Birthing While Black During Emergencies

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Abstract

My graduate studies have built on my extensive experience as a maternal healthcare practitioner, with a particular focus on the intersections of health and racial inequity, sexual violence, and LGBTQ2S+ issues. My research focuses on reproductive justice during emergencies, including the COVID-19 global pandemic. Specifically, I am examining the experiences of Black Canadians who are pregnant and/or giving birth during the pandemic. It is well-documented in the United States that Black women have disproportionately negative maternal health and childbirth outcomes. These inequitable outcomes have led to a response from a reproductive justice movement that works to redress negative outcomes for Black women as a result of racism. In Canada, there has been a push to collect race-based data to identify health inequities, and advocates have pushed for Public Health agencies to name anti-Black racism as a public health issue. Nevertheless, despite the recognition that Black women have more negative reproductive outcomes due to systemic anti-Black racism, Canada lags behind other Western countries in documenting the impact of anti-Black racism on maternal and infant health. My research responds to this immense gap by doing exploratory, qualitative research with Black mothers/individuals, and birth workers in order to paint a picture of their experiences. My work will contribute to an understanding of the impact of anti-Black racism on maternal health in Canada, especially during a major public health crisis such as the COVID-19 pandemic that is disproportionately impacting the Black community. The final outcome of my plan of study is a portfolio that is housed on a website that I built (www.birthingwhileblack.ca). #BirthingWhileBlack in Canada is a hub for the rough cut of my documentary film '*Birthing while Black during COVID-19,*' which consists of interviews with Black mothers who were pregnant or gave birth during the pandemic, and Black birth workers; a manuscript submitted for publication '*Unpacking emergency response: anti-Black racism and other barriers faced by pregnant and lactating asylum claimants in Quebec, Canada'*; the development of the conceptual framework of '*First Food Sovereignty*' as a policy tool that centers the most vulnerable; and the *blueprint series*, an art installation. What these stories inform us, that is new, is that Black families in Canada are giving birth in a state of survival mode because they are acutely aware of the threat of anti-Black violence existing in the healthcare system. Their trauma responses consist of going into "freeze" mode, making themselves small and invisible, silencing themselves, and not bringing attention to themselves. Even in the face of a pandemic, what they fear most for themselves and their children, is systemic anti-Black racism.

FOREWORD

For many birthing parents, pregnancy and childbirth are considered a sacred and spiritual chapter of their life. It is often an intense period of vulnerability; it is a time of intense fragility, strength and, for many, it is an empowering experience. As the body is pushed to its limits and beyond, the birthing individual is invited to trust and surrender to the unknown, the suffering, and the pleasure. Pregnancy, childbirth, and parenting in Canada, under normal conditions, are already challenging. But what is it like for a pregnant asylum seeker who arrives in Canada within days/weeks/months of giving birth? What is it like to be scared, alone in a foreign country, and birth one's first child? What is it like to birth as a Black individual during a global pandemic? Pregnancy and childbirth can end up being a site of trauma instead of power and spiritual connectedness. In telling stories of pregnant Black asylum seekers and Black women who have given birth during COVID-19, I am hoping to identify some of the systemic barriers to a mind, body, and spirit connection when one is forced to give birth under emergency circumstances.

2017 was the turning point when I realized that if I wanted to change government health policy, I needed to pursue graduate studies. I chose Environmental Studies with the understanding that Canada and the world will experience an increase in emergencies and natural disasters, and that we are ill-equipped to support pregnant people and infants during those difficult times. Black and other racialized communities are particularly vulnerable to poor outcomes. I did not anticipate that I would experience a pandemic during my studies. I chose to deal with the crisis by making an offering to the Black community through documenting birth stories. I remember being at a birth in March 2020 and wondering: how are people processing the stress and trauma of birthing during a pandemic? As far as I knew, no one was offering parents the opportunity to unpack with a therapist the distress of birthing during a pandemic as part of their discharge plan from health facilities. I asked myself: can I provide the opportunity for healing to take place by bearing witness to their experience, by simply recording their birth story and giving it to them? With that in mind, I created a project where birthing Black parents and Black birth workers had the opportunity to tell their experience of the pandemic in an audio/visual project called *Birthing While Black During COVID-19*. By interviewing participants and documenting their experience in real-time, this research project serves three purposes, it: (1) creates a record of the experience of childbirth in the midst of a crisis, (2) provides information and much-needed analysis on COVID-19's impact on Black people and childbirth, and (3) gives participants who are already at risk of experiencing existing structural violence, such as systemic racism, the opportunity to tell their own stories.

This portfolio fulfills the components laid out in the Plan of Study: pregnancy and childbirth, institutional anti-Black racism, and visual and cultural productions. I examined the factors behind the mistreatment and violence against pregnant individuals in Canada by listening to first-hand accounts of Black mothers' and birth workers' experience of COVID-19. I researched media outlets' coverage of the experience of pregnant people during the pandemic, participated in webinars, and integrated those elements as B-roll in the film. Furthermore, I met my objective of obtaining general knowledge of how Black feminist theorists approach the question of social and structural violence in settler societies by participating in the seminar *Imagining Slavery and Freedom* with Dr. Christina Sharpe. The content of that seminar provided me with the knowledge to analyse the data collected from the participants employing Black feminist thought which is centered on the perspectives and experiences of Black women (Collins, 2014). My manuscript "*Unpacking emergency response: anti-Black racism and other barriers faced by pregnant and lactating asylum claimants in Quebec, Canada*" integrates the same theoretical foundation in order to interrogate, through a case study, how institutional discriminatory practices can be situated within a colonial history of systemic racism. Lastly, I met my learning objective of creating knowledge using cultural production for advocacy purposes by examining artistically, through visual and cultural production, how mothering continues to be an act and a tool of resistance for Black communities to global patterns of violence. By amplifying those voices I am employing a methodology used in art activism..

In closing, while completing my coursework and research in the Master in Environmental Studies program, I have presented my work at conferences, had my work accepted in a book, submitted a manuscript for publication in a peer-reviewed journal, and have been active in leading various reproductive justice community-based initiatives. Most recently, in January 2021, I was invited by the Centre for Research and Education on Violence Against Women and Children, Western University, to present on the topic of 'Looking Within : Anti-Black Racism and the Gender-Based Violence Sector in Canada'. In June 2020, I presented my work at the Environmental Studies Association Conference 'Confronting Colonialism and Anti-Black Racism'. While conducting my research, publishing and presenting, I've also contributed to the University community by teaching two course sections on health equity as a Teaching Assistant in the Faculty of Health and as an active member of the Faculty of Environmental and Urban Change Equity Committee.

DEDICATION

To my mother, Malefiya Zeleke, for showing me the blueprint on how to nurture and lead with love.

To my children, Méshama and Alama, for being my lifelong teachers.

To the birthing Black women and babies, for holding me as I held you.

To all the Black birth workers, yes, we know.

ACKNOWLEDGMENT

"*I imagine good teaching as a circle of earnest people sitting down to ask each other meaningful questions.*" Alice Walker

With gratitude,

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PREAMBLE

being seen
being heard
being understood

In partial fulfillment of the requirements for the degree of Master in Environmental Studies at York University, I designed a website, #BirthingWhileBlack in Canada www.birthingwhileblack.ca, to host my portfolio. The following pages describe each one of the three components of the portfolio with a concentration on cultural production: (1) documentary film, (2) manuscript submitted to a peer-review journal, and (3) art installation.

SECTION 1:

Documentary film 'Birthing While Black During COVID-19'

"Feminist oral history must go beyond merely recruiting stories from oblivion and instead embed those stories in deeper narratives and praxis of social change." F. Davey, Kris DeWelde, N. Foote

1.1 Introduction

This national research project, in the form of a web documentary film, explores how birthing during the COVID-19 pandemic impacts Black families in Canada. Drawing from a reproductive justice theoretical framework, and using feminist oral history methodology, my research explores the experiences and perspectives of birthing Black women and individuals, and Black birth workers during a global pandemic.

1.2 Background

In Canada, there has been a recent drive to collect race-based data to identify health inequities; advocates have pushed for Public Health to name anti-Black racism as a public health issue (CBC, June 11, 2020). Despite the recognition that Black women have more negative reproductive outcomes due to systemic anti-Black racism, Canada lags behind other Western countries in documenting the impact of anti-Black racism on maternal and infant health (CBC, July, 2021). Since the beginning of COVID-19, members of the Black community, Black health leaders and Black academics have been bringing critical attention to COVID-19's impact on Black communities and calling for the collection of race-based data (Alliance for Healthier Communities, 2020). There is a body of nascent research in Canada documenting the disproportionate impact of the coronavirus on Black and low-income communities (Alliance for Healthier Communities, 2020, Dalla Lana School of Public Health, 2020). According to data from Toronto Public Health, Black people and other people of colour make up 83% of reported COVID-19 cases in Toronto (CBC, July 30, 2020).

Can normalized violence against Black women be intensified, and structural violations of women's rights become more entrenched during an emergency? Based on the findings from my research, it appears that discriminatory measures are reflected in existing structural systems and are amplified

during an emergency or a crisis. By sifting through Black community-led recorded webinars (Dalla Lana School of Public Health, 2020), statements, and reports (The Black Experiences in Health Care Symposium Planning Committee, 2020), I was able to situate anti-Black violence within the healthcare system historically and within the current context for the movement for Black lives. Unfortunately, these mainstream conversations, like the ones I've identified, led by the Black community, do not directly address the needs of pregnant and birthing Black people in Canada. Based on my observations, this is consistent with national Black agendas omitting or deprioritizing issues affecting Black children and Black women's health. Therefore, the voices of the participants from my film are vital in filling this missing gap.

My research contributes to this immense void in knowledge by doing exploratory, qualitative research with Black mothers/individuals, and birth workers in order to paint a picture of their experiences. My work contributes to an understanding of the impact of anti-Black racism on maternal health in Canada, especially during a major public health crisis such as the COVID-19 pandemic that is disproportionately impacting the Black community.

The research questions:

1. What are the experiences and perspectives of Black people who give birth during COVID-19 in Canada?
2. What are the institutional barriers/challenges faced by Black people giving birth during COVID-19 in Canada?
3. What are the experiences and perspectives of Black birth workers during COVID-19?

1.3 Theoretical framework

I have identified reproductive justice as the theoretical framework to guide this project. Reproductive justice examines the ways in which interlocking systems of oppression, such as white supremacy and patriarchy, lead to disproportionate and differential outcomes for racialized pregnant people and their children (Ross, 2017). Reproductive justice is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities," according to SisterSong Women of Color Reproductive Justice Collective (SisterSong, 2021). If the stories we want to tell are for the purpose of creating a blueprint for our survival, we must center women's voices and prioritize trust and relationship building. Ergo, I see our

(Black people) collective filmmaking process as being part of a wider tactic for survival, away from the white gaze and state violence (Squires, 2002).

1.4 Methodology: feminist oral history

The radical roots of feminist oral history, like that of reproductive justice, resonate with me as a methodology because as Sherna Berger Gluck (2011) put it, "documenting women's simultaneous agency and oppression empowered both us and the movement and contributed to a very critical re-visioning of women's history" (Berger Gluck, p.64). Through this methodology, participants have a shared authority over the process, interview, outcome of the conversation, and project as a whole (Anderson et al., 1987). They have agency on how their story will be told - they are the knowledge producers and interpreters of the collective experience. For instance, I gave each participant a copy of our recorded interview, an outline of the storyboard, and the transcript of their segment. I invited them to submit photos and videos and asked for input about the direction of the project. At the end of the interview, they had the option of withdrawing from the study but still maintaining a copy of the interview (while I destroyed my copy) or continuing to participate in the project. They all chose to participate.

1.5 Positionality

Part of the reason I was successful with the recruitment process is because I have a relationship, based on trust, with the grassroot reproductive justice movement in Canada. When I launched the callout, people either knew me personally, knew of my work, or were able to Google me or vet me through the community. Based on my track record, they trusted me enough to tell their stories authentically. This was evident in the ease in which people freely spoke and allowed me to witness their vulnerabilities during our interviews. Also, my background in providing trauma-informed care was very useful because four of the mothers met me for the first time and felt comfortable enough to cry, to be vulnerable, and to leave the interviews saying that it was "healing" and "therapeutic". Considering that I was a stranger, and we were meeting over video, on Zoom, it is striking that such an intimate environment was able to be created with ease.

Participants were asked to speak on a subject matter that was for some distressing, traumatic, triggering and was happening in real-time. Although I provided them with a list of mental health support resources after the interview, somehow it did not feel like enough. As the researcher, I also found it

gut-wrenching to be a witness to their trauma and found myself fighting tears during the interviews. Frankly speaking, I still cry when I listen to some of the interviews because it is painful to watch Black people constantly be in survival mode, no matter where they reside. For example, I interviewed people in Ontario, Quebec, and New Brunswick, and I heard the same statements over and over again; whether it originates from the moms or the birth workers, there is a shared "knowing" about what it means to birth while Black, i.e. to survive. It has been a humbling experience to listen to people's stories and wisdom.

1.6 Recruitment

On June 6, 2020, I sent out a letter inviting 18 Black birth workers primarily located in Ontario to participate in this research project. I received a large amount of interest; however many did not think they had something significant to contribute because they had not attended births since the pandemic in March, 2020. The public health lockdown measures prevented birthing individuals from having companions or had limited companions of choice to one. Invitations to participate in the research were posted on facebook and Instagram. Groups such as The Ocama Collective and The Obstetric Justice Project promoted the research project. Those posts were widely re-shared.

Final interviews were conducted with 11 participants: 1 pregnant woman in Quebec, 1 pregnant woman in New Brunswick, 2 pregnant women in Ontario, 2 postpartum mothers in Ontario, 1 childbirth educator/pregnant mom, 1 doula in Quebec, 2 doulas in Ontario, and 1 Lactation Consultant (IBCLC)/nurse in Ontario. I did two additional interviews but excluded them from the data analysis. The first was with a director at UNFPA (United Nations Population Fund), the UN sexual and reproductive health agency, to provide some global perspective. Unfortunately, there was a technical problem and the recording was not saved. The second interview was conducted in April 2021 with a participant who was days away from giving birth. I was hoping to get a perspective of what it's like to give birth a year into the pandemic, but in the end, I chose not to include it because it derailed the focus of the study which was on the initial response to the pandemic.

The interviews were semi-structured, conducted over Zoom, and lasted approximately 1hr15min. They were conducted in English, except for one which was in French. I did not need an interpreter because I speak French.

1.7 Accountability

Being accountable to the participants remains an integral part of my personal ethics. What I expect from myself is higher than what was approved by the Research Ethics Office. For example, although I have received formal consent from the majority of participants to proceed as I see fit with the material, my intention is to continue checking-in with them and creating a process that is inclusive and collaborative.

Furthermore, my attempt to dissolve the separation, and hierarchy, between subject/expert in research can be seen in my decision not to assign a title to the participants in the final cut of the film- I did not want the viewer to attach a label of 'expert' based on the title of who was speaking. There is no separation between experts and mothers; they were all bringing their expertise as individuals who navigate the Canadian landscape as Black bodies and spirits who either have experienced or been a witness to the violence enacted on birthing Black people. They will however be identified by their first names.

1.8 Limitations:

- The film reflects the experience of heteronormative family structures. One perspective that I wanted to include but that did not materialise is of a doula who supports regularly non-heterosexual-cisgender families. The doula I had in mind also identifies as transgender but unfortunately, was unable to participate at the time.
- Because I am not a filmmaker, I spent a lot of time teaching myself through YouTube how to use video editing software and learn how to make a documentary film. I couldn't fully execute my artistic vision because I did not have the technical skills.
- There were other significant themes that emerged from the interviews that I was unable to include in the rough cut of the film but that are worthwhile mentioning: infant food insecurity, domestic violence, mental health, the midwifery model of care, and grief/cultural practices.

TIMELINE	
May - Sep. 2020	• Receive approval from the Ethics Office • Recruit participants • Conduct interviews • Research
Sep - Dec. 2020	Research! Research! Research! Send copy of interviews to participants
Jan - April 2021	• E-mail participants to inform them that the project has been expanded and ask for feedback

	• Categorizing the codes • Transcription
May 2021	Create a storyboard by cutting the 20 hrs interview down to 1 hr. Customizing coding system
June 2021	• Collect B-roll: pictures and audio from participants, stock media images and newspaper headlines about COVID-19, pictures and video from my personal file at births • Contact participants with the script, the segment that they are profiled in, and re-confirm consent • Learn how to use DaVinci Resolve video editor
July 2021	Learn how to build a website and upload videos (for private view only) Submit rough cut to supervisor

1.9 Anticipated Outcomes

This research project contributes much-needed research to the academic literature on pregnancy and childbirth in Canada during a crisis. According to one midwife, Manavi Handa, there are many lessons Canadian midwifery could have learnt from the experience of the SARS epidemic, and yet, "there is almost no academic literature on this subject" (Handa, 2020). We now find ourselves in the midst of a global pandemic more widespread and fatal than SARS, and this lack of existing academic literature is perhaps hindering our capacity to provide adapted birthing care in the face of another crisis. Now that we are living through COVID-19, the opportunity to provide early, real-time academic analysis has once again presented itself.

By taking the time to acknowledge the specific challenges of childbirth for Black women and individuals during the COVID-19 pandemic, this research project humanizes and validates participants' experiences. Furthermore, this work will help fill a gap in the academic literature on childbirth during a crisis in Canada. While race-based data is important, qualitative research fills in the picture. While the current research tells us that there is health inequity and disproportionate outcomes i.e through stats, there is a dearth of research that documents the actual perspectives of parents and birth workers. I'm hoping that my research will amplify the voices of Black parents and birth workers on what those experiences actually look like.

The film gallery is set up as five thematic mini-documentaries/episodes: Pregnancy, Interventions, Freeze! Execute! Comply! Oblige, Push Story, and We Know. The first episode begins by describing what it has been like to be pregnant during COVID-19. It captures the chaos, and what participants describe as the "breakdown of the system". Those under the care of midwives fared slightly better because the

midwifery model of care is based on continuity of care. Their experience supports existing literature on the benefits of the midwifery model of care, for example,"continuity of midwifery care has positive effects on infant neurodevelopment when mothers experience disaster-related stress in pregnancy" (Simcock et al, 2018, p.1).

The subsequent episodes dive into the specific experience of Black people. Participants situate their experience as part of the history of chattel slavery, rapid advancement in the field of gynecology, and ongoing obstetrical violence that causes Black women to die at a much higher rate then white women. When I first started interviewing participants I noticed a look of terror in their eyes when they expressed their fear of not being heard, or believed, or that their pain would not be taken seriously. It is a look that I have observed on trauma survivors, except in this case it is ongoing trauma experienced collectively by birthing Black people. This trauma stems from a particular medical history involving Dr. Marion Sims who sought to repair fistula by conducting surgical experiments, without anesthesia, on enslaved women. He gained notoriety as the "father of modern gynecology"; the modern-day speculum, for instance, is designed from the revolutionary tools and techniques conceived by Sims (Jackson, 2020; Ross, 2017). The women were unable to consent or to reject the procedures because as enslaved women they were considered property. As Black people they were believed to not feel pain in the same way as white people (Jackson, 2020). For instance, those procedures, after they were finessed on enslaved Balck women, were used to treat white women *with* anesthesia. Sims practiced his technique on 10 women- Anarcha, for instance, endured the violation 30 times (Ojanuga, 1993). Sims manipulated the institution of slavery to conduct unethical experiments in the advancement of his career whereas enslaved women such as Anarcha, Lucy and Betsy endured excruciating pain. He also degraded and humiliated them by inviting other physicians to come to watch as he performed the surgeries (Ojanuga, 1993). Sims, who later became the president of the American Medical Association in 1875 and the American Gynecological Society in 1879 gained his foundational knowledge from an institution that relegates Black women to sub and supra humans. The field of medicine has a history of selling or leasing enslaved people - dead or alive- to perform experiments on (Jackson, 2020). Physicians are groomed and gain their foundational knowledge about medicine in institutional cultures that continue to uphold and celebrate the accomplishments of those who perpetuate violence, all the while silencing or blaming the victims. Physicians create metrics such as IQ tests to justify their violence because "for violence to be normalized it needs to operate on a continuum of political, economic and social arrangements" (Shaheen-Hussain, 2020, p. 113).

The last episode challenges how knowledge is produced and the epistemology of the West. Participants assert that they "know" because their survival depends on it. They are not waiting on colonial

tools of data collection and analysis to inform their practice. Rather, they insist on grounding the conversation within the realm of sacred ancestral knowledge of resistance. When they go into the birth room, they are aware of the spirits of Anarcha, Lucy and the countless other Black women who continue to experience obstetrical violence. For example, when I attended a C-section involving a Haitian refugee woman, I ended up bearing witness to her screams because she could feel herself being cut open; the anesthesiologist had not administered the medication properly. This “knowing” has led to a collective response of resistance from Black midwives. One participant describes how her midwife, although exhausted from attending multiple births, stayed with her because she knew the risk of leaving a vulnerable Black woman in the hands of a white establishment. At the beginning of the pandemic I was supporting two high-risk pregnant women- one who was followed by a Black midwife and the other by a white OB-GYN. The Black midwife successfully advocated for additional support and the other one did not want to consider it. When the client approached her OB-GYN for the same type of support, the idea was shut down immediately under the pretext that the policies were in place for everyone. The difference between the two providers is that the Black midwife designed a care plan based on the needs of the client who is Black and the OB-GYN wanted to follow general policies even though, statistically, her client was likely to experience institutional violence. Simply put, the Black midwife practiced equity and the white OB-GYN practiced equality.

SECTION 2: Manuscript

The second component of my portfolio, located in Appendix A, is a manuscript that I submitted to a peer-reviewed journal titled *"Unpacking emergency response: anti-Black racism and other barriers faced by pregnant and lactating asylum claimants in Quebec, Canada"* based on an intervention that I did in 2017. The feedback that I've received from the reviewers is that "This manuscript explores a topic that is not well-researched, and demonstrates numerous contributions to the literature base." Nevertheless, the review process has been challenging because the manuscript is not a typical research article and does not fit conventional parameters of how research is conducted, i.e. ethics review, methods and role of the 'researcher'. Rather, the article captures the intervention of grassroots reproductive justice activists who conducted research in the midst of a crisis, independent of academia, for the purpose of responding to the needs of pregnant people and infants. This process has led me to interrogate: how can community-based research that emerges organically during a crisis, out of the lived experience of the members, be considered as 'legitimate research' by academia without having to go through the Ethics Board?

In the same article I introduce a theoretical framework, First Food Sovereignty, that I developed during my MES to understand the cascade of medical interventions that impact the ability of a newborn to access optimal nutrition, which in turn can help inform policy and practice towards pregnant and lactating parents during emergencies. To date, the literature has not considered infant feeding holistically as an interconnected singular phase from in utero to age two, and I would like to offer a new conceptual framework to describe this phase of a child's nutritional experience.

SECTION 3: Art installation

The last component of my portfolio is an artistic exploration, through visual and cultural production, on how mothering continues to be an act and a tool of resistance for Black communities to global patterns of violence. I curated an art installation titled the *blueprint series* which explores, through a human rights lens, institutional factors that hinder the right of the child to have access to optimal nutrition during transnational movements. It speaks to a connection between gender-based violence and the conditions that prevent a child from having access to human milk.

IV. CONCLUSION & RECOMMENDATION

I've chosen to express my research outcome primarily through cultural production because I would like to raise awareness about Black maternal and birthing individuals' health in Canada in an accessible manner. Culture is a lived expression, and through this research project Black mothers and Black birth workers simultaneously took on the roles of subject, expert, and audience. I chose the documentary film-making style because it is an important tool in voicing grassroots resistance. This format allows for women's voices to be heard, seen and recorded.

In closing, I have serious concerns and am alarmed by the way hospitals have been operating in regard to pregnant and birthing Black people during COVID-19. They have exasperated already existing inequalities such as gender-based violence and infant food insecurity. Systemic violence such as anti-Black racism in health care and obstetrical violence were common prior to the pandemic, necessitating for example the physical presence of birth companions (doula) to advocate for the rights of families as the first line of defense. During COVID-19, hospitals have had carte blanche to do whatever they want, without accountability and transparency, under the pretext of emergency. Draconian measures and attitudes such as forcing women to take the epidural, or to birth alone, were the norm during the initial response to the pandemic in Canada (Archer, 2020). These measures were not evidence-based, violated human rights, and were contrary to the WHO recommendations.

In the same way that general public health recommendations put those living in domestic violence in environments of greater risk by isolating them at home with their abusers, we need to ask --what are the recommendations that are putting Black families at a greater risk of systemic violence? What does an emergency response that centers the experience of Black people and families look like? What kind of public health response do Black folks need in Canada? Those are the questions we should be asking because it might surprise folks to know that COVID-19 has not been the biggest threat to Black maternal health. My sense, based on what the participants reported, is that obstetrical violence and anti-Black racism pose a greater risk to pregnant and birthing Black people than COVID-19. We need to recognize that Black families need protection against unconscious bias and systemic racism when navigating the healthcare system. Who are the essential workers protecting Black maternal health and infant food security? What are their needs during COVID-19, and how do they need to be supported? The participants I've spoken to have identified not having a birth companion of choice who can advocate for their rights,

such as a doula, as having exposed them to increased physical and psychological harm. They expressed concern about the long-term impact of such traumatic experiences not only to the birthing parent but to the children. Having an advocate can make a difference in addressing and interrupting intergenerational trauma, as well as Black mortality. Therefore, I'm advocating for three main interventions that have emerged from my portfolio:

1- Birth companions (doulas) and Lactation Consultants should be considered as essential workers especially when it comes to Black families. Every family should have the right to have a birth companion present during prenatal appointments, labor, and postpartum care. This is separate from and is in addition to having one support person present, such as a partner;

2- Demand that hospitals be transparent about their policies, and provide data about the experience of Black birthing people and infant feeding practices;

3- Require hospitals to develop a protocol to address anti-Black racism and obstetrical violence during COVID-19, and come forward with public health recommendations that take those factors into consideration.

Moving forward

The goal of the website, #BirthingWhileBlack in Canada, is to create a multi-media knowledge hub for members of the Black community, to discuss the experience of birthing while Black in Canada using the concept "for us, by us". This is in part to address the lack of Canadian specific research, and to host content created by Black Canadians. The site will be launched with my research portfolio, but the goal is for others to use it to upload their stories in multiple formats (audio, video, text, pictures, art). One participant commented "the way people consume websites is quite different from how they consume academic texts, so how you present the information will depend on whom you're hoping will benefit from it. Is it other academics? Is it Black birthing folks? What particular unique experiences are you hoping to reflect on this website?" I don't have all the answers at this time because I am hoping that other participants will chime in, and that we, collectively, determine the focus of the website. For example, when I initiated a preliminary dialogue about using the film from my thesis on the website, one participant responded, "If the portions about my mother-in-law's COVID diagnosis are redacted, I would be OK with a written version of our interview that you can present on a website". A couple of participants asked for their faces not to be shown either because of confidentiality reasons or because they did not like how they looked on camera. Alternatively, as a participant pointed out, it is possible to, for example, present some of the stories in a podcast format, or pitch it as a story idea to a women's magazine.

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Appendix A

Unpacking emergency response: anti-Black racism and other barriers faced by pregnant and lactating asylum claimants in Quebec, Canada

by
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Abstract

This article paints a picture of the institutional and social barriers that birthing Black people face in Canada by examining closely the experience of Haitian asylum seekers in the summer of 2017. This paper traces gender-based violence and its correlation to infant feeding, and by posing the question "How are infants fed?" as a point of departure, it unpacks global patterns of violence impacting infants, pregnant and lactating Black people. It concludes by asserting that a lack of holistic understanding when it comes to birthing while Black perpetuates health inequity and anti-Black racism and obstructs a competent emergency and disaster response plan. Recommendations on how Canada can create and deliver more effective health services to pregnant and lactating women during large scale emergencies and natural disasters are also offered.

"The master's tools will never dismantle the master's house."

– Audre Lorde

Introduction

It is well-documented in the United Stated that Black women have disproportionately negative maternal health and childbirth outcomes, including higher rates of maternal mortality, infant mortality and complications during childbirth. These disproportionate outcomes have led to a reproductive justice movement led by Black, Indigenous, and People of Color (BIPOC) that draws attention to and redresses negative outcomes for Black women as a result of anti-Black racism, capitalism, imperialism, patriarchy and white supremacy (Ross, 2017). For example, historical advancements in the field of obstetrics and gynecology are based on experimental procedures on enslaved Black women- needless to say - without their consent or anesthesia. These types of violence did not end with chattel slavery, they are ingrained in a violent medical culture, more specifically a core foundation of obstetrics and gynecology medicine, all over the world, and not just in the United States. In Canada, there has been a push to collect race-based data to identify health inequities and advocates have pushed for Public Health to name anti-Black racism as a public health issue (CBC, June 11, 2020). Nevertheless, despite the recognition that Black women have more negative reproductive health outcomes due to systemic anti-Black racism, Canada lags behind other Western countries in documenting the impact of anti-Black racism on maternal and infant health.

Recent public health responses to the COVID-19 pandemic have demonstrated the failure of government officials to put in place recommendations based on the specific needs of Black people (Alliance for Healthier Communities, 2020; Handa, 2020) and birthing families (The Obstetric Justice Project et al., 2020). There is also a body of nascent research in Canada documenting the disproportionate impact of the coronavirus on Black and low-income communities (Alliance for Healthier Communities, 2020, Dalla Lana School of Public Health, 2020). According to data from Toronto Public Health, Black people and other people of color make up 83% of reported COVID-19 cases in Toronto (CBC, July 30, 2020).

Drawing from Critical Race Theory and a reproductive justice theoretical framework, this article interrogates the interventions made vis-a-vis birthing Black women, and their families, during emergencies. These failures exist in a longer context in which Black communities have had disproportionately negative health outcomes due to anti-Black racism (Timothy, 2020; Dalla Lana School of Public Health, 2020, 2020a).

This article will paint a picture of the institutional and social barriers that birthing Black women face in Canada by examining closely the experience of Haitian asylum seekers in the summer of 2017. I will discern the unique challenges that the families faced- challenges that grassroot reproductive justice and birth workers such as myself have clear knowledge of, but that remain invisible in research and policy-making. I will argue that this lack of holistic understanding when it comes to birthing while Black perpetuates health inequity and anti-Black racism and obstructs a competent emergency and disaster response plan (Alliance for Healthier Communities, 2020; Dalla Lana School of Public Health, 2020, 2020a; Owens & Fett, 2019).

The article is divided in two sections. The first is a descriptive case study account of the innovative work that SafelyFed Canada-Montreal Team (SFC-Mtl), an ad hoc group of

professionals - including myself - with an expertise in addressing infant feeding during emergencies, undertook to respond to the needs of pregnant and lactating asylum seekers in 2017. I'll speak to the institutional barriers that we encountered and our responses to these obstacles. The second section uses critical race theory to analyze the case. I draw from the concept of intersectionality (Crenshaw, 1991) to analyze the experiences of being Black, a woman, pregnant, and an asylum seeker in relation to health disparities. I will make the argument that anti-Black racism, anti-refugee and misogynistic attitudes, and inadequate public health attention to the impact of medicated births in the planning of emergency preparedness policies are the dominant threats at the institutional level (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008). I'll end by providing recommendations for policy and practice.

1. Case Study

Background

The case study for my review is Canada's response to the unprecedented number of Haitian asylum seekers that crossed the unofficial U.S.-Canada border in the summer of 2017 in Quebec (Noel, 2017). As a result of the 2010 Earthquake (Mullings, Marion, & Peake, 2010) which killed hundreds of thousands of people and displaced over 1.5 million Haitians, the United States government issued Temporary Protected Status (TPS) to more than 58,000 Haitian immigrants (Bergeron & Messick, 2014). In 2017, the US government revoked the TPS and forced many Haitians to leave the United States (Noel, 2017). In the summer of 2017, over 12, 000 Haitians crossed over to Canada, requesting protective status, through the unofficial New

York/Quebec border (Government of Canada, 2020) fearing a return to unsafe conditions in Haiti (Noel, 2017). Among the asylum claimants were pregnant and lactating women (Ljunggren, 2018). The governments of the province of Quebec and Canada were not well prepared to receive a large number of asylum claimants and both the political and media discourse at the time demonized asylum claimants (Gaucher & Larios, 2020, Maynard, 2017). The asylum claimants were placed in temporary shelters, including the Olympic stadium, as the government debated how to address the issue (Noel, 2017).

Method of Data Collection & Analysis

The data collection methodology that I use to analyze this case study is participatory observation consisting of the following: interventions that I was a witness to, written and verbal field reports from service providers, analysis of demographic information on residents, conversations on facebook, and informal conversations with refugee families and approximately a dozen service providers- lactation consultants, birth companions, nurses, and social workers. To generate an explanation of how social and structural violence impacts Black maternal health and infant feeding in times of emergencies I listened to families, and members of the Canadian Black community, including academics, who critically connected Black health to anti-Black racism, which in turn allowed me to interpret the data I had collected.

Intervention

SafelyFed Canada- Montreal team, brought together experts in emergency infant feeding, birth companions, and Lactation Consultants to create an intervention to provide breastfeeding and birth support for refugee families being temporarily sheltered at a YMCA in Montreal. The

intervention was 6 months long, from August 2017 to January 2018. Shelters are generally run by social workers and social service workers, in this case, on and off-site, by government agents of the Regional Program for the Settlement and Integration of Asylum Seekers (PRAIDA). There is a large body of literature that speaks to the ways in which social work fails to address systemic oppression in the provision of individual level services. This case was one example where social workers and social service workers ended up being complicit in systemic racism towards Black refugees, and the most vulnerable among them, Black refugee infants.

Our intervention had multiple components:

1. Needs assessment: physically visiting the site and assessing safety and sanitation; speaking to families; speaking to social workers, nurses, and shelter administrators in order to determine the support and resources available and any challenges regarding birthing and infant feeding.

2. Conducting comprehensive clinical assessments of mothers and babies and provide support related to lactation in accordance with *Clinical Competencies for the Practice of International Board Certified Lactation Consultant (IBCLCs)*

3. Creating an infant-feeding room and providing multilingual educational and material resources to support safe feeding.

4. Advocacy and accompaniment during medical appointments and births by doulas, and directing families to culturally appropriate community-based resources.

5. Facilitating pre and post-natal discussion groups on mental health, nutrition,infant feeding and perinatal related concerns.

Our entry point

The news coverage indicated that among the asylum seekers were Haitian women giving birth within days of arriving in Canada (Staley, 2018) as well as babies and young children crossing the US/Canada border (Ljunggren, 2018). Yet we knew nothing about this vulnerable group beyond their images in the media. As a birth worker and as an International Board Certified Lactation Consultant whose work is focused on reproductive justice (reproductive rights + social justice) a theoretical perspective coined by African-American feminists in 1993 (Ross, 2017), I was concerned about how the needs of pregnant and lactating Black asylum claimants and their children were being met or not met in this emergency situation. Reproductive justice examines the ways in which interlocking systems of oppression such as white supremacy and patriarchy lead to disproportionate and differential outcomes for racialized pregnant people and their children, and draws attention to how racial and gender-based violence are reproduced. Ross (2017) explains that the movement for reproductive justice "has impressively built bridges between activists and the academy to stimulate thousands of scholarly articles, generate new women of color organizations, and prompt the reorganization of philanthropic foundations… As a theory, it can be used to explain groups of facts and make predictions about reproductive politics" (p. 288). Reproductive justice, as a theoretical framework, reflects my praxis as a birth companion. It captures the intersectional lived experiences of the Black families whom I've supported for the past 12 years in my capacity as a queer diasportic Ethiopian mother who advocates on issues pertaining to pregnancy and infant feeding with a focus on racial equity, sexual violence, and LGBTQ2+ issue.

It is important to situate obstetrical violence within a violent genocidal and colonial history of systemic racism towards the Indigenous people of Turtle Island. In 2016, a literature review on 'Canadian Indigenous women's experiences and perspectives of maternal healthcare

during pregnancy, childbirth, and the postpartum period' was published in *Diversity & Equality in Health* by Sangita et al. They identified racism, women's limited control over their care, and colonial policies as contributing factors to health disparities for Indigenous women. Sangita et al. (2016) argued "Indigenous women in Canada have a two times higher risk of maternal mortality in comparison to the general Canadian population. Indigenous women also experience higher rates of adverse outcomes including stillbirth and perinatal death, and, in some cases, low-birth-weight infants, prematurity and infant death." (p. 335)

I plan to build upon the reproductive justice framework which originated from the experience and scholarship of radical African-American feminists and situate it within anti-Black racism in Canada. When people were directed to shelter at the Olympic stadium, we wondered, considering that there are risks associated with artificial bottle feeding and sanitation during evacuation and migration (Deyoung, Chase, Branco, & Park, 2018, 1827; Gribble & Berry, 2011), how were infants fed safely? Did they have access to a fridge to store milk? Did they have access to boiled water to sanitize bottles and prepare powder formula? What was happening to the women who gave birth within days and weeks of arriving in Canada? Where were they discharged to once they gave birth? No one seemed to be able to give us answers. Therefore, I collaborated with other Lactation Consultants and birth workers to conduct a needs assessment for pregnant and lactating asylum claimants who had ended up being housed temporarily in shelters. We ultimately found that the conditions in which they were being housed were unsanitary, unhealthy and a risk to the well-being of their newborn children (Staley, 2018).

Initially, we had three major concerns: the first was the weather. Because it was summer and extremely hot, we were concerned about infants and young children getting sick from drinking from bottles of milk that had been sitting in the heat (Staley, 2018; Gribble & Berry,

2011). It was possible that children were getting sick but that it was not being traced back to contaminated milk (Gribble & Berry, 2011). The next concern pertained to common breastfeeding challenges, for example, a short term decline in milk production (Deyoung, Chase, Branco, & Park, 2018)- out of concern mothers may initiate supplementation with formula by bottle feeding- this inadvertently contributes to a decline in milk production (Gribble & Berry, 2011; Deyoung, Chase, Branco, & Park, 2018). Our third concern was addressing mental health concerns for the baby and mother. In times of stress, studies have demonstrated that breastfeeding reduces the stress levels in both child and nursing parents (Deyoung, Chase, Branco, & Park, 2018; Gribble & Berry, 2011). As asylum seekers, not only were they in a highly stressful and precarious situation, but they arrived in Canada with a history of trauma (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014).

I reached out to sources at CBC - producers, and journalists - hoping at the very least to get an answer to the question "where can I find information about the number of pregnant women and infants crossing into Canada on a daily basis?" What I discovered was that no one had the answers because they were not asking those questions. We also reached out to local Haitian organizations, asking the same questions. They too, did not know. They had not taken into account nor planned for the particular needs of pregnant and lactating women. Nor did they understand the needs involved in infant feeding during an emergency.

Eventually, through their network in the Black community, the Black Birth Workers and Lactation Consultants of Montreal received confirmation that women and children were being housed at the YMCA shelter. When we contacted the staff of the YMCA and the Regional Program for the Settlement and Integration of Asylum Seekers (PRAIDA is the Quebec government agency affiliated with the health ministry and tasked with providing asylum

claimants with housing, food and clinical services) we could not get a clear answer about the number of pregnant women and infants, and the conditions surrounding infant feeding. Eager to offer our expertise to support pregnant and lactating women during this crisis, we approached PRAIDA. I remember my team and I feeling baffled by the response from the social service agencies and immigration officials when we volunteered our professional services as IBCLCs, ready to fill the gap left by the government. With SafelyFed Canada as part of our team, an organization that specializes in addressing infant feeding during emergencies, we did not anticipate our offer being rejected. Our experience was not unique- a few years later, during COVID-19, the Quebec government rejected Dr. Joanne Liu's offer to support the government's efforts, despite her 25 years of expertise in pandemic preparedness, including having led the fight against Ebola, and her role as President Of Doctors Without Borders (Langlois, 2020). Tabasum Masumbuko Abdul-Rasum is another Montreal-based racialized expert, who manages emergency health systems and coordinates international responses (UNICEF, WHO, Red-Cross) who volunteered her expertise during the pandemic to the Quebec government, only to be rejected (Ruel-Manseau, 2020).

Institutional Barriers: shelters, medical offices, and hospitals.

Despite the initial rejection, we were finally granted access to the temporary shelter for women and children at the YMCA. Having gained access, we conducted a site assessment and produced a report based on the assessment. Our conclusion was that access to care was obstructed by structural, organisational, social, and cultural barriers (Melaku, 2019). Below, I summarize some of the key barriers that we identified.

Infant feeding: I observed that inside the temporary shelter there was unsafe handling, preparation, and storage of breastmilk substitutes due to a lack of appropriate resources, support and education. Families used the sinks in bathrooms to wash infant feeding devices such as bottles, cups, and teats. I recall vividly how a mother pointed to a bucket to show me where she was washing her baby's bottles. In addition, people did not have access to boiled water to prepare formula safely past 8 pm because the cafeteria was closed. Instead, they used tap water, and consequently, the babies were exposed to a number of bacteria. Similarly, people were preparing unsterile powder formula and giving it to babies under 3 months old which is not generally recommended because of the potential harm to the baby. The alternative is single use ready-made sterile formula (Gribble & Berry, 2011). However, those are extremely costly and the families did not have the financial means to purchase them. Finally, families left bottles of milk, for an extended period of time, in their hot rooms because they did not have access to a fridge. Overall, we had serious concerns regarding infants being fed formula and malnutrition.

Breastfeeding discouraged/ formula feeding encouraged: At some hospitals, formula was routinely introduced and given to babies after mothers had expressed a desire to exclusively breastfeed. The staff explained that post c-section they do not allow mothers who are alone to breastfeed on demand at night (Melaku, 2019; Staley, 2018; Robinson, Fial, & Hanson, 2019). This practice contradicts Quebec Governments' own public health policy on infant feeding which states "Ne donner aux nouveau-nés aucun aliment ni aucune boisson autre que du lait maternel, sauf indication *médicale"* [**Do not give newborns any foods or beverages other than breastmilk, unless *medically* indicated]** (Dionne & Jetté, 2001, p.45) Rather than following public health recommendations, mothers were released from the hospital with a case of formula to last them a few days and without education about infant feeding preparation (Staley, 2018).

There is a wide-range of evidence demonstrating the benefits of breastfeeding in the prevention of respiratory illness, and diabetes long into adulthood (Stuebe, 2020). And the positive impact of human milk on the neurodevelopment of preterm infants is high (Tromp et al., 2017). Mothers who breastfeed also benefit from its protective component, including a reduction in hypertension and cardiovascular disease, Type 2 diabetes and breast cancer (Louis-Jacques et al., 2017; Stuebe, 2020).

Pregnancy and childbirth: When it was time to give birth, mothers reported feeling "disempowered, humiliated, disrespected, violated, and traumatized" (Melaku, 2019, p.5)- responses to what has been characterized as 'obstetrical violence'. Black birth workers (doulas) and the community-based nurses pointed out various systemic barriers to receiving prenatal care (Melaku, 2019). Single mothers and those who had c-sections were the most vulnerable (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014). Repeatedly, when pregnant women, in their last trimester asked to see a doctor for prenatal care they were denied. Rather, they were informed by the PRAIDA staff to go to the emergency department at the hospital if they felt any abnormality with their baby (Melaku, 2019). Not being able to receive prenatal care put them and their child at greater risk of health complications in addition to the compounded stress that comes from navigating a foreign healthcare system (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014). Ironically, a significant number of Haitian women were receiving regular prenatal care in the United States and had brought with them their complete medical file, yet they were unable to access health care in Canada.

Consent: Navigating the healthcare system was very difficult in part because of linguistic barriers and Western medical culture (Melaku, 2019; Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014). Institutions did not have clear protocols in place on how to communicate with

patients who did not speak French or English. They did not provide interpreters, thereby denying families the right to make informed medical decisions. Mothers also reported feeling forced to consent to a procedural x-ray scan for TB screening when their fetus was under 12 weeks (Melaku, 2019). They spoke of feeling overwhelmed and afraid that if they do not sign the consent form their refugee claimant application would be denied.

Institutional & social barriers: Various informants in the health care system explained that many ob-gyn were averse to accepting asylum claimants as patients. When some doctors eventually agreed, there were additional barriers imposed by some offices when families called to make an initial appointment for prenatal care. Unlike practices for the general population, asylum seekers were told to present themselves in person when booking a medical appointment even when they offered to fax their government issued medical certificate. This discriminatory practice of forcing pregnant women to show up was an additional barrier to accessing services especially for single mothers with young children (Melaku, 2019).

Some of the health workers I've spoken to noticed that doctors were disproportionately performing higher rates of c-sections on Black asylum claimants than the general population (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014). A c-section has serious ramifications for a child in that a newborn is immediately separated from the birthing parent for hours on end thereby denying it skin-to-skin contact (Stuebe, 2020). Skin-to-skin contact immediately after birth has several adaptive benefits, such as reducing stress and helping to stabilize the baby's heartbeat and breathing (Stuebe, 2020). Following a c-section, breastfeeding is also likely to be delayed, and artificial feeding introduced (Hemati et al., 2018).

Organizational barriers- lack of centralized real time data: The YMCA held over 500[1] residents (Melaku, 2019), and we speculated that a third of the population were under the age of twelve. At any given moment there were roughly 40 pregnant women at the shelter at different stages of their pregnancies, including days away from giving birth (Melaku, 2019). It was impossible to have accurate data about children under the age of three months because there was no centralized real-time data collection. Consequently, the presence of infants under one month was frequently undetected by staff.

Lack of continuity of care: Because asylum claimants stayed in temporary shelter for two weeks, and the majority did not have a local phone number, this rendered them vulnerable to lack of continuity of care. Health professionals had not taken into account the conditions that challenged communication with transient populations and therefore were not able to properly provide necessary services.

Our intervention: programming in the temporary shelter

Overall, we ended up doing the job that public health was supposed to be doing but neglected to do. Not only did they not ensure proper care and facilities, but they placed unnecessary roadblocks in our way. Front-line workers, however, were supportive, at the risk of being reprimanded by their racist managers for working with us. Between August 2017 and January 2018 we initiated and delivered a very successful perinatal and infant feeding program. We managed the programs autonomously, and with no additional cost to the YMCA or the government. The YMCA allocated an infant feeding room with a sink and microwave in response to our safety concerns, however, they made it clear that they would not be responsible

[1] Based on SafelyFed Canada-Mtl unofficial data collection of the residents at the shelter, during the period Sep. 2017-Jan. 2018, approximately: 100 were pregnant,154 were babies under 24 month. From which, approx. 15% attended prenatal groups, and 50 pregnant women received doula support over WhatsApp.

for the contents of the room, replenishing supplies (such as sterilization bags), or the operation of services (Melaku, 2019). This was left up to the SFC-Mtl team, as volunteers. A lactation consultant donated a refrigerator while SFC-Mtl researched culturally and linguistically appropriate educational material in Haitian Creole and consulted with a Haitian breastfeeding specialist (Melaku, 2019).

A collaboration between a PRAIDA social worker and SFC-Mtl eventually emerged: when there was a pregnant woman in need of a birth companion, the social worker notified the SFC-Mtl team. Often the pregnant women arrived alone, without a partner or family member, and the presence of a birth companion provided emotional support as well as practical help. Because there was a high demand for birth companions, only some high risk pregnant individuals were being served: single mothers, pregnant mothers with children under the age of 3, women who had undergone a c-section, and women who were pregnant with multiple babies. When a birth companion was assigned to a case, mothers received timely care, access to a healthcare professional who was best equipped to respond to the needs of the family (i.e., high-risk pregnancy are referred to an OBGYN, or normal pregnancy to a midwife), and to services in the wider community. A number of studies highlight the effectiveness of trained birth companions in reducing health complications in comparison to births without doula support especially amongst at-risk populations (Bohren, Cuthbert, Fukuzawa, Sakala, & Hofmeyr, 2017).

Then… things fell apart

On January 17, 2018 Corporate Knights magazine (Staley, 2018) printed an interview with me about my initial site assessment of the shelter as part of their coverage of breastfeeding during emergencies. Displeased with the public disclosure of the assessment, the Director of the

YMCA and PRAIDA, the Quebec government agency affiliated with the health ministry and tasked with providing asylum claimants with housing, food and clinical services revoked my right to volunteer at the shelter. I was informed over email "the comments reported yesterday in "Corporate Knights" give a very negative image of the YMCAs of Quebec by describing alleged inadequate sanitary conditions, even though the clinical duties regarding asylum seekers are a responsibility of PRAIDA, our privileged partner...as a consequence, your interventions and visits to the YMCA are no longer needed" (Melaku, 2019, p.8). The YMCA and PRAIDA chose to end a highly successful, essential service, that was mitigating mistreatment and violence against women and children because the public was now aware that children and pregnant asylum seekers were not safe in Canada. Why was the government intent on concealing the challenges faced by pregnant asylum seekers instead of collaborating with the SafelyFed Canada-Mtl team and improving their conditions?

I do not have an answer to the question however I am aware that this was not the first attempt by officials in charge of asylum claimants at preventing community-based health professionals to deliver key services in the human rights protection of infants and pregnant people. A few weeks prior to banning me at the shelter, a retired Haitian labour and delivery nurse, who had initiated the prenatal groups, and the only professional at the shelter who spoke Haitian creole (the mother tongue of the majority of the asylum seekers from Haiti) was banned from the temporary shelter, without cause, under the false pretext of "former employees of PRAIDA are not allowed to volunteer"(Melaku, 2019, p. 8). When she worked at the shelter as a public health nurse, her manager reprimanded her for helping asylum claimants "too much" during her free time. In fact, senior management expressed that refugees should not get the same treatment as the general population because "they are not Canadian, and don't pay taxes"

(Melaku, 2019, p.8). When PRAIDA tried to relocate the Haitian nurse out of the shelter, she quit her position as a public health nurse and came back as a volunteer.

It is important to consider the role of race and racism in this narrative. The nurse and I were the only two volunteer Black program leaders running a very successful program. We had the cultural competency, whether through common language or shared culture to respond to the myriad emotional and psychological needs that the families presented. We advocated for the families and held institutions to account. And when institutions refused to provide essential services to pregnant women and infants, we organized volunteers to do so. We operated as independent professionals, not bound to any institution, who prioritizes the needs of families over politics. It is my understanding that officials were resistant to our advocacy in the promotion of the rights of women and access to safe, timely, respectful care during pregnancy, childbirth and during the post-partum period.

2. Black Maternal Health and Emergency Preparedness Recommendations

In this half of the article I will connect the elements raised in the case study to a broader analysis of Black maternal health. I've identified anti-Black racism, anti-refugee and misogynistic attitudes, and inadequate public health attention to the impact of medicated births in the planning of emergency preparedness policies as the dominant institutional factors that hinder the right of the child to optimal nutrition and of the birthing parent to safe reproductive health.

Anti-Black racism

Anti-Black racism in Canada has been declared a national health crisis by health specialists in the Black community (Alliance for Healthier Communities, 2020). Health disparity

in perinatal care is directly linked to systemic racism (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008; Dominguez, 2008, Greenwood, Hardeman, Huang, & Sojourner, 2020) as demonstrated by a recent study which found that Black babies were three times more likely to die under the care of a white doctor than a Black doctor (Greenwood, Hardeman, Huang, & Sojourner, 2020). Racism enacted at the attitudinal and behavioural level (Clark, Anderson, Clark, & Williams, 1999) of perinatal institutions plays an important role in birth outcome disparities (Owens & Fett). Although the data linking racism to birth outcomes in Canada is limited, studies investigating the disparities in birth weight along racial lines in Canada have established the results to be similar to that of the United States (McKinnon et al., 2015; Auger, Chery, Danier, 2011).

Pregnant Black asylum claimants are at the intersection of patriarchy, white supremacy and imperialism (Maynard, 2017; Klein, 2017). In addition to experiencing a greater number of stressful life events than the general population (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014; Maynard, 2017) psychosocial stressors such as the ones I've identified earlier create a state of general and pregnancy related anxiety that negatively impacts birth outcomes (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014). Adverse events *in utero*, inadequate nutrition, delayed prenatal care and general health problems, are linked to low-birth weight and pre-term rates. Moreover, children born of Black mothers have a higher-rate of pre-term birth than their white counterparts (Campbell et al.; Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014; Mckinnon et al., 2015). Amongst Haitians in Quebec, the disparity in birth outcomes has risen over time leading to severe adverse health outcomes for children whose mother was born in Haiti and spoke Creole (Auger, Chery, Danier, 2011). *Rising Disparities in Severe Adverse Birth Outcomes Among Haitians in Quebec, Canada, 1981–2006* is one of the few studies to investigate the role

of race in Canadian perinatology. The authors were able to identify racial discrimination and financial insecurity (unemployment, poverty) as the main factors behind the disparities in pre-term birth, low-birth weight and small-for-gestional-age for Haitian-born mothers relative to Canadian-born mothers (Auger, Chery, Danier, 2011). The long term impact of low-birth weight is many, including an elevated rate of respiratory problems, higher prevalence of asthma, diabetes, hypertension and cardiovascular problems, and delay in cognitive development (Campbell et al. 2017).

Anti-refugee and misogynistic attitudes

As it stands, Canadians perceive racialized pregnant asylum claimants as untrustworthy, fraudulent, deceptive, and undeserving of Canadian services (Maynard, 2017; Gaucher and Larois, 2020). Racist and misogynistic rhetoric dominate public discourse (Gaucher and Larois, 2020). The images are often stereotypical and the language used to describe them alludes to criminality, for example, 'illegal'. This feeds into xenophobia, as refugees are perceived as a threat (Gutiérrez Rodrîguez, 2018; Mullings, Marion, & Peake, 2010). Canadian based studies support a link between hostile public discourse and adverse health outcomes (Chase, Cleveland, Beatson, & Rousseau, 2017). This discourse is dominant in institutional culture within the healthcare system, "about 49% of respondents agreed on restricting refugee claimants' access to health care based on the argument that refugee claimants take advantage of the Canadian health system" (Rousseau, Oulhote, Ruiz-Casares, Cleveland, & Greenaway, 2017, p. 6). Auger, Chery and Danier's (2011) work corroborate these findings. Montreal's health care providers' negative perceptions about refugees appear to be confirmed once they have contact with them within an institutional context (Rousseau, Oulhote, Ruiz-Casares, Cleveland, & Greenaway, 2017). In

comparison, a PRAIDA nurse noted that when 25,000 Syrian refugees arrived in 2016 they were received with a warm welcome by Canadians (Klein, 2017; Maynard, 2017).

Mainstream media is complicit in vilifying Black women and presenting them as undeserving of the Canadian health system (Gaucher and Larois, 2020; Maynard, 2017). The media's vilification of Black pregnant asylum seekers is but one of the multiple forms of discrimination against Black women and children, the roots of which are historical and complex. The particularity of this hatred, directed at those who exist at the intersection of Blackness and womanhood can be characterized as misogynoir, a term coined by Moya Bailey "to describe the particular brand of hatred directed at black women in American visual & popular culture" (Bailey, 2010).

The impact of medicated births in the planning of emergency preparedness policies

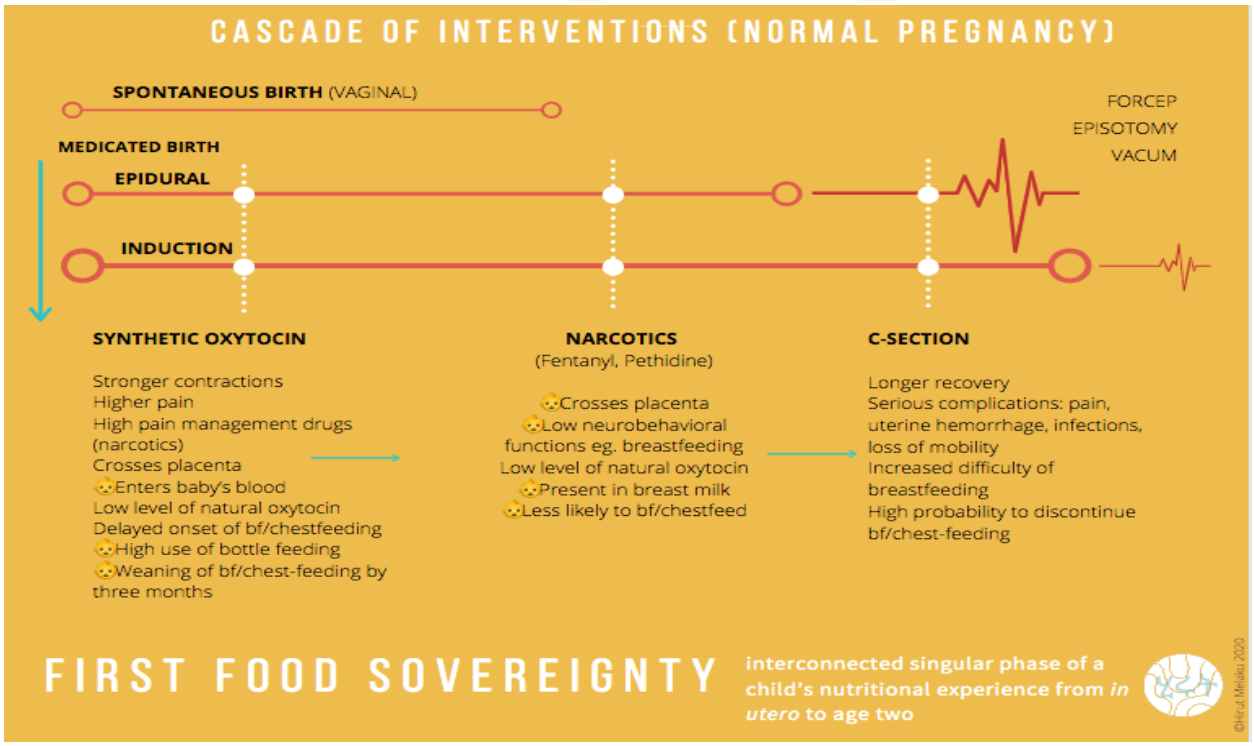
Earlier I spoke of how adverse effects *in utero* contribute to low-birth outcomes, and the role of breastfeeding in mitigating the adverse health outcomes (Tromp et al., 2017) relating to that. I will now address how access to human milk is impacted by medicalized births. To date, as far as I know, the literature has not considered infant feeding holistically, as an interconnected singular phase from *in utero* to age two, and I would like to offer a new conceptual framework that I call First Food Sovereignty (FFS) to describe this phase of a child's nutritional experience. Specifically, I am addressing the diet of the gestational parent during pregnancy, the presence of drugs during labor, the type of birth, skin-to-skin in the first hour after birth, and post-partum care. This conceptual framework is useful to not only understand the cascade of medicated interventions that impact the ability of a child to access optimal nutrition during normal times

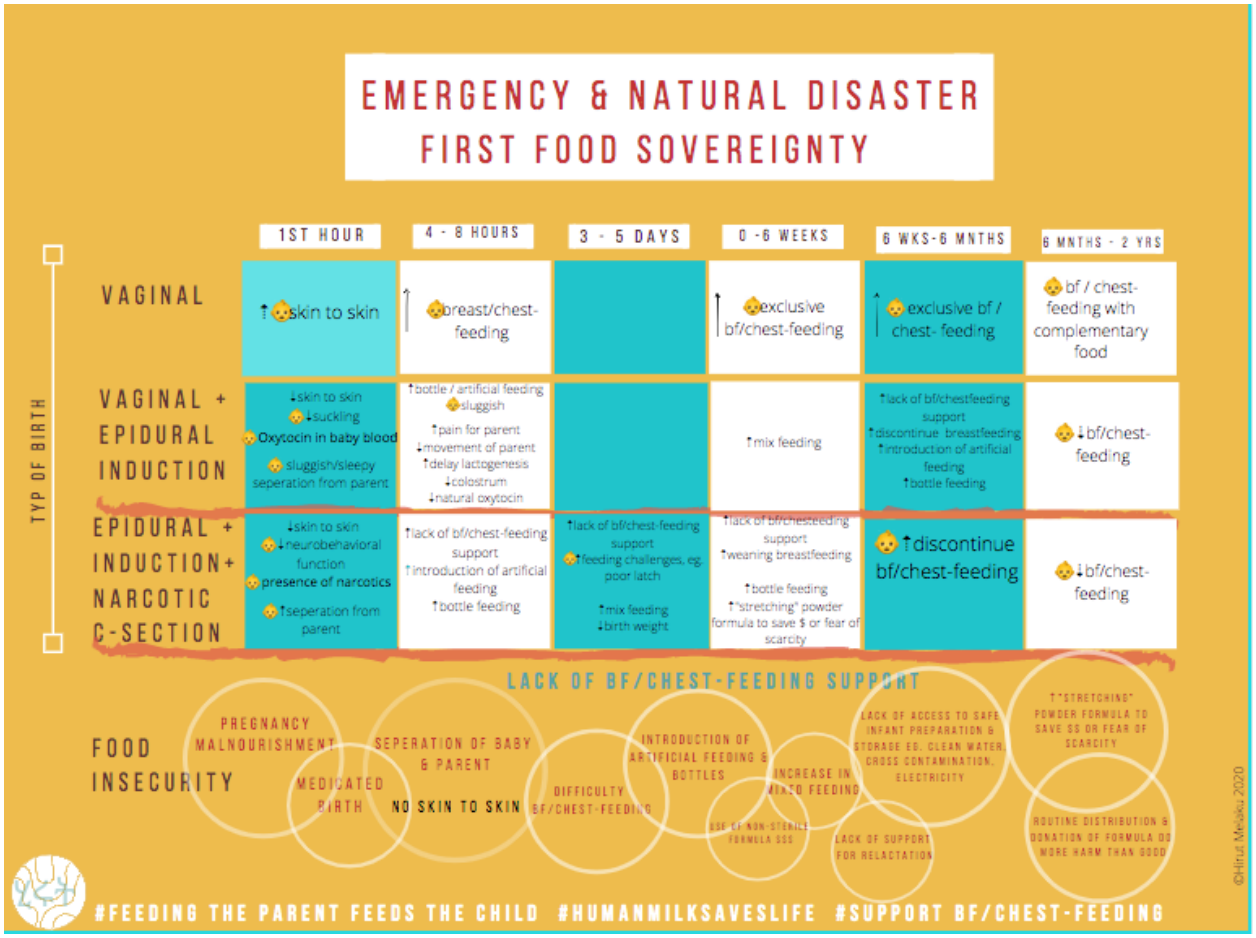
but can help inform policy and practice with pregnant and lactating people and infants during emergencies.

I'll begin by outlining a common understanding of how the cascade of interventions during a medicated birth poses a threat (Hemati et al., 2018) to First Food Sovereignty. In a normal birth, it begins with labor where Pitocin, a synthetic drug, might be introduced to stimulate contractions. Pitocin is administered through an IV and requires continuous fetal monitoring (Hemati et al., 2018). Before Pitocin, an artificial rupture of membranes is often executed, which increases the risk of infection and makes labour more painful. This is followed by Epidural, a drug injected on the spine that restricts lower body movement by numbing it to help with pain management (Gutiérrez Rodríguez, 2018). Both of these interventions limit freedom of movement, continuous fetal monitoring and increased discomfort. Often, due to continuous fetal monitoring and as a side effect of those medications, there might be a need for an emergency C-section because the baby is in distress (a common problem), i.e. the baby's heart rate is too high or too low, or the birthing parent has an infection. Consequently, this can lead to the child not receiving skin to skin in the first hour of its life (Stuebe, 2020, Brimdyr et al., 2015). Ongoing separation of mom and baby is also a possibility. For instance, mom could be in the recovery room while the baby is in observation. Due to the drugs given for the c-section, there might be a 3-5 days delay in the coming of mom's milk or the baby might demonstrate slow feeding reflexes until the drugs are out of its system (Pérez-Ríos, Ramos-Valencia, & Ortiz, 2008; Brimdyr et al., 2015 ; Hemati et al., 2018). During this period, the baby is normally fed artificial milk with occasional colostrum from the mom. By then, the baby might have gotten used to bottle feeding (Hemati et al., 2018) and is unmotivated to put in the extra work that

breastfeeding requires (Albokhary et al., 2014; Pérez-Ríos, Ramos-Valencia, & Ortiz, 2008). In all, it might take weeks for breastfeeding to be established.

Figure 1 and 2 illustrate this cascade of interventions





Policy & practice recommendations

There are a lot of questions, and research to be done, to decipher if breastfeeding outcomes are causation or correlation when it pertains to medicated births. Studies have demonstrated lower breastfeeding rates associated with epidural anesthesia and drugs administered for induction of labor (Wiklund et al., 2009, Jordan et al., 2009, Hematzi, 2018). First Food Sovereignty is concerned with the process that sets off a cycle of interventions which occur in conjunction with medication, and that can impact breastfeeding. The following recommendations are my attempt, based on what I have witnessed as an activist-scholar, in bridging the gap between academia and grassroot reproductive justice activists in Canada who

have noted that discriminatory and racist measures may amplify already existing structural violence during an emergency or a crisis.

1.Consider exclusive breastfeeding as part of an emergency preparedness plan, and ask the question "how are infants fed?"

In times of emergency, and mass migration, human milk and the protection of the breastfeeding dyad should be an essential part of the emergency preparedness plan (Gribble and Berry, 2011). For example, in the case above where the asylum claimants didn't have access to a fridge or boiled water breastfeeding was the safest option, and the support of lactation consultants should have been made available to them. Gribble and Berry (2011) argue for the promotion of exclusive and continued breastfeeding "as an emergency preparedness activity by emergency management organizations as well as health authorities." (p. 6). *The Effect of Mass Evacuation on Infant Feeding: The Case of the 2016 Fort McMurray Wildfire* is the first study "that identifies social and situational factors" pertaining to infant feeding during large scale evacuation due to wildfire in Canada (DeYoung, Chase, and Branco, 2018, p.126) . During the evacuation there was an increase in the use of artificial feeding and a decrease in human milk consumption. The World Health Organization states that artificial feeding should not be introduced unless it is acceptable, feasible, affordable, sustainable, and safe (AFASS). And yet, most of the asylum claimants in 2017 lived in conditions or contexts that were not AFASS (Pérez-Ríos, Ramos-Valencia, & Ortiz, 2008).

It is important to distinguish between the needs of breastfed infants and the needs of artificially-fed infants in high income countries. The foundational literature on infant feeding in times of emergencies internationally is *The Operational Guidance of Infant Feeding In Emergencies* (IFE) (Infant Feeding in Emergencies Core Group, 2014). Unfortunately, the IFE

fails to interrogate the interconnectedness of pregnancy and labor as a contributing factor in infant feeding planning. The recommendation to "Protect, promote and support early initiation of exclusive breastfeeding in all newborn infants" (Infant Feeding in Emergencies Core Group, 2014, p.13) is inadequate to guide policies in high-income countries which tend to have a higher rate of medicalized births than low-income countries. Canada, for example, not only lacks a clear, or streamlined, guideline for infant feeding during emergencies but health institutions, in response to the COVID-19 pandemic, have failed to take into consideration infant feeding when making policies about labor and delivery.

By asking the question 'how are infants fed?', and using First Food Sovereignty as the framework to answer the questions, policy makers will have a holistic understanding of the experience of the birthing parents and their children, and be in a better position to plan accordingly.

2. Intersectional analysis of emergency preparedness

There needs to be a frank conversation on what an emergency response for pregnant Black women looks like- one that takes into account obstetrical violence, anti-Black racism, immigration status, disability, sexual orientation and other factors that makes them vulnerable to systemic violence (Dalla Lana School of Public Health, 2020). It begins by asking the question 'what does an emergency response that centers the experience of pregnant Black people and Black children look like'?

3. Birth companions as essential workers

Based on the case study that I've described it is safe to conclude that Black families need protection against unconscious bias and systemic racism when navigating the healthcare system. Trained Black birth companions (doulas) are essential in the protection of Black maternal health and infant food security because like Black doctors, they understand that it is at the perinatal level that Black children first experience individual and institutionalized racism. The birth workers who came in support of the asylum seekers in 2017 did so because they were rooted in the Black community- they were invested in saving lives, and interrupting intergenerational trauma resulting from white supremacy and patriarchy.

Conclusion

Social work intersects with reproductive justice policy and organizing efforts in seeking policy and service delivery change. Shelters are generally run by social workers and one of the first social service settings that refugees encounter. In this article I examined the situation facing infants and pregnant and lactating Black asylum seekers in Canada and the systemic barriers they faced in receiving care. Broadly, I inquired about how Canada can create and deliver more effective health services to pregnant and lactating Black women during large scale crises. This case analysis contributes to social work teaching and practice in the areas of anti-oppressive service provision in the shelter and settlement services. In particular, it offeres an understanding of anti-Black racism, and Black feminist approaches to service provision. Using a reproductive justice framework, I explored institutional factors such as managerialism that use racist practices predicated on citizenship, that hinder the right of the child to have access to optimal nutrition (Pérez-Ríos, Ramos-Valencia, & Ortiz, 2008) during transnational movements, and that

constraint progressive social work practitioners. I spoke to a connection between gender-based violence and the conditions that prevent a child from having access to human milk. I investigated the factors behind the mistreatment and violence against pregnant Black women in Canada and connected pre- and post-partum experiences, pre- and post-partum environments, and policies related to infant food security that lead to inequitable health outcomes for Black women and their children.

My experience serving and advocating for the rights of pregnant and infant asylum seekers in Canada was the catalyst for this publication and the questions that I've asked. Drawing upon Canada's response to the unprecedented number of Haitian asylum seekers, many having moved to the United States in the aftermath of the 2010 earthquake in Haiti, and who crossed the unofficial U.S.-Canada border into Quebec in 2017, this article attempted to trace obstetrical violence and its correlation to infant feeding. As "natural" disasters intensify under 300 years of capitalism, I hypothesize that Haiti will remain vulnerable to an increased frequency and intensity of disasters, and Haitians will continue to migrate to Canada and the United States, and will continue to be exposed to anti-Black systemic racism and anti-immigrant policies. Ultimately, this may hinder the right of the child to access human milk and safe nutrition, and lead to long-term inequitable health outcomes. In order to provide competent service provision to Black children, social work service providers need to ask themselves when designing programs- can normalized violence against birthing Black women be intensified and structural violations of women's rights be more entrenched during an emergency? If so, and how does that hinder a child's access to safe and optimal nutrition?

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