All My Babies,* which the Georgia Health Department used as an instructional training film.
Maude Callen	01_004	(1898-1990) Public Health Nurse, Nurse-Midwife, & Midwife instructor N. Carolina. Director of the Maude E. Callen clinic in 1953.
Mabel Keaton Staupers	02_004	(1890-1989) Nurse. She worked for racial equity in the nursing profession. She led efforts for Black nurses to be a part of the educational, institutional and organizational structure of nursing in the U.S.
Margaret Charles Smith	02_005	(1906-2004) Midwife. Delivered over 3,500 babies in Alabama. Co-authored the autobiographical book *Listen to me Good* detailing her life and career.
Dr. Virginia M. Alexander	02_007	(1900-1949) Physician and Master of Public Health. Delivered many babies and founded the Aspiranto Health Home in Philadelphia where she taught classes to and cared for new families.
Dr. Roselyn Payne Epps	01_007	(1930-2014) Physician. First Black American to be local and national president of the American Medical Women's Association, first Black American and first woman president of Washington D.C.'s chapter of the American Academy of Pediatrics, and first Black woman president of the Medical Society of D.C.
Dr. Lena Francis Edwards	01_008	(1900-1986) Physician. One of the first Black women to be board certified as an obstetrician-gynecologist and gain admission to the International College of Surgeons. Dedicated her career to care of the poor regardless of their ability to pay for services.
Dr. James McCune Smith	01_011	(1811-1865) Physician. First Black American to earn a medical degree, and first U.S. Black-run pharmacy.
Dr. Rebecca Lee Crumpler	01_006	(1831-1895) Physician and writer. First Black woman to earn a medical degree in the U.S. Author of *Book of Medical Disclosures,* one of the first published works from a Black writer.

Source: https://guides.mclibrary.duke.edu/blackhistorymonth; https://www.platypusmedia.com/post/black-history-month-honoring-black-midwife-pioneers; https://www.blackpast.org/african-american-history/staupers-mabel-keaton-1890-1989/; https://cfmedicine.nlm.nih.gov/physicians/biography_5.html; https://cfmedicine.nlm.nih.gov/physicians/biography_96.html; https://cfmedicine.nlm.nih.gov/physicians/biography_102.html.

Racism as a co-morbidity

Racism as a co-morbidity describes how racism functions as a co-morbidity. This finding further explains how the weathering effect of racism that BIPOC individuals experience affect health across the lifespan on individual and population levels. Racism and the effects of racism predicate other inequitable and disproportionate circumstances that Black and other birthing POC are entering into prenatal care. Racism in all forms, particularly structural racism is responsible for the individual level manifestation of illness and disease that Black and other birthing POC suffer disproportionately from such as hypertension, preterm birth, and complex psychosocial issues (e.g., experiencing homelessness, oversurveillance by police and other agents of the state, poverty and living in neglected neighborhoods) (Chambers et al., 2019; Chan et al., 2021). Dr. Roselyn Payne Epps shares her perspective on these individual level factors that affect PRH that medical professionals are typically more focused on. However, she also points to the structural forces such as racism that affect health and specifically preterm birth:

> I think sometimes as medical providers we definitely focus more on the medical, you know, the numbers, the hypertension, the diabetes, the obesity, things like that. But certainly, I think food security, violence in communities…police brutality in communities, stress as we've…been learning about over the years, whether that's from racism experienced on a daily level. And…daily violence, not having access to good food and parks and places with green open spaces I think can definitely affect mental health and stress levels that I think we're learning more and more about as being risk factors for preterm delivery.

Midwifery models of care support a holistic approach to patients and have the opportunity to contextualize both individual- and structural-level factors associated with adverse maternal and neonatal health outcomes including preeclampsia and preterm delivery. Physicians expressed the need for more recognition of racism as a comorbidity in effort to move away from the deeply ingrained narrative that individual level inequities are the responsibility of the person affected rather than products of racist structures and systems.

Midwives shared that even if there is more recognition of racism as a co-morbidity, they are not trained to address racism in healthcare settings. Midwife Mary Eliza Mahoney describes not feeling trained in or having the tools to address the link of racism with preterm birth. She expressed not knowing how to have this conversation which might point to needing training around how to discuss racism as a comorbidity. Additionally, she also questioned if it was appropriate to have this conversation, pointing to something deeper and more insidious regarding racism and perhaps why it is so difficult to dismantle:

> I had a centering pregnancy group that was primarily African American women, and one of the things that I had wanted to talk about was racism and preterm birth, and I couldn't really find a lot to support what that conversation should be, if it should be. I think my goal was to shed light on the need to shift away from a focus on individual behaviors as the most important levers in changing health outcomes.

Physicians shared similar views and described being trained to relate to a specific type of patient as "standard," one that is disproportionately white and well-resourced and not feeling flexible in their approach. Dr. Rebecca Lee Crumpler shared learning to idealize the standard patient as a white, well-resourced person, labeling other patients "different," and represented an example of how white supremacy is infused throughout healthcare:

> … we didn't know how to have that conversation…and instead characterized that family in a way that was very pejorative and negative, and I think we had sort of mastered communication with one type of one group of women but not learned how to be sort of more diverse and flexible in how we communicate with people... I was actually on this phone call…talking about how to support women with sort of great psychosocial needs who come in and out of our system or utilize other systems in San Francisco and the Bay Area, and one of the nurses was like "I just wasn't trained to do this kind of work," and this is a Black woman who is an excellent nurse, I think is one of the most respectful people, and she just felt that this had not been part of her training as a nurse, how to provide this very holistic care, how to sometimes deviate her approach, how to be accepting of maybe people who present differently, interact with us

> differently and also that so often if people don't fit the sort of model of what we envision to be the ideal patient that we struggle with them. And I think too often Black women are seen as different, and so when they ask or do something that may be different than we're used to…we don't know how to respond...

The current models of care are training providers to be ill-equipped in tending to the needs and life circumstances of huge swaths of the birthing population, most dramatically those who are BIPOC identified. Rather than addressing the structures that create inequities and disparities and properly training healthcare providers, dominant white culture tends to blame individuals for the effects of social and structural conditions such as racism and poverty.

Healthcare systems inability to address needs of Black birthing people

Healthcare systems inability to address needs of Black birthing people describe the systems-based structural and institutional barriers to care within healthcare including but not limited to insurance problems (e.g., gaps in care, unclear communications regarding insurance); and lack of auxiliary support related to healthcare (e.g., no childcare for patients). Midwives describes how it is not necessarily care that needs to change, but factors in the system that block folks from care that should pivot. Midwife Maude Callen describes how a failed communication regarding insurance coverage can lead to someone being late to prenatal care and in this scenario missing half of their needed care:

> I don’t know that you need to change prenatal care. I think you need to change the system, which is different. So, what I mean by that is if I am an African American woman who is unemployed and I am pregnant, I was born and raised here in California, I qualify for Medicaid…But yet when I call to get an OB appointment…I may live three blocks down the street (from Hospital 1), I’m told, “Oh, well--” I don’t have health insurance yet…you might want to call (Hospital 2).” “No. I want to have my baby here. It’s three blocks down the street.” “Well, if you come here, you might get a bill.” Well, I don’t… understand that that bill will be covered because I qualify for Medicaid, so then I say, “Okay, fine,” and I hang up the phone…I’m eight weeks-- it may take

> me…until I'm 20 weeks to get the Medicaid so that now I can come in here and get the prenatal care…it's not the prenatal care, it's the system...

Clinicians also shared that healthcare systems and insurance coverage policies make it challenging to build trust and continuity with patients. Trust and continuity are also core tenants of the midwifery model. Furthermore, clinicians stressed that confusion and miscommunications regarding Medicaid eligibility is a barrier to health for birthing people given that the majority of pregnant people do not get approved for public insurance coverage until their second trimester of pregnancy. Additionally, physicians expressed that if birthing individuals are only eligible for insurance once they become pregnant, they don't have the opportunity to treat chronic issues that may affect pregnancy health. Dr. Roselyn Payne Epps shares how lack of care between pregnancies drives higher rates of disease:

> …indicated preterm delivery for preeclampsia…is a major driver to preterm birth rates too. Spontaneous preterm labor is also. But if you have chronic hypertension going into a pregnancy that's not well controlled that can be a problem. And so, if the healthcare interpregnancy isn't there either…it exacerbates some of the same problems we see during pregnancy.

This systemic barrier makes it challenging for providers to address many primary care issues pre- and inter-conception that directly affect the safety of the current pregnancy such as chronic hypertension, in addition to impacting the persons health overall and across the lifespan.

Physicians also expressed healthcare systems lack the infrastructure to provide auxiliary support such as childcare for single parents who are in need of inpatient care. Dr. Lena Francis Edwards describes the policy of how a person may not receive care in the inpatient setting with a child unless they have another caregiver for their child(ren):

> I think a big stressor that we have is childcare, I think especially for patients who are single mothers who need to be admitted and that we often put them in this difficult situation where they have to decide whether or not they're going to prioritize their health or the health of their current pregnancy and their children because we don't have the ability to have children in-house without another adult, and that's-- I think that affects African American families more than others.

In this scenario, a parent without support people in their life would have to choose between their health or the safety of their children.

Healthcare system prioritizing providers over patients is a failed system

Healthcare system prioritizing providers over patients is a failed system explains how care is focused more on the provider's or institution's needs rather than those of the patient. Evidence points to patient-centered care as the gold standard to bring about the most optimal health outcomes and patient experiences (Epstein & Street, 2011; Julian et al., 2020; Levesque et al., 2013). However, many of our physician and midwife participants detailed ways in which current culture favors the provider or the institutions ease of healthcare provision rather than patient goals, outcomes, or experience. Dr. Virginia M. Alexander describes how care delivery is highly affected by the preferences of the particular provider rather than driven by protocol or patient needs and desires: " …a lot of the time, I think, what happens now is that the provider's style and where they land dictates what happens, and we need to shift that." Dr. Rebecca Lee Crumpler further illustrates this point as she questions the very possibility of being able to move towards a patient-centered equity model with the current underpinnings of "for-profit" healthcare rooted in a provider-oriented hierarchy:

> If we still operate in our structure where people get charged for healthcare… and we still provide obstetric care from a very medicalized, provider-centric model then even if we do this amazing work around equity will we transform how we provide care, how care is experienced?

Both physicians and midwives expressed a tension between healthcare being a "for profit" business rather than a "for health" model centered around the person needing care. Clinicians specifically stressed their concern over being able to provide the kind of care that patients would describe as excellent and equitable within the time constraints of 15-minute appointments dictated by the "for-profit" model. This "for profit" model is in direct contradiction to person-centered care, one of the key tenants of the midwifery model.

Additionally, midwives stressed the need for healthcare institutions to come up with structural level solutions to better serve communities of color. Midwife Mary Coley put forth a solution to bring

healthcare providers to the community: " …I wish that we were like out in the community. Out in the community doing more outreach with hours that the community needs, not what we need." She shared that bringing care into communities is not only more convenient for patients, but also shifts the provider-centric power dynamic and restores focus on the patient.

Midwife Margaret Charles Smith shares an example of how providers can have a skewed, paternalistic view, that often lacks the humility to acknowledge the boundaries of knowledge. She shares perspective on how to level the power dynamics between patient and provider by shifting conversations away from labeling patients as "non-compliant" towards providers taking a deeper listening role to understand when patients disagree with their recommendations:

> In health care there's a hierarchy, and there's definitely assertion of power around…our policies, and…our recommendations, and…the patient's best interest at heart, and we're first in the realm of birth care. It's even more complex because…we're protecting this baby, in that hierarchical framework, and…paternalistic framework, we lose sight of-- Well, actually the family holds the greatest love and responsibility for themselves and for their children, like we're here as partners in that. We are not the supreme decider or kind of arbiter of what that protection looks like. So that comes up…around like someone's like refusing. Are they refusing, or are they declining? You know, and how willing are we to stay in partnership when families decide they actually don't want to do what we're recommending. Do we see that as-- are we compelled to distance ourselves or does that actually bring us closer to this base of like curiosity about, you know, okay, you don't want to do X, tell me about what feels like the next step to you, and how can I support you in making that choice in an informed way, and making that choice in a way that feels like you're being heard in this space.

Margaret Charles Smith points out how with a necessary shift in provider perspective from being skeptical of patient perspectives to trusting that the patient holds their and their child's best interest can foster a deeper connection and an opportunity to shift the hierarchical structure of a typical healthcare encounter and likely bring greater patient satisfaction.

Patients are the experts as the optimal healthcare model

Patients are the experts as the optimal healthcare model describes patient outcome and perception of care as the most important marker of success. One of the core principles of midwifery, is that patients are the ultimate authority in their health and life experiences. Both physicians and midwives urged the importance of sharing birthing people's perspective of protective and risk factors associated with healthy pregnancy and birth. Clinicians went further to share that it is essential to recognize, respect and celebrate the resiliency, resources, and expertise of Black birthing people. Dr. Lena Francis Edwards describes the importance of identifying patient advantages in addition to their vulnerabilities:

> …trying to do both an asset and needs assessment of patients…not always framing things…that they lack or…that they might be missing, but, like, also highlight the things that exist that make people resilient… to withstand all of the adversity and have been that has been, facing the African American community. Like, it's, you know, we frame it as…there is this weakness or this victim sort of type of narrative, but I think that there's also a lot of strength and resilience and obviously we experience things at increased frequencies, but it's not because we're, like, lesser people or, like, not meant to have babies and have healthy pregnancies. I think that focusing on the strengths and why it's so important for us (providers) to do better is, like, is more-- and the whole equity piece of it I think is really important to emphasize. It's not like a we're saving Black babies and Black moms. It's like we're just, we're showing up for them when we need to show up, in the same way we show up for all of our patients.

Having the patient positioned as the expert brings focus to their strengths and assets rather than emphasizing only their barriers and detriments for which the predominately risk-focused models tend to concentrate on (Black Mamas Matter Alliance, 2018).

The Centering® model of prenatal care which prioritizes community and a horizontal distribution of knowledge rather than a provider-led hierarchical distribution is a manifestation of model of care that fixes patient as expert (Chen et al., 2017). Midwives, including midwife Mabel Keaton Staupers discussed the benefits of the Centering® model of prenatal care as an intervention to racism in PRH care:

> More centering pregnancy for-- I know at (Hospital 1) they started a centering pregnancy group for…Black pregnant people, and I think that would be an amazing thing to have here too. We do centering…at (hospital-affiliated prenatal program). I think also having the centering groups off-site like that is really nice to get it out of the institution and into a place that is more homey, more friendly and takes away some of the connotations of all the institutional racism that has preceded… I think centering is an amazing way to do prenatal care, and it really brings together communities, and…it's a nice way for people to be heard and to participate in their own care.

The RJ and CRT frameworks align with the group prenatal care model by urging providers to both examine the power and privilege they hold when entering into patient encounters as well as recognizing the patient as the true expert in the room who has lived in their body and circumstances for the entirety of their lives.

Benefits of interdisciplinary healthcare teams grounded in Reproductive Justice

Benefits of interdisciplinary healthcare teams grounded in RJ describe how the current midwifery and medical models will benefit by being infused with RJ theory. Interdisciplinary healthcare teams are made up of various practitioners who focus are different aspects of patient health (e.g., physicians, midwives, nurses). Physicians and midwives shared how pregnancy and birth are the only time when people who are healthy are also recommended to come into healthcare quite often and be subjected to a plethora of tests, treatment plans, and opinions on how to navigate normal physiologic processes. Dr. Virginia M. Alexander explains how the medical models' narrow view of PRH is overmedicalizing how someone should experience pregnancy. Additionally, she offers a new perspective on how to improve perinatal care that aligns with the RJ principle of self-determination. Dr. Alexander further reflects on how the majority of women could never come into prenatal care and still safely birth at home.

> …even before I started learning about all the disparities, I genuinely believe that it's a problem that in the U.S. we're essentially forcing women to deliver in hospitals…So, I think I fall more as a provider from the perspective of we are way overmedicalizing prenatal care, and if you look at it from that lens then, again, it's not just because-- As healthcare providers, we should not be

> prescribing exactly what someone's supposed to be doing with their pregnancy because for a majority of women, they could never come to prenatal care and deliver at home and they'd be absolutely fine-- a majority, but not all. And so, what I think the role of prenatal care is, is simply to watch, to do education, and then when things look like they may be going in a bad direction to work with the family to explain that, and then come up with a way to just make sure they're not actually going in that, or if they are, to do something about it.

Dr. Alexander and other physicians and midwives expressed the need for a more flexible type of care that incorporates the combined nursing, midwifery and medical models in preventative care through education, intervention for complications, and directed by the individual seeking care.

Dr. James McCune Smith shares the concern regarding being able to adjust the current models of PRH care in order to bring about equity. Dr. Smith places emphasis on relationships between patient and provider and the inclusion of other members in these interdisciplinary teams:

> Midwives are relationship builders, and, you know, so midwives and doulas, I think, are—absolutely have to be part of the solution, so new models of care versus—or in complement to kind of tinkering with what exists, but there's just—I think we have to be mindful of that there's just really severe limitations on the existing system.

Physicians, including Dr. Smith speaks to the concern and desire for change, but also the fear that change may not be possible in the current medical model of care.

Midwifery at its core value and literal translation means "with women" and refers to the midwife's reciprocal relationship and allyship with the birthing person rather than a unidirectional practitioner-patient relationship. Midwives, including midwife Margaret Charles Smith describes the need to look at the holistic experience of prenatal care from more than just what the midwife or physician are offering in care model. She shared that if the goal is to offer something health affirming, the entire experience must be evaluated to be welcoming and healing:

> I think explicit welcome and respect, that needs to infuse everything we do, from outreach to even inviting people into our clinical spaces from the moment they walk on campus. What's the

> signage? What's the smile? What's the eye contact? What's the introduction? What's the sheriff doing? What's the waiting room like? Is it a comfortable and respectful space? And then the communication, as I've talked about all those elements actually being present in every encounter with every person on the team. And I think the ways in which team members communicate with each other, so actually as much as we can doing the work and reducing the workload on families. because I feel like it's enough to ask to be a parent, to have a newborn, to be pregnant, to navigate all the complexity of living in the city and living in the city as a Black woman. Like whatever we can do as a healthcare team to make that experience of engaging in care actually-- gosh, could it even be relaxing and feel like an appreciative space as opposed to another thing. Another thing to be managed… I feel like that's the lens we should use. If this were a healing space or if this were a regenerative space.

Margaret Charles Smith emphasizes the importance of relationships between team members as well as those with patients. If an RJ-informed model can create more horizontal lines of collaboration rather than a hierarchical structure, team members may more readily be in relationship with each other and the patient. Midwives were focused on the relationship with their patient. The act of being in relationship takes care and intention as well as introduces vulnerability. The exposed position of a provider not trying to change a patient (or team member) but rather to be in relationship with them during a most intimate time in their lives takes great emotional work on part of the practitioner (Hunter, 2010). This emotional work is not typically the focus of the medical care model but rather a sequela that contributes to burnout.

Dr. Rebecca Lee Crumpler encompasses the urgency of engaging all PRH providers in solutions to address racism in healthcare as a matter of safety. Multipronged approaches including upstream supports prior to birth are needed to improve PRH inequities facing Black birthing people. Using hypertension management as an exemplar she explains:

> I think we have to admit that racism is part of our culture, and it's part of the lived experiences of many people, including our patients, and so to take care of them then we have to be forced to address it. It's kind of like we try and treat high blood pressure, but medications only go but so

> far, and if you're not addressing the underlying causes of what causes high blood pressure, you'll never really make any progress. And I think in our country you could argue that we will never have excellent maternal and neonatal outcomes unless we think very thoughtfully about equity and elimination of disparities, different models of care, and so you can continue to come up with whatever structures we want around quality assurance, but if we haven't truly addressed these larger sorts of issues of structural violence then we'll be lost. And unfortunately, we know we're terrible at treating things once they've manifested. When someone comes in in pre-term birth, we don't know how to stop it. They deliver. We may help blunt or delay the effects for a few days, but we don't really stop it, and sometimes preeclampsia-- that's horrible. Maybe we get them a few more weeks, but we don't eliminate it at that time, and so I think we have to think broader. We have to push ourselves to think about sort of what are those underlying causes and really shift from a disease-focused mentality to a wellness and well-being, and I think in that regard racism is a state of oppression and violence, and so you can never really be well if you're immersed in sort of a racist culture or racist medical system and so forth.

Within this quote, Crumpler is identifying both prevention efforts and individual factors combined with structural barriers and stresses the need to shift the focus in order to keep patients and the greater community safe. She and other physicians and midwives lean towards solutions like focusing on anti-racism, relationship building, connection, respect and celebration of personal, cultural, and ideological differences. This shift in focus could bring the care team into partnership with the patient to identify strengths and assets to support positive health outcomes, while also addressing risk. Teaching future healthcare providers RJ, CRT, PHCRP, and midwifery theory is one method to provide a holistic view to dismantling oppression and racism in the current PRH models.

Discussion

This study adds to our understanding of how provider type (e.g., physician, midwife) and care model (e.g., medical, midwifery) play an essential role in Black birthing people receiving optimal care as evidenced by provider experience, perceived patient experience, health outcomes, and overall maternal mortality and morbidity. We found that the intersections of racism; healthcare's inability to address the needs of Black birthing people; and the healthcare system prioritizing providers over patients all contribute towards detrimental PRH care experience for both patient and provider. We found that redefining patient as expert and the benefits of interdisciplinary teams grounded in reproductive justice offer inventive solutions in the reimagining of an equity focused PRH model.

Our study found that model of care did impact provider perspectives of structural- (e.g., transportation, housing) and institutional (e.g., policies, practices) barriers that contribute to reproductive health inequities among Black birthing people and families in San Francisco. Physicians and midwives both deemed racism as the driver for structural and institutional barriers. However, physicians tended to stay aligned with their medical/pathology model of training as they pointed to problems and possible solutions. Alternatively, midwives had a more holistic view of drivers and remedies to the inequitable climate of PRH care which stemmed from patient experience and values. Physicians admitted that they cannot be patient-centered when provider style guides care and how their training has set them up to treat one type of patient (e.g., disproportionately white and well-resourced). Midwives generally called for a new model of care naming how the current system does not support the practice of midwifery. They cited policies and location of services as key barriers to the necessary relationship and trust building between patient and provider. Physicians generally referred to transportation, and policies in the institution (e.g., no childcare) as creating disproportionate barriers to Black birthing people.

Furthermore, this study found a general consensus among all provider types (e.g., physician, midwife) that they are ill-equipped to address the inequities facing the Black birthing community within the current system of care delivery. Both physicians and midwives shared that the "for profit" structure of

healthcare was not congruent with optimal health and a satisfying experience for their patients. However, this study determined that models of care do inform how providers view actionable items specific to eliminating health inequities. Physicians expressed the need to focus on racism as a co-morbidity to shift focus away from individual-level factors. Midwives highlighted the relationship between patient and provider as center to improving care. Physicians recognized solutions to the current inequitable state of PRH care would need to include more midwives, doulas, and other team members into the interdisciplinary team to build relationships and thus better care. Midwives introduced an intervention of bringing care into the community rather than being siloed in the hospital. Additionally, midwives expressed the need for more group-based prenatal care such as the Centering® model to prioritize patient and community knowledge and decentralize the provider-centric model.

One unexpected finding from this study is that both physicians and midwives expressed a need for a new care model and system of care delivery. With these findings, our team proposes a modification of the midwifery model for application by all provider types that could radically shift PRH care. Using a human rights approach to perinatal care, RJ-CRT-informed midwifery theory may be operationalized by all PRH care providers, not only midwives, to move racial health and justice forward in a way that serves and honors all birthing people. This novel model reflects an iterative process that may offer institutions and providers methods to improve PRH care for all patients by specifically focusing on improving care experience and outcomes of Black birthing people. While midwifery theory acknowledges the many racial inequities in PRH care, without situating it within the broader RJ frame, subsequent racial harm and inequities will persist. It is not enough to be non-racist in the care of patients, clinicians must be anti-racist to combat and dismantle the status quo which is inherently racist. The key components of RJ, CRT and public health critical race praxis supplement the current midwifery theory with an anti-racist core to create an RJ–CRT-midwifery-informed perinatal and reproductive healthcare approach that honors the patient in all of their strengths, barriers and co-morbidities including racism.

These key components of RJ including supporting the human right whether or not to become a parent, highlight the important point that everyone deserves an equitable and optimal experience of family

making free from forces of oppression. Furthermore, all deserve to make these choices in conditions conducive to full health and well-being, including the separation of sexual pleasure with reproduction as restorative of the human right to self-determination. When considering CRT, the acknowledgment of the social construction of race, providers can identify and confront their own biases to equitably serve their BIPOC patients and understand how racism functions as a co-morbidity and cause of racial health disparities and inequities. Finally, applying these principles to the root of traditional Midwifery Theory – a holistic relationship-based care model that cements the unwavering trust in the patient as experts in their experience while reaffirming provider position as partner whose role is to offer information and options related to sexual and reproductive health without inserting their own agenda. See Figure 4 below for a visual representation of the combined theories and view of this proposed model.

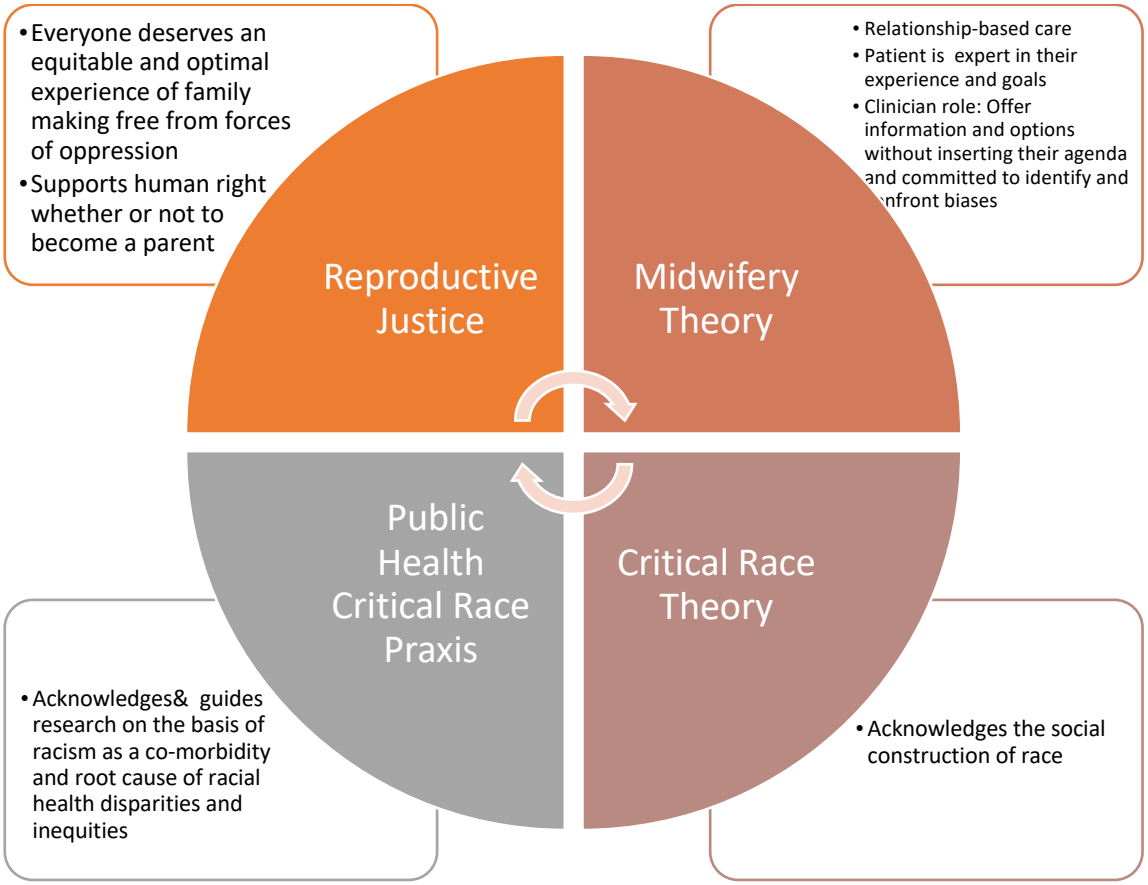

Figure 4: RJ-CRT-Midwifery-Informed Reproductive Healthcare Approach.

Racism is a multi-pronged structure that threatens birthing persons mortality and morbidity more than any other factor. In order to shift the trajectory of MMR in the U.S. and beyond, we propose this model as basis for intervention creation. We are looking towards PRH care that not only keeps birthing people statistically safe but allows space for the individual values, goals and culture to be centered. This model, if incorporated by both the medical and the midwifery professions, offers the opportunity to reimagine and restructure PRH care that views patient as expert and leader of their healthcare team. Additionally, though this model may be merged into both the medical and midwifery model, the presence of and distinction between physician and midwife is essential. It is necessary for physicians to remain experts in surgical procedures and complex disease processes, just as it is essential for midwives to remain the experts in normal. In this definition of scope, patients will receive the most optimal care, and the relationship between the two professions may become more equalized and have potential to heal the past history where obstetrics aimed to replace midwifery. We propose this model will supplement and offer space to both the medical and midwifery models to adapt to the current needs of those seeking PRH care. If pregnancy, birth, and the entirety of PRH were more universally viewed as normal life processes in need of diverse scaffolding depending on the strengths and vulnerabilities of each individual rather than as a pathology, the use of interdisciplinary teams led by patient desires would be salient. For example, one patient may seek more medical guidance and intervention, whereas another birthing person maybe benefit from more community-based care with minimal midwifery and no medical involvement. Under the guidance of RJ, the interdisciplinary team would hold the shared belief that the health of the patient is contingent on flipping the provider-topped hierarchy to correctly place the patient at center with providers as auxiliary supports.

It is important to contextualize this model and its potential for transforming PRH care within existing studies. The work of Scott et al., (2019) aligns with our findings in their statement that new care models were needed if we are to move toward equitable PRH care. They also highlight the need for pre- and inter-conception care, the strength of group prenatal care, home visiting programs, and known best practices that support infant bonding and lactation in the immediate postpartum period. Additionally,

Scott et al., (2020) cite the Black paper entitled “Setting the Standard for Holistic Care of and for Black Women” by Black Mamas Matter Alliance (BMMA) which also uses the RJ framework and evidence to support more equitable care for Black birthing people and is aligned with the American Nursing Association (ANA) guidelines specific to patient autonomy and respectful care (BMMA, 2018). Altman et al., (2020) call for more nuance when understanding the specifics around the structural and institutional changes detailed by women of color receiving PRH care in San Francisco, regarding the need for greater continuity in PRH care provision. Suggestions included structuring services in order to reduce burden on patients by creating more flexible schedules (e.g., evening, weekend hours), consolidating care to one location, and including comprehensive healthcare coverage across the lifespan so patients are not limited based on insurance status.

By contrast, Julian et al., (2020) criticizes the provider-centric models of care and pushes for community-informed and synchronistic approaches while emphasizing the application of an RJ lens in the creation of new models for PRH. The authors further create a call-to-action list that works to decentralize power away from providers and back to patients (Julian et al., 2020). McLemore & Choo, (2019) further support the notion that Black birthing communities must be centered rather than merely included in intervention plans and new models to disrupt the current trend of racial inequities present in PRH and the structural barriers present that continue to keep community voices from being heard and highlighted.

Finally, the BMMA Black paper (2018) aligns with our findings that trust and informed consent are crucial components to any model as they are essential elements to the patient-provider relationship (BMMA, 2018). Furthermore, as stated in the Black paper “care through a Reproductive Justice lens will always prioritize consent over provider bias” emphasizes that in order to provide equitable care, there must exist true informed consent (BMMA, 2018 p.11). Kotaska, (2017) speaks of the history of informed consent, bodily autonomy and paternalism in obstetric care as highly subjective and evolving. To truly have informed consent, providers must be transparent and non-coercive in the options, safety, and competency of these options, and then respect and uphold the choices of patients (Kotaska, 2017). The discrepancy of allegiance that guides care creates a fissure in institutional PRH care that may be filled

with paternalism, racism, and obstetric violence (Newnham & Kirkham, 2019). Newnham & Kirkham, (2019) refer to "rhetorical autonomy" in their examination of autonomy and care ethics in midwifery when they discuss how providers "gain consent" rather than fully laying out options and centering care around patients' desires and goals rather than those of providers or the institution. Even the term "informed consent" presupposes that arriving at consent is the goal, rather than centering the process of informed decision-making. The RJ–CRT-PHCRP lens layers the human rights approach over the midwifery model in order to override the dominant culture of provider and institutional hierarchy and restore patient as expert.

Strengths, Limitations, and Ethical Considerations of the Study

There are multiple strengths and limitations of this study. The first strength is the focus on voices of clinicians who directly interface with the healthcare system, namely PRH providers who provide care in two large healthcare institutions that serve a large range of the birthing community in San Francisco, California. Second, Midwives and physicians who provide direct patient care have one intimate view on the drivers of institutional racism and barriers to providing optimal healthcare and thus optimal experiences and health outcomes to Black birthing people in San Francisco. Our team proposes that our results and recommendations may be replicable and impactful in other settings (e.g., urban, rural, hospital, community PRH). However, we acknowledge the goal of qualitative research is to capture the variation of responses, not to be misinterpreted as generalizability. Third, another strength lies in the parent study CREATE, which was informed by PHCRP and included interface with community advisory members in addition to CRT and RJ informed scholars. These intergenerational and multi-experiential perspectives informed both the conceptualization and design of the study as well as the analysis.

One limitation of this analysis is that it does not include the direct voices of the Black birthing community. The research team recognizes that provider perspectives must be contextualized with those of Black birthing people to be holistic. In order to create meaningful and impactful changes in experiences and outcomes of pregnancy, birth and lifetime well-being of Black birthing people, their families, and communities; their voices must be centered. However, we recognize that providers cannot engage as true

partners without understanding their own limitations and gaps in knowledge. A second limitation is these data were collected in a single geographic area in one of the most expensive cities in the U.S. Finally, despite these limitations, our work builds on the findings of other studies and provides additional evidence for synthesis of themes. For example, Altman et al., (2020) focuses on the voices of women of color in San Francisco who urge providers to listen to (and include their voices in interventive plans) as experts in their experience and offer concrete recommendations for providers around interpersonal trainings such as implicit bias and education focused on reducing stereotyping and discrimination.

Midwifery and medicine are considered both an art and a science and therefore cannot remain static. In our proposed model of an RJ–CRT-Midwifery-informed PRH model, providers and institutions must be dynamic in their approach to meet community needs. For example, this model may present institutional challenges as it exposes a need to shift the way, by whom, and where care is provided. Newnham & Kirkham, (2019) describe their plea for the humanization of birth by strengthening the connection between provider and patient rather than provider and institution (Newnham & Kirkham, 2019). This very same relationship between patient and provider and the key midwifery principle of supporting patient as expert and autonomous in their experience must remain centered above those of the institution. Both provider and institution must continue to strive to create healing spaces of ethical, honoring, and excellent care that upholds the patient and their desires at center while providers remain in an active, loving relationship with patients. This relationship and professional dedication to the art of medical and midwifery practice will ensure healing, celebration of PRH, and most importantly less damage to the Black birthing community. Our recommendation for future research is to include both providers as well as the birthing community in conversations and discussions.

Clinical Implications and Conclusions

Based on our collective clinical experience as a research team, we view the clinical implications of this work to have broad application in the real world. These applications are wide and may range from but are not limited to a redefined role of provider, the creation of algorithms of how to address racism in the healthcare environment, to patient satisfaction tools built into electronic medical records (EMR) that trigger provider accountability, to doulas available to all and covered by all insurance types, to patient navigators dedicated to the safety and experience of patient, to community tools like participant-led PRH support groups, community-based care, community advisory participants in research, and consumer technology such as like the Irth© app which functions to report which providers are considered safe to Black birthing people (https://irthapp.com/).

The participants in this study and previous research citing voices of Black birthing people state that the current system is not equitable or focused on patient needs, values, and desires (Davis, 2019; Epstein & Street, 2011; Julian et al., 2020; Levesque et al., 2013). We need greater vision, institutional and federal investment, and commitment to provider/patient partnership to reimagine what PRH care could look like if it was truly serving those it claims to serve, the birthing person, their family, and greater community. Congresswomen Alma Adams and Lauren Underwood along with many community partners and cosponsors in the House and Senate have put forth the Black Maternal Health Momnibus Act of 2021, an updated version of the 2020 proposed legislation to address many upstream systems and policies that can improve reproductive health inequities and support efforts such as ours which focuses specifically on care (Booker, 2021). Through this new model, a radical dedication towards justice, human rights, and human connection rooted in anti-racism must be at center to redefine how we engage with being co-conspirators in dismantling PRH inequities.

Pregnancy, birth, and the entire reproductive lifespan have been occurring long before any health professions or their professional organizations were conceived. The ancestral and community knowledge of birthing people from all cultures and ethnicities are woven into this fabric that physicians and midwives are now privileged to be a part of. Expertise and ownership are tenants of white supremacy and

must be dismantled for clinicians be able to participate in equitable PRH care rooted in birth justice. (Nash, 2019; McLemore, M.R., 3/12/21 1555).

References

American College of Obstetricians and Gynecologists. (2001). Code of Professional Ethics

American College of Obstetricians and Gynecologists Joint Statement: Collective Action Addressing Racism. (2016). Retrieved September 15, 2020, https://www.acog.org/en/News/News Articles/2020/08/Joint Statement Obstetrics and Gynecology Collective Action Addressing Racism

American College of Nurse Midwives. (2012). Core Competencies for Basic Midwifery Practice. http://www.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000050/core%20comptencies%20dec%202012.pdf

Altman, M. R., McLemore, M. R., Oseguera, T., Lyndon, A., & Franck, L. S. (n.d.). Listening to Women: Recommendations from Women of Color to Improve Experiences in Pregnancy and Birth Care. *Journal of Midwifery & Women's Health*, *n/a*(n/a). https://doi.org/10.1111/jmwh.13102

Altman, M. R., Oseguera, T., McLemore, M. R., Kantrowitz-Gordon, I., Franck, L. S., & Lyndon, A. (2019). Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth. *Social Science & Medicine*, *238*, 112491. https://doi.org/10.1016/j.socscimed.2019.112491

At, G. (1992). The weathering hypothesis and the health of African American women and infants: Evidence and speculations. *Ethnicity & Disease*, *2*(3), 207–221.

Bailey, Z. D., Feldman, J. M., & Bassett, M. T. (2021). How Structural Racism Works—Racist Policies as a Root Cause of U.S. Racial Health Inequities. *New England Journal of Medicine*, *384*(8), 768–773. https://doi.org/10.1056/NEJMms2025396

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, *389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Berg, M. (2005). A Midwifery Model of Care for Childbearing Women at High Risk: Genuine Caring in Caring for the Genuine. *The Journal of Perinatal Education*, *14*, 9–21. https://doi.org/10.1624/105812405X23577

Bill Text—AB-241 Implicit bias: Continuing education: Requirements. (n.d.). Retrieved June 25, 2019, from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB241

Bill Text—SB-464 California Dignity in Pregnancy and Childbirth Act. (n.d.). Retrieved May 9, 2021, from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB464

Bonaparte, A. D. (2015). Physicians' Discourse for Establishing Authoritative Knowledge in Birthing Work and Reducing the Presence of the Granny Midwife. *Journal of Historical Sociology*, *28*(2), 166–194. https://doi.org/10.1111/johs.12045

Bonds, A., & Inwood, J. (2016). Beyond white privilege: Geographies of white supremacy and settler colonialism. *Progress in Human Geography*, *40*(6), 715–733. https://doi.org/10.1177/0309132515613166

Booker, C. A. (2021, February 22). *Text - S.346 - 117th Congress (2021-2022): Black Maternal Health Momnibus Act of 2021* (2021/2022) [Webpage]. https://www.congress.gov/bill/117th-congress/senate-bill/346/text

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah, M. O., Docherty, M., Aguilera Nunez, M. G., Barcelo, N., Goodsmith, N., Halpin, L. E., Morton, I., Mango, J., Montero, A. E., Rahmanian Koushkaki, S., Bromley, E., Chung, B., Jones, F., Gabrielian, S., Gelberg, L., … Wells, K. B. (2019). Community Interventions to Promote Mental Health and Social Equity. *Current Psychiatry Reports*, *21*(5), 35. https://doi.org/10.1007/s11920-019-1017-0

Castillo, E. G., Isom, J., DeBonis, K. L., Jordan, A., Braslow, J. T., & Rohrbaugh, R. (2020). Reconsidering Systems-Based Practice: Advancing Structural Competency, Health Equity, and Social Responsibility in Graduate Medical Education. *Academic Medicine*, *Publish Ahead of Print*. https://doi.org/10.1097/ACM.0000000000003559

Chambers, B. D., Arabia, S. E., Arega, H. A., Altman, M. R., Berkowitz, R., Feuer, S. K., Franck, L. S., Gomez, A. M., Kober, K., Pacheco-Werner, T., Paynter, R. A., Prather, A. A., Spellen, S. A., Stanley, D., Jelliffe-Pawlowski, L. L., & McLemore, M. R. (2020). Exposures to structural racism and racial discrimination among pregnant and early post-partum Black women living in Oakland, California. *Stress and Health*, *36*(2), 213–219. https://doi.org/10.1002/smi.2922

Chambers, B. D., Arega, H. A., Arabia, S. E., Taylor, B., Barron, R. G., Gates, B., Scruggs-Leach, L., Scott, K. A., & McLemore, M. R. (2021). Black Women's Perspectives on Structural Racism across the Reproductive Lifespan: A Conceptual Framework for Measurement Development. *Maternal and Child Health Journal*, *25*(3), 402–413. https://doi.org/10.1007/s10995-020-03074-3

Chambers, B. D., Baer, R. J., McLemore, M. R., & Jelliffe-Pawlowski, L. L. (2019). Using Index of Concentration at the Extremes as Indicators of Structural Racism to Evaluate the

Association with Preterm Birth and Infant Mortality—California, 2011–2012. *Journal of Urban Health*, *96*(2), 159–170. https://doi.org/10.1007/s11524-018-0272-4

Chan, A. L., Guo, N., Popat, R., Robakis, T., Blumenfeld, Y. Y., Main, E., Scott, K. A., & Butwick, A. J. (2021). Racial and Ethnic Disparities in Hospital-Based Care Associated with Postpartum Depression. *Journal of Racial and Ethnic Health Disparities*, *8*(1), 220–229. https://doi.org/10.1007/s40615-020-00774-y

Chen, L., Crockett, A. H., Covington-Kolb, S., Heberlein, E., Zhang, L., & Sun, X. (2017). Centering and Racial Disparities (CRADLE study): Rationale and design of a randomized controlled trial of centering pregnancy and birth outcomes. *BMC Pregnancy and Childbirth*, *17*(1), 1–13. https://doi.org/10.1186/s12884-017-1295-7

Cobbinah, S. S., & Lewis, J. (2018). Racism & Health: A public health perspective on racial discrimination. *Journal of Evaluation in Clinical Practice*, *24*(5), 995–998. https://doi.org/10.1111/jep.12894

Collier, A. Y., & Molina, R. L. (2019). Maternal Mortality in the United States: Updates on Trends, Causes, and Solutions. *NeoReviews*, *20*(10), e561–e574. https://doi.org/10.1542/neo.20-10-e561

Davis, Dána-Ain. (2019). Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing. *Medical Anthropology*, *38*(7), 560–573. https://doi.org/10.1080/01459740.2018.1549389

Davis, Dana-Ain. (2019). *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*. NYU Press.

Dawley, K., & Burst, H. V. (2005). The American College of Nurse-Midwives and Its Antecedents: A Historic Time Line. *Journal of Midwifery & Women's Health*, *50*(1), 16–22. https://doi.org/10.1016/j.jmwh.2004.09.011

Epstein, R. M., & Street, R. L. (2011). The Values and Value of Patient-Centered Care. *Annals of Family Medicine*, *9*(2), 100–103. https://doi.org/10.1370/afm.1239

Ford, C. L. (2016). Public Health Critical Race Praxis: An Introduction, an Intervention, and Three Points for Consideration. *Wisconsin Law Review*, *2016*, 477.

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine*, *71*(8), 1390–1398. https://doi.org/10.1016/j.socscimed.2010.07.030

Franck, L. S., McLemore, M. R., Williams, S., Millar, K., Gordon, A. Y., Williams, S., Woods, N., Edwards, L., Pacheco, T., Padilla, A., Nelson, F., & Rand, L. (2020). Research priorities of women at risk for preterm birth: Findings and a call to action. *BMC Pregnancy and Childbirth*, *20*(1), 10. https://doi.org/10.1186/s12884-019-2664-1

Frye, V., Camacho-Rivera, M., Salas-Ramirez, K., Albritton, T., Deen, D., Sohler, N., Barrick, S., & Nunes, J. (2020). Professionalism: The Wrong Tool to Solve the Right Problem? *Academic Medicine*, *95*(6), 860–863. https://doi.org/10.1097/ACM.0000000000003266

Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. (2006). "Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States. *American Journal of Public Health*, *96*(5), 826–833. https://doi.org/10.2105/AJPH.2004.060749

Golden, S. D., & Earp, J. A. L. (2012). Social ecological approaches to individuals and their contexts: Twenty years of health education & behavior health promotion interventions.

Health Education & Behavior: The Official Publication of the Society for Public Health Education, *39*(3), 364–372. https://doi.org/10.1177/1090198111418634

Goode, K. (2014). Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism. *Dissertations, Theses, and Capstone Projects*. https://academicworks.cuny.edu/gc_etds/423

Grad, F. P. (2002). The Preamble of the Constitution of the World Health Organization. *Bulletin of the World Health Organization*, *80*(12), 981–984.

Guerra-Reyes, L., & Hamilton, L. J. (2017). Racial disparities in birth care: Exploring the perceived role of African American women providing midwifery care and birth support in the United States. *Women and Birth: Journal of the Australian College of Midwives*, *30*(1), e9–e16. https://doi.org/10.1016/j.wombi.2016.06.004

Gulati-Partee, G., & Potapchuk, M. (2014). Paying Attention to White Culture and Privilege: A Missing Link to Advancing Racial Equity. *The Foundation Review*, *6*(1). https://doi.org/10.9707/1944-5660.1189

Hardeman, R. R., Medina, E. M., & Kozhimannil, K. B. (2016). Dismantling Structural Racism, Supporting Black Lives and Achieving Health Equity: Our Role. *The New England Journal of Medicine*, *375*(22), 2113–2115. https://doi.org/10.1056/NEJMp1609535

Hogan, V., Rowley, D. L., White, S. B., & Faustin, Y. (2018). Dimensionality and R4P: A Health Equity Framework for Research Planning and Evaluation in African American Populations. *Maternal and Child Health Journal*, *22*(2), 147–153. https://doi.org/10.1007/s10995-017-2411-z

IRTH app: https://irthapp.com/

NBEC. (n.d.). Retrieved May 9, 2021, from https://birthequity.org/

Hunter, A., Devane, D., Houghton, C., Grealish, A., Tully, A., & Smith, V. (2017). Woman-centred care during pregnancy and birth in Ireland: Thematic analysis of women's and clinicians' experiences. *BMC Pregnancy and Childbirth*, *17*(1), 322. https://doi.org/10.1186/s12884-017-1521-3

Hunter, B. (2010). Mapping the emotional terrain of midwifery: What can we see and what lies ahead? *International Journal of Work Organisation and Emotion*, *3*. https://doi.org/10.1504/IJWOE.2010.032925

Joint Statement: Collective Action Addressing Racism. (n.d.). Retrieved September 15, 2020, from https://www.acog.org/en/News/News Articles/2020/08/Joint Statement Obstetrics and Gynecology Collective Action Addressing Racism

Jones, C. P. (2002). Confronting Institutionalized Racism. *Phylon (1960-)*, *50*(1/2), 7–22. JSTOR. https://doi.org/10.2307/4149999

Julian, Z., Robles, D., Whetstone, S., Perritt, J. B., Jackson, A. V., Hardeman, R. R., & Scott, K. A. (2020). Community-informed models of perinatal and reproductive health services provision: A justice-centered paradigm toward equity among Black birthing communities. *Seminars in Perinatology*, 151267. https://doi.org/10.1016/j.semperi.2020.151267

Kemet, S. (2019). Insight Medicine Lacks—The Continuing Relevance of Henrietta Lacks. *New England Journal of Medicine*. https://doi.org/10.1056/NEJMp1905346

Khosla, R., Zampas, C., Vogel, J. P., Bohren, M. A., Roseman, M., & Erdman, J. N. (2016). International Human Rights and the Mistreatment of Women During Childbirth. *Health and Human Rights*, *18*(2), 131–143.

Kotaska, A. (2017). Informed consent and refusal in obstetrics: A practical ethical guide. *Birth*, *44*(3), 195–199. https://doi.org/10.1111/birt.12281

Kramer, M. R., Strahan, A. E., Preslar, J., Zaharatos, J., St Pierre, A., Grant, J. E., Davis, N. L., Goodman, D. A., & Callaghan, W. M. (2019). Changing the conversation: Applying a health equity framework to maternal mortality reviews. *American Journal of Obstetrics and Gynecology*, *221*(6), 609.e1-609.e9. https://doi.org/10.1016/j.ajog.2019.08.057

Ladd-Taylor, M. (1988). "Grannies" and "Spinsters": Midwife Education under the Sheppard-Towner Act. *Journal of Social History*, *22*(2), 255–275.

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Likis, F. E. (2018). Racism, Racial Bias, and Health Disparities: Midwifery's Work Continues. *Journal of Midwifery & Women's Health*, *63*(4), 393–394. https://doi.org/10.1111/jmwh.12893

Luna, Z., & Luker, K. (2013). Reproductive Justice. *Annual Review of Law and Social Science*, *9*(1), 327–352. https://doi.org/10.1146/annurev-lawsocsci-102612-134037

MacDorman, M., & Declercq, E. (2019). Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017. *Birth (Berkeley, Calif.)*, *46*(2), 279–288. https://doi.org/10.1111/birt.12411

Maina, I. W., Belton, T. D., Ginzberg, S., Singh, A., & Johnson, T. J. (2018). A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Social Science & Medicine*, *199*, 219–229. https://doi.org/10.1016/j.socscimed.2017.05.009

McLemore, M. R., Berkowitz, R. L., Oltman, S. P., Baer, R. J., Franck, L., Fuchs, J., Karasek, D. A., Kuppermann, M., McKenzie-Sampson, S., Melbourne, D., Taylor, B., Williams, S., Rand, L., Chambers, B. D., Scott, K., & Jelliffe-Pawlowski, L. L. (2020). Risk and Protective Factors for Preterm Birth Among Black Women in Oakland, California. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-020-00889-2

McLemore, M. R., & Choo, E. K. (2019). The right decisions need the right voices. *Lancet (London, England)*, *394*(10204), 1133. https://doi.org/10.1016/S0140-6736(19)32167-1

Nelson, A. (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. *Journal of the National Medical Association*, *94*(8), 666–668.

Nelson, S. C., Prasad, S., & Hackman, H. W. (2015). Training providers on issues of race and racism improve health care equity. *Pediatric Blood & Cancer*, *62*(5), 915–917. https://doi.org/10.1002/pbc.25448

Newnham, E., & Kirkham, M. (2019). Beyond autonomy: Care ethics for midwifery and the humanization of birth. *Nursing Ethics*, *26*(7–8), 2147–2157. https://doi.org/10.1177/0969733018819119

NQF: NQF Launches Health Equity Program. (n.d.). Retrieved May 9, 2021, from https://www.qualityforum.org/NQF_Launches_Health_Equity_Program.aspx

Owens, D. C. (2017). *Medical Bondage: Race, Gender, and the Origins of American Gynecology*. University of Georgia Press. https://library.oapen.org/handle/20.500.12657/30659

Owens, D. C., & Fett, S. M. (2019). Black Maternal and Infant Health: Historical Legacies of Slavery. *American Journal of Public Health*, *109*(10), 1342–1345. https://doi.org/10.2105/AJPH.2019.305243

Owoseni, A. V. (2020). From Portraits to Role Models—Why We Need Black Physicians in Academic Medicine. *New England Journal of Medicine*, *383*(23), 2204–2205. https://doi.org/10.1056/NEJMp2027850

Perriman, N., Davis, D. L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery*, *62*, 220–229. https://doi.org/10.1016/j.midw.2018.04.011

Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries, W. L. (2016). The Impact of Racism on the Sexual and Reproductive Health of African American Women. *Journal of Women's Health (2002)*, *25*(7), 664–671. https://doi.org/10.1089/jwh.2015.5637

Riggan, K. A., Gilbert, A., & Allyse, M. A. (2020). Acknowledging and Addressing Allostatic Load in Pregnancy Care. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-020-00757-z

Roberts, S. C. M., & Nuru-Jeter, A. (2010). Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care. *Women's Health Issues*, *20*(3), 193–200. https://doi.org/10.1016/j.whi.2010.02.003

Ross, L. J. (2017). Reproductive Justice as Intersectional Feminist Activism. *Souls*, *19*(3), 286–314. https://doi.org/10.1080/10999949.2017.1389634

Scott, K. A., Bray, S., & McLemore, M. R. (2020). First, Do No Harm: Why Philanthropy Needs to Re-Examine Its Role in Reproductive Equity and Racial Justice. *Health Equity*, *4*(1), 17–22. https://doi.org/10.1089/heq.2019.0094

Scott, K. A., Britton, L., & McLemore, M. R. (2019). The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in "Mother Blame" Narratives. *The Journal of Perinatal & Neonatal Nursing*, *33*(2), 108–115. https://doi.org/10.1097/JPN.0000000000000394

Shaw, J. C. A. (2013). The Medicalization of Birth and Midwifery as Resistance. *Health Care for Women International*, *34*(6), 522–536. https://doi.org/10.1080/07399332.2012.736569

Skloot, R. (2011). *The immortal life of Henrietta Lacks* (1st pbk. ed). Broadway Paperbacks.

Souter, V., Nethery, E., Kopas, M. L., Wurz, H., Sitcov, K., & Caughey, A. B. (2019). Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births. *Obstetrics & Gynecology*, *134*(5), 1056–1065. https://doi.org/10.1097/AOG.0000000000003521

Swaine, Z. (2011). Medical Model. In J. S. Kreutzer, J. DeLuca, & B. Caplan (Eds.), *Encyclopedia of Clinical Neuropsychology* (pp. 1542–1543). Springer. https://doi.org/10.1007/978-0-387-79948-3_2131

Tufford, L., & Newman, P. (2012). Bracketing in Qualitative Research. *Qualitative Social Work*, 80–96.

Vedam, S., Stoll, K., Rubashkin, N., Martin, K., Miller-Vedam, Z., Hayes-Klein, H., & Jolicoeur, G. (2017). The Mothers on Respect (MOR) index: Measuring quality, safety, and human rights in childbirth. *SSM - Population Health*, *3*, 201–210. https://doi.org/10.1016/j.ssmph.2017.01.005

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., & Declercq, E. (2019). The Giving

Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health*, *16*. https://doi.org/10.1186/s12978-019-0729-2

Wailoo, K. (2018). Historical Aspects of Race and Medicine: The Case of J. Marion Sims. *JAMA*, *320*(15), 1529–1530. https://doi.org/10.1001/jama.2018.11944

Wallace, M. E., Green, C., Richardson, L., Theall, K., & Crear-Perry, J. (2017). "Look at the Whole Me": A Mixed-Methods Examination of Black Infant Mortality in the US through Women's Lived Experiences and Community Context. *International Journal of Environmental Research and Public Health*, *14*(7), 727. https://doi.org/10.3390/ijerph14070727

WHO | Prevention and elimination of disrespect and abuse during childbirth. (n.d.). WHO. Retrieved September 23, 2020, from http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/

Williams, D. R., & Cooper, L. A. (2019). Reducing Racial Inequities in Health: Using What We Already Know to Take Action. *International Journal of Environmental Research and Public Health*, *16*(4). https://doi.org/10.3390/ijerph16040606

Williams, D. R., & Wyatt, R. (2015). Racial Bias in Health Care and Health: Challenges and Opportunities. *JAMA*, *314*(6), 555–556. https://doi.org/10.1001/jama.2015.9260

Wren Serbin, J., & Donnelly, E. (2016). The Impact of Racism and Midwifery's Lack of Racial Diversity: A Literature Review. *Journal of Midwifery & Women's Health*, *61*(6), 694–706. https://doi.org/10.1111/jmwh.12572

Yancy, C. W. (2020). COVID-19 and African Americans. *JAMA*, *323*(19), 1891–1892. https://doi.org/10.1001/jama.2020.6548

Publishing Agreement

It is the policy of the University to encourage open access and broad distribution of all theses, dissertations, and manuscripts. The Graduate Division will facilitate the distribution of UCSF theses, dissertations, and manuscripts to the UCSF Library for open access and distribution. UCSF will make such theses, dissertations, and manuscripts accessible to the public and will take reasonable steps to preserve these works in perpetuity.

I hereby grant the non-exclusive, perpetual right to The Regents of the University of California to reproduce, publicly display, distribute, preserve, and publish copies of my thesis, dissertation, or manuscript in any form or media, now existing or later derived, including access online for teaching, research, and public service purposes.

DocuSigned by:
Tamara Nelson
66E55F39601C4A0...
Author Signature

5/22/2021
Date