**You have no answer that Black women don’t already possess.**

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[Karen A. Scott, Stephanie R. M. Bray, Ifeyinwa Asiodu & Monica R. McLemore](https://www.blackwomenbirthingjustice.org/blog/author/Karen-A.-Scott%2C-Stephanie-R.-M.-Bray%2C-Ifeyinwa-Asiodu-%26amp%3B-Monica-R.-McLemore)

In April 2018, the [Black Mamas Matter Alliance](https://blackmamasmatter.org/) sponsored the first ever [Black Maternal Awareness week](https://blackmamasmatter.org/bmhw/) to highlight the shameful tragedy of preventable maternal deaths of women during childbirth – a burden disproportionally experienced by Black women. This event was the culmination of a conversation that many have been having amongst themselves including birth workers, clinicians, researchers, public health experts, funders, perinatal & systems re-designers and policymakers, but NOT with each other. The resulting actions from this awareness week include three pending pieces of legislation from [Representative Robin Kelly (D-Ill), Senator Kamala Harris (D-CA)](https://robinkelly.house.gov/media-center/in-the-news/how-the-momma-act-will-help-to-reverse-america-s-rising-maternal-mortality), and a [bipartisan bill](https://www.petition2congress.com/ctas/maternal-mortality-legislation-hr-1318-s-1112-115th) from Jaime Herrera Beutler (R-WA), Diana DeGette (D-CO), and Ryan Costello (R-PA). Additionally, several states including New Jersey, Vermont, New York and others have proposed to expand access to doulas by allowing them to be reimbursed by public insurance as a potential mitigation strategy for poor birth outcomes. As four Black women - a board-certified OB/GYN, a CEO of a non-profit committed to lifting families out of poverty, and two clinician-scientists, nurses, and public health scholars – we have been cautiously optimistic about the possibility of new resources being available to combat these appalling disparities.

In determining how those resources are invested, we must question the frame of various stakeholders (i.e., birth workers, clinicians, funders, perinatal & systems re-designers and policymakers) currently participating in conversations about Black women and maternal health. This frame is too often defined by a default that is not based on Black women’s experiences or that of Black people. As a consequence, assumptions about Black women’s inability to know what they need drive where resources are invested and in whom. More often than not, problems and solutions end up being defined by people who are not Black. The lack of inclusion of Black voices further perpetuates a default standard that begets inadequate and irrelevant analyses and solutions. In short, there is no answer to solving this crisis that Black women do not already know. It is in their lived experiences and resilience that drives innovation and belonging - and we as stakeholders should take heed.

The lack of focus on and investment in human-centered-designed solutions to address Black women’s poor birth outcomes stems from the perpetuation of default standards and systems steeped in patriarchal white supremacy and divorced from those experiencing the greatest burden. When the default human to protect and affirm - in human design thinking - is a white woman, the solutions prop up existing structures and ultimately will fail. When the healthcare workforce does not reflect the population being served, it matters. When healthcare providers do not listen to or trust Black women, it can have life-threatening consequences for everyone. When the reflexive response in health care and public health is to devalue, demoralize and pathologize Black womanhood and motherhood, then entire generations suffer from statistical discrimination and bias leading to inappropriate assessment and ineffective policies. When solutions are designed without the input of those we purport to help, we stifle innovation and maintain inequities.

Even more frustrating are the barriers to truly unleashing the power of Black women’s innovation. These barriers include structural factors grounded in a gendered racism that continue to center descriptions of social determinants of health and health disparities, without acknowledging an asset based-understanding of the values and strengths that Black women possess. Additionally, without accompanying funding, training, or investment in diversification of the workforce, we diminish our capacity to mitigate the effects of these social determinants of health and health disparities.

For example, the DIVESTMENT from the social safety net creates a supremacy of clinical services, which in turn reinforces a broken system aimed at fixing what is sick as opposed to fostering all that is well. Furthermore, prioritization of medical care as the leading determinant of health perpetuates a false narrative and hierarchy of power, knowledge, and distribution of resources that emphasizes curing common diseases over caring for diverse human beings (or populations).  In other words, no investment in prevention leads to increased spending on treatment and costly interventions - a simple principle highlighted by public health scholars.

The current maternal health system in the United States functions in a manner that decenters the sanctity and normalcy of birth. For some, birth represents opportunities to reimagine themselves or to reconcile past traumas.  However, the current education and training of obstetrician/gynecologists (OBGYNs) prioritizes medicalization and risk stratification of birth as opposed to honoring Black women’s bodily and spiritual memory, integrity and autonomy. Although OBGYNs bring a level of medical and surgical specialization that some birthing persons may require, many more could benefit from the level of advocacy, intimacy and cultural humility provided by midwives throughout birth, particularly Black Midwives. In addition to midwives, culturally-concordant doulas provide an additional skill set and support also needed during birth. While OBGYNs are trained to manage time and multiple births usually outside of the hospital, Doulas are trained to move with time and the bodies of Black women during the entire birth. There is a unique way of being with birthing families that Doulas cultivate that OBGYNs and midwives cannot, given the current rigid infrastructure and chaotic operations of the maternal health system.

The birth culture within many hospitals continues to reinforce cultural arrogance the prioritizes births by OBGYN as the norm at the exclusion of births with Midwives and doulas in the home or birthing centers. Furthermore, high level risk designation sometimes requires many Black women to obtain healthcare services at multiple prenatal care sites, high risk consultation, weekly antenatal testing, periodic ultrasounds and blood tests, and receipt of weekly medications. Many of the sites do not utilize compatible online platforms that allow for communication across sites and systems. Thus, the privacy of pregnancy and childbirth is transformed into a public experience in which Black women’s performance of motherhood comes under the surveillance and scrutiny of practitioners and politicians. Moreover, private foundations then capitalize on the opportunity to do what public payers and health systems have failed to by strengthening the data monitoring and quality improvement processes, only to fund individuals and groups who look nothing like the bodies most affected by disparities and inequities in maternal health. The chronicity of unethical approaches to maternal health services research and workforce diversification must no longer be tolerated in silence.

So, what is the way forward? How can and should a broken maternal health system be redesigned to serve the needs of all pregnant people? And what responsibilities do birth workers, clinicians, funders, perinatal & systems re-designers and policymakers have to the people experiencing the greatest burden of these conditions?

First, for birth workers and clinicians there must be authentic engagement with Black women. This is hard work and requires investment in cultural brokers, those who are known and trusted by Black women including Black women themselves. It requires a change in thinking who has the best solutions to fostering and improving health.

Second, it requires the will to see Black women as an investment in a future workforce. And it requires that all current legislation and funding be directed toward investment in Black women and girls including education, employment, affordable housing, and dismantling of mass incarceration, child protective services, and other punitive structures that are used to control and assimilate Black people according to a default standard.

Third, it requires unapologetic support of Black women in paid, leadership and research roles, to drive the agenda for all stakeholders at every level. It also requires that not only do Black women have a seat at the table during systems redesign or initiation of research projects, but that they also lead those processes. In so doing, Black women will likely dismantle the hierarchy of language and resources utilized in order to best translate Black women’s wisdom into evidence-based practices and policies that are more culturally relevant, responsive, and relational.

Finally, policymakers need both reinvest in the social safety net, claiming these investments as social and public health goods - as opposed to our current understanding of them as “entitlements.” A collective approach is necessary for reductions in poor pregnancy related outcomes as opposed to multiple bills that address pieces of this problem. Elected officials should follow the lead of the Black Mamas Matter Alliance and establish a center of excellence in Black women’s livelihood to set the standards and best practices in the care of and research with, for, and by Black women.

Together this change can happen; however these efforts must be led by Black women.

Additional Resources

[Setting the Standard for Holistic Care of and for Black Women](http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf) by Black Mamas Matter Alliance.

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