Anti-Black Racism and Maternal Health in the Greater Toronto Area

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Abstract

In June 2020, the Toronto Board of Public Health declared anti-Black racism a public health crisis. Yet, race-based data with respect to the maternal healthcare experiences of Black women in Canada is limited (Turner et al., 2020). Recognizing perinatal care as a site of racialization (Bridges, 2011), this study uses Critical Race Theory (Crenshaw, 2011) and Reproductive Justice Framework (Ross & Solinger, 2017) to investigate the relationship between race and perinatal experiences of Black women. This research conducted a document analysis of postpartum material (Weber & Hilfinger Messias, 2012) and collected semi-structured interview data from 7 Black women (Hayes & Casstevens, 2017) who delivered a child in January 2020 to May 2023 and sought care in a hospital in the Greater Toronto Area. It is evident that approaches for person-centred care are needed in the Canadian health care system, as it is critical in providing Black women with dignified care.

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Black Mommas **by Tanya Barnett**

I lie awake at night.

Slowly dying on the inside.

I am a Black momma.

I am supposed to be strong.

I am afraid.

I am weak.

I cannot breathe.

I feel the world's hate.

I cannot protect my kids.

I call on the ancestors for protection.

Nothing new under the sun.

Black mommas did this centuries before.

Black mommas

kidnapped

trafficked

laid in filth on ships

worked plantations

raped

birthed Black babies in fields

suckled white babies

cried at the foot of trees.

Black mommas

supposed to be strong

afraid

weak

cannot breathe.

Called on the ancestors for protection.

They survived.

I will survive.

Table of Contents

1. Introduction

The Toronto Board of Public Health unanimously voted to recognize anti-Black racism as a public health crisis since June of 2020. Despite this recognition, Toronto does not collect race-based, equity-informed, and sociodemographic data that may be used to sufficiently address the health disparities in Canada, and Toronto, specifically (Dayo et al., 2023; Nnorom, et al., 2019; Siddiqi, 2015). However, amidst the COVID-19 pandemic in July 2020, the first analyses of socio-demographic disaggregated data by Toronto Public Health were introduced (McKenzie, 2021). It was found that, "[r]acialized groups were overrepresented in covid-19 cases and hospitalizations; and Black populations, and Latino populations had covid-19 case rates 6-11 times that of the White population" (McKenzie, 2021, p. 100812). There is still little data to evaluate anti-Black racism and its specific intersections with maternal health care in Canada.

Within the United States, racism and maternal health care is more extensively studied. Studies have determined that Black women are three times more likely to die from pregnancy-related causes than white women (CDC, 2022). Studies also suggest that Black women are more likely to receive a lower quality of obstetric care than their white counterparts (Petersen et al., 2019), including issues such as dismissal of pain (Badreldin et al., 2019) and higher rates of neglect and maltreatment from care providers (Vedam et al., 2019). Such discrepancies in pregnancy-related mortality and morbidity demand vigorous and comprehensive data and analysis. With improved data collection, we will be able to better understand realities of Black women in Canada, as well as better inform strategies (Howell, 2018) that allow for safe, equitable care for all.[1]

[1] Recognizing that people of all gender identities, expressions, etc. can birth children and thereby need access to perinatal care, in this study all participants identified as women. As such, the term "Black women" is used

This research investigates the relationship between race and the reproductive realities faced by Black women in perinatal care in Toronto, Canada. This research is theoretically informed by Critical Race Theory (CRT) (Crenshaw, 2011) which emphasizes the diverse manner in which race and racial (white) supremacy are socially constructed and represented, without biological basis, and used to create racial hierarchies. A key concept of CRT is intersectionality, an analytical framework, which is attentive to interconnected social categories (race, gender, class, etc.) that create a complex convergence of oppression (Crenshaw, 1994). Intersectionality is a tool to better understand and analyze oppression; specifically, the way it is produced and shaped by interlocking disadvantage or discrimination (racism, sexism, classism, etc.) (Collins, 2019; Collins & Bilge, 2016). CRT is thus notionally relevant in recognizing the unique identities and experiences of Black women in a Canadian context. This research is also theoretically informed by Black feminist scholarship on reproductive science and technology—namely the work of Khiara Bridges, Dorothy Roberts, and Loretta Ross—and thereby reliant upon the intersectional and critical feminist approaches that are best encapsulated by the Reproductive Justice Framework (Ross & Solinger, 2017). Reproductive Justice was predicated on the intersectional analysis of the right to privacy framework established by Roe v. Wade and used intersectionality to reinforce the notion of choice: i.e., the right to have a child, the right to not have a child, and the right to parent a child or children. Combined, Critical Race Theory and the Reproductive Justice Framework inform data collection and analysis for this research.

I have conducted this research from my positionality as a person of colour, specifically of Indo-Caribbean descent and first generation Canadian. I am also a cisgender, heterosexual woman that is hopeful to be a mother in the future. As an undergraduate student in the School of

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throughout. It is important to note that little is known about the experiences of Black women in perinatal care in Canada, but even less research is available with regards to the experiences of gender-diverse people.

Kinesiology and Health Science at York University, I learned various Western approaches to movement and medicine which mostly emphasized biological determinism with respect to health—but thrived in coursework which emphasized sociocultural theories and approaches. I also volunteer in the Neonatal Intensive Care Unit (NICU) at a hospital in York Region. This sparked initial interest in the reproduction of race in health care, specifically for Black pregnant women, and reaffirmed stories previously understood as maybe unique or incidental personal histories. I continue to volunteer as a graduate student and appreciate the ongoing insight into a medical hospital and stresses endured in routine perinatal care and a more intensive unit. As an MA student, and hopeful PhD student, I am increasingly more interested in the social construction of race and racism, particularly as a determinant of health, and the specific intersection between health and anti-Black racism.

To conduct this research, I have leveraged my volunteer position to conduct a document analysis of relevant material disseminated to women in postpartum care (Weber & Hilfinger Messias, 2012). I also used this experience and emergent expertise to inform the careful collection of qualitative data, which focuses on the birth stories and perinatal realities of Black women (Lucyk, 2018) in order to address the following research questions: i) How is race, commonly approached as biological in the medical world, socially constructed in the Canadian health care system?; ii) What are the reproductive realities of Black women during perinatal care?; and iii) What would a patient-centred approach to maternal health entail for Black women? All qualitative data (relevant documents/material and interview data) have been managed via NVivo 14 qualitative software, as this program allowed for the analysis of data, as well as the careful and systematized creation of each theme. I am hopeful that the qualitative data collected in this study can be used to better recognize the experiences and perspectives of Black

women seeking maternal health care. Specifically, this research will add to Canadian studies on perinatal health care (Dayo et al., 2023; Niles et al., 2021; Ray et al., 2018; McKinnon et al., 2016). Studies focused on the United States, recognize perinatal care as a key site of racialization (see especially, Bridges, 2011). The careful documentation of these realities is needed to improve (gendered and racial) inequities in Canadian health systems and services (Dryden & Nnorom, 2021; Pederson et al., 2010). All people deserve equitable, safe, and effective reproductive care, and this research is a glimpse into the perinatal realities of Black Canadian women in the Greater Toronto Area (GTA).

In the second chapter of this thesis, I offer a review of the relevant North American literature (focused specifically on the United States and Canada) related to anti-Black racism and maternal health. Through the review of this literature, I primarily intend to demonstrate that little scholarship has been conducted in Canada with respect to maternal health and anti-racism. I also intend to illustrate that this absence is significant because of the historic approaches to Black female bodies in medicine and labour. To make this argument, I interrogate the biological construction of race and lived consequence of ideologies such as biodeterminism (Roberts, 1999), bio-logic (Oyěwùmí, 1997) and naturalization (Hammonds, 2006) that reinforce racial difference and hierarchies in benefit of whiteness. Histories of gendered-racial violence as manifested through chattel slavery, Jim Crow, the Civil Rights era, informed and were directly informed by dominant Western (white supremacist) approaches to the body, (re)produced through dominant medical approaches to care. This too inspired and instructed the perpetual and persistent fight for bodily autonomy and reproductive justice (Prather et al., 2018). Anti-Black racism is thus better understood as a social determinant of health, as Black women, and gender-diverse people are afforded unjust and cruel treatment, lack of care and premature death as a

result. I end this literature review with the scholarly work of Black women and gender-diverse people who have dedicated their research and activism to challenging anti-Black racism in health care and make known, with the purpose to change, the inequities endured by Black women and gender-diverse people in maternal care.

In the third chapter, I begin with an overview of the diverse populations within the regions which comprise the Greater Toronto Area. This will offer a look into the Black and minority populations which occupy and therefore utilise available regional hospitals. I then offer a more thorough explanation of the theories employed in this research project: i.e., Critical Race Theory (CRT) and Reproductive Justice Framework. Combined, these inform the proposed methodology of Critical Ethnography through their shared commitment to challenge power inequities (Allen, 2017), which is evidently an objective of this research. I explain the process in collecting semi-structured interview data, which has granted each participant the opportunity to share their own personal experience with maternal health care and therefore formulate, or attempt to formulate, a shared perception of their reality that privileges their needs in a care system. The remainder of the chapter discusses the inclusion criteria and means of participant recruitment, completion of data analysis, and maintaining researcher reflexivity.

The fourth and fifth chapters present the findings of this study, including an outline of the themes that emerged from the semi-structured interviews and the analysis of hospital postpartum documents. These themes are discussed in relation to the three research questions which I aimed to examine (mentioned above, also listed in Table 1). Specifically, the fourth chapter discusses themes surrounding the participants' perspectives of the social constructions of race in the health care system and specifies the ways in which race is reproduced whilst seeking reproductive care, specifically through racial contempt, viewing Black bodies as robust, and depictions of the Black

mother as the ‘bad mother’. The fifth chapter assesses themes in relation to Black women’s reproductive realities while seeking care, specifically, the need for a midwife as the primary care provider, improved communication management, and looking for trust and representation in health care. Finally, respectful maternity care as well as the midwifery care model are offered as key avenues to address more person-centred approaches to prioritize the dignity of patients, as well as foster communication and trust. To conclude, the findings of this study demonstrate realities of some of the most vulnerable people in Canadian society with respect to health care at the critical moment of reproduction and motherhood, and stresses the importance of future conversations and contributions in this respect.

2. Literature Review

2.1. The Black Female Body in Medicine

2.1.1 – Biological Construction of Race

Since African people were first forced into slavery in the Americas, advocates of anti-Black racism and white supremacy have weaponized science to justify racial inequality (Smedley, 2007). Race can be understood as arrangements of classifications—such as morphological traits, phenotypic markers, geographies, heredity, and genetic variations—used to describe bodily difference, function and preassign associated identities. Graves (2010) analyzes the deployment of biological race as linked to the fifteenth century and the formulation of biological difference to rationalize colonial conquest and domination. From this historical perspective, Graves (2010) discusses race as a tool to control and bolster white supremacist ideologies that privilege morphological variation as biological evidence of racial and economic domination. Oyěwùmí (1997) examines how "body-reasoning and the bio-logic that derives from the biological determinism inherent in Western thought have been imposed on African societies" (p. x). In her analysis of African women in the Western context, she articulates biological difference as a tool for colonial occupation and heteropatarchial dispossession. Oyěwùmí (1997) writes:

> … It is misleading to postulate two forms of colonization because both manifestations of oppression are rooted in the hierarchical race/gender relations of the colonial situation. African females were colonized by Europeans as Africans and as African women. They were dominated, exploited, and inferiorized as Africans together with African men and then separately inferiorized and marginalized as African women. It is important to

> emphasize the combination of race and gender factors because European women did not occupy the same position in the colonial order as African women (p. 122).

The concepts of body-reasoning and bio-logic are derived from biological determinism and used to continually affect Black women in the postcolonial world. For instance, in Olympic competition, Black women are often subjected to the absurdity of biological rationalization. For example, Caster Semenya, Aminatou Seyni, Margaret Wambui and Francine Niyonsaba were all scrutinized for their physical appearance and forced to verify their sex through still debated diagnostic technologies (López, 2021). Black women are repeatedly made the target of Western science and biological inquiries to the extent that the specific experience of Black women in sport is not exceptional but rather can perfectly "illustrate the white fascination with and disregard for black bodies" (Pieper, 2014, p. 1569).

The notion of racial difference littered throughout colonial histories are unsurprisingly epitomised in scientific racism and medical science. Bourke (2014) observes the historical use of scientific knowledge related to human anatomy to perpetuate biases related to pain perception of enslaved African people with "Slaves, 'savages,' and dark-skinned people generally depicted as possessing a limited capacity to truly feel, a biological 'fact' that conveniently diminished any culpability amongst their so-called superiors for any acts of abuse inflicted on them" (p. 302). The use of biological difference as rationale for domination afforded relentless experimentation upon bodies of Black people—that such rationalities were predominately produced from within health science, it should be little shock that their impact remain evident within contemporary medical practice. Medical racism is the result of the continuation of colonial processes—wherein Black bodies were continuously dehumanised, ill-treated and neglected in the service of colonial-capitalist advancement—through the pretext of science.

Through their investigation of people in medical school, Hoffman et al. (2016) demonstrate that those trained in the medical professional tend to perceive the Black body as biologically different; particularly, as related to the tolerance of pain, Black people are perceived to be "stronger" (p. 4296). Cerdeña et al. (2020) demonstrate that, despite the evidence and research conducted to support the notion that race is an incidental biological feature, it is still persistently used as biological basis for distinction in clinical medicine. People that practice medicine are often represented as altruistic, however, the histories of scientific investigation which inform contemporary practice reveal medicine to be not an impartial institution, exempt from racial inequities, but an organization established through systemic and structural racism. A prominent example of this structural racism is the persistence of race-based medicine; a system by which research characterizes race as a fundamental, biological factor, frequently used in medical practice and ultimately resulting in inequitable care (Cerdeña et al., 2020). In relation to pain perception and treatment, Black people, particularly women, receive limited medication for pain and less likely to receive an opioid—the appropriate treatment—for severe pain (Nelson, 2002). The standpoint of race as a biological variable is one that proves invalid yet continues to have strong grounds in the medical world.

Similar to the manner in which Oyěwùmí (1997) argues that body-reasoning and bio-logic derive from biological determinism, and medical racism arguably does too. Byrd & Hughey (2015) define the relation between medical racism and biological determinism as "the belief that race is anchored in a person's genes and, thus, racial inequality is largely the result of biological predispositions that condemn the average member of certain racial groups toward a life of mediocrity and servitude, while members of other races are genetically propelled toward lives of success and dominance" (p. 10). In their article, Hammonds (2006) agrees that biology

as a "naturalizing discourse" is one that must be contested because race represents more than just biology, but also the line between nature and society. Race is structured difference, and in the context of medicine, it is used to reduce people to categories based on their physical appearance, without adequate recognition of the socio-cultural and environmental influence on physiological variation (Hall, 2017). As Hammonds (2006) extends: "If we want to avoid this naturalization of the inequities of our current health care system… we must abandon any use of race that fails to capture the true complexity of human genetic variation… [and] confront the problem of race and racism in America and understand that they are not the same thing". If race is used as a biological marker to structure power and difference historically and within contemporary societies, it is ill-advised to view the medical profession as immune from racism.[2]

Biodeterminism is a term used by Roberts (1999) to further contest the belief racial (white) supremacy is transmitted through the human genome. She argues that Black biological inferiority is especially harmful to Black women who are alleged to inflict damage onto their unborn children who are destined to lives of irrevocable inferiority (1999). This belief is poisonous to Black women and children as there are social and psychological consequence to a belief in ideologies of biodeterminism. Jarry (2019) emphasizes the scientific fact that human beings are 99.9% identical based on their genetic makeup. While that 0.1% does exist, he highlights that this difference does not represent any distinctions between race, but instead, the dissimilarities that exist within the same races (2019). Race is not a biological construct, but a social construction that is repeatedly redefined and repurposed to benefit white supremacist social, political, and economic itineraries (see also, Rollock & Gillborn, 2011; Ferber, 1999).

[2] The use of 'health care system' to insinuate the system/institution by which people receive the care they need (a common noun); the use of 'health care' refers to the verb/action similar to medical care, patient care, etc. in which patients receive specific care from their provider.

2.1.2 – The Black Female Body

To fully grasp the reality of medical racism, it is imperative to understand the intersection between race and gender or the manner in which the Black female body is continually oppressed and positioned within society. Sitting at the base of the social hierarchy, Black women are challenged with many inequities, both as women, and individuals of colour. Renowned scholar, Collins (2006), argues that Black women exist at a distinct point where two dominant systems of oppression intersect: race and gender. This position is also understood as 'intersectionality', a term coined by Collins (2006) to further illustrate the many spaces in which inequalities overlap. The experiences of Black women in the health care system are therefore a direct result of these oppressions in action. Oyěwùmí (1997) argues this very idea, as "[t]he racial and gender oppressions experienced by African women should not be seen in terms of addition, as if they were piled one on top of the other… [As Elizabeth Spelman] writes: 'How one form of oppression is experienced is influenced by and influences how another form is experienced'" (p. 123). The diverse and unique realities of Black women are distinctly interconnected to their individual political and economic positions—thus, it is important to understand specific commonalities despite obvious variation.

Black women have an unfortunate and long history of oppression in the Americas. Prather et al. (2018) argue that periods in American history which are unique to Black women's health disparities include slavery, Jim Crow laws, the Civil Rights era, and post-Civil Rights. In their analysis it is evident that the race-based and gender-based experiences of Black women have caused, and still give rise to, numerous sexual and reproductive health conditions (2018). The compounded nature of these oppressions has led to the bodies of Black women to become subjugated to this very day.

From times of slavery, Black women have been degraded and dehumanised as trial subjects in the medical sciences (Prather et al., 2018; Cronin, 2020). Cronin (2020) examines the legacy of Doctor James Marion Sims, also regarded as the 'father of modern gynaecology' in the 1840s and 1850s. Using Sims' memoir as narrative, Cronin (2020) argues that Sims' medical experimentations on enslaved women in the United States demonstrate issues of ethics, consent, and agency. While Sims was praised for his perseverance and diligent work finding a surgical cure for the condition known as obstetric fistula, enslaved women Betsey, Lucy and Anarcha were few of the many subjected to Sims' repetitive surgical experimentations. Cronin (2020) defines obstetric fistula as, "a debilitating condition most frequently caused by prolonged, obstructed labour, which results in permanent bladder leakage, sometimes bowel leakage, and sometimes both. If the fetus cannot fit through the birth canal… and the blood supply to entrapped tissues is shut off" (p. 7). Enslaved women who so frequently experienced this condition many times had a malformed pelvis, caused by nutritional deficiencies. In the specific cases of Anarcha, Betsey and Lucy, their abnormal pelvises led to obstetric fistula forming during childbirth, which directly impacted their value as slaves. A Black female slaves' primary asset to her slaveholders had been her capacity to reproduce, however, due to their conditions, Sims had requested Anarcha and Betsey's slaveholders to keep the pair for medical experimentation with the promise of keeping them alive (Cronin, 2020).

In the end, Anarcha had 29 vaginal surgeries done on her without anaesthetic drugs before Sims was 'successful' in his experimentation (Cronin, 2020). Cronin (2020) concludes that, "Sims' story retains its relevance because it represents a clear point at which race, gender and class intersect with medicine" (p. 6). Black enslaved women were not regarded as people, but rather bodies with reproductive abilities which would further the economic capital of white

slaveowners. Cronin (2020) further elaborates on Sims' belief that non-Black people were invulnerable to the pain caused from surgical procedures, such as those endured by Anarcha. Such that, despite anaesthetic drugs later becoming available during the time of Black female slaves' vaginal surgeries, Sims did not believe it was required for those who were "not quite white" (2020, p. 11).

James Marion Sims is just one of the health professionals who contributed to racial discrimination in the health care system. Young French surgeon, François Marie Prevost, was regarded as the 'Father of Caesarean Section' in the late eighteenth and early nineteenth century (Owens, 2017; Prasad, 2022). Prasad (2022) consults historian Cooper Owens, who explains that in the 1790s, Prevost began his surgical endeavours after the completion of his medical training in Haiti, being France's most economically valuable colony. There he began to practice caesarean sections on enslaved Black women in attempts to perfect the procedure. However, as Haiti had been progressing towards abolishing slavery, Prevost ventured to Louisiana where he continued his experimental surgeries on enslaved women. Louisiana is now one of the top three states in the United States with the highest number of caesarean sections performed on Black female patients (Owens, 2017). In a Californian study, it was similarly found that caesarean rates were significantly higher for Black women than women of other races, with an unadjusted rate of 36.8% for both elective and emergency caesareans (Huesch & Doctor, 2015).

Delving into studies of American gynaecology during the nineteenth century, many medical journals emerged from white male doctors who sought to lead and dominate an innovative medical field. Owens (2017) writes, "The blending of science and medicine that occurred during the nineteenth century opened up space for research and even more rigid racial categorization to occur" (p. 19). They continue:

> Racial reification occurred in these journals when questions emerged about whether certain diseases, features, and behaviors were endemic to women of African descent, for example, steatopygia (enlarged buttocks), elongated labia, low-hanging breasts, and lasciviousness. The discourses on bondwomen and other racialized "inferior" bodies gave rise to the "black" female body serving as "a resource for metaphor," … The descriptors in the American grammar book on race range from "Hottentot Venus" and "fancy girl" to "humble negro servitor." And one of the most common descriptive terms for enslaved black women was "breeder" (p. 19).

Scientific investigation labelled the bodies of Black women as "physical specimens" and used their reproductive organs as clinical material to help cure sicknesses and conditions faced by white women. "Although the biomedical research that nineteenth-century doctors conducted sought to locate the alleged biological differences between black and white people, white doctors used black women's bodies in their research because they knew that black women's sexual organs and genitalia were identical to white women's" (Owens, 2021, p. 21). The manipulation of the Black female bodies under the guise of biological and racial difference served to reinforce racial hierarchies and the dominance of whiteness.

Black women were wrongfully labelled as a symbol of service and potential extraction. Wilson (2021) analyzed the treatment of Black women, particularly the use of their bodies, which included public nudity, the violent verification of their reproductive abilities, and rape for (male) sexual pleasure as well as for economic advancement. Much of this influenced the representation of Black women through the stereotypical, Jezebel. Described in the work of Jewell (1993), the image of the "bad-black-girl" or Jezebel was used to legitimate sexual assault of (mostly) white men: "slave owners who privately coerced their female slaves, or

surreptitiously offered them harsh alternatives if they were unwilling to submit to their owner's sexual whims, attributed these liaisons to the hypersexuality of the female slave who was purported to be the aggressor or seducer" (p. 37). The depiction of African American women as eager, available, and willing sexual partner served to rationalize the violence of men with relative power and wealth as it failed to prevent their further reproductive and sexual exploitation (Prather et al., 2018). These histories continue to significantly impact their quality of care in the medical system—particularly in the depiction of unmarried-pregnant Black women.

Enslaved Black women were sexually exploited for the economic advancement of their slave owner. This exploitation was perpetuated in reproductive economies and the use of their bodies after birth. Enslaved Black women were frequently used as wet nurses for white babies, which by default, denied or limited Black women opportunities to nurse their own babies. Allers (2021) elaborates:

> "'…Wet nursing required slave mothers to transfer to white offspring the nurturing and affection they should have been able to allocate to their own children' (140). And since breastfeeding reduced fertility, slave owners often forced Black women to stop breastfeeding early so they could continue breeding, often to the detriment of their own infant's health. The stunted breastfeeding experience created a stunted mothering experience and commodified Black women as breeders and feeders (p. 690).

Black enslaved women were exploited for their breastmilk and reproductive capabilities. In this way, the Black female body was targeted as a site for potential economic extraction (through their labour, breastmilk, reproduction, etc.), as Black women were denied the same opportunities to love and nourish their own children. The deliberate separation of Black women from their biological children, denied their opportunities to mother their own children—and instead to

mother as a form of labour in comparison to the white mother, who is accepted as the ideal, normative mother. This widely accepted notion is still evident in the contemporary Eurocentric formulation of Black motherhood, particularly for an unmarried Black mother, often constructed as a "welfare queen" in neoliberal and conservative discourse (see Cohen, 2020).

Patricia Hill Collins (2021b) describes 'Mammy' as one of the Eurocentric images which represented Black motherhood. Collins explains, "Like one of the family, Mammy conscientiously 'mothers' [the] white children, caring for them and loving them as if they were her own. Mammy is the ideal Black mother for she recognizes her place" (2021b, p. 152). Due to the ongoing role which Black women have played in the lives of white families, the stereotype of 'Mammy' was created to represent the willing, but inferior, Black mother. It is evident that the discursive construction of Black women must be dismantled to adequately address the material disparities that Black women disproportionately face as a result—and this research is an investigation into the contemporary manifestation of oppressive legacies in health care. The exploitation of Black women in slavery—the violent use of their bodies in labour and reproduction—is evidence of the assumed access to their bodies that biological difference/domination has perpetually permitted.

After the abolishment of slavery, the Black Codes and Jim Crow laws were put in place from late nineteenth century and well into the twentieth century (Prather et al., 2018; Guy, 2020) to legalize racial segregation. The Black Codes, also known as the Black Laws, were introduced to constrain the rights and freedoms of free Black individuals. Black Codes and Jim Crow segregationist strategies are most often associated with the United States but were also exercised in Canada. Black people were segregated, denied equal access to, and blatantly excluded from education, employment, housing, transportation, immigration, commercial businesses, and health

care (Henry, 2021). This in turn forced Black people to work for low salaries, denied them the right to vote, attend public schools, and prohibited equal treatment. Guy (2020) notes that the inheritances of these unjust systems persist even to this day, affecting all areas of Black life, especially health. They elaborate on the gendered effects of the Black Codes and Jim Crow laws:

> In some states, laws regarding rape protected only white women although some sources contend that African American women were more often victimized by this crime. In the absence of laws to protect African American women, rape served to control them, which likely affected their self-esteem and self-worth. Lynching was also used to punish both women and men who sought racial equality through civil rights. Many African American women also endured public gang rape and genital mutilation before being lynched (Guy, 2020, p. 252).

Despite the abolition of slavery, racial oppression continued through Black Codes and Jim Crow laws which legalized the marginalization of Black communities within Canada and the United States.

With respect to health care, Prather et al. (2018) highlight that the "inhumane healthcare provided during the Black Codes/Jim Crow era was replaced with limited, poor quality, or no health services for many African Americans, particularly those living in poverty during the Civil Rights era" (p. 252). At the time, the reproductive freedom of Black women was excluded from the broader movement on abortion which lacked a consideration for intersectionality or the diverse manner in which social categories intersect and interlock to create individual and group differentiated oppression (James & Busia, 1993). As cited in James & Busia (1993), Loretta Ross explains, "African-American women were also profoundly committed to the clinics because they knew teen pregnancy and death from septic abortions were the leading causes of death for Black

women. Before the legalization of abortion, 80 per cent of deaths caused by illegal abortions involved Black and Puerto Rican women" (p. 158). Alarmingly, Georgia's Black maternal death rate due to illegal abortion was 14 times the rate of white women between 1965 and 1967 (James & Busia, 1993). With statistics such as these, the disparities are reflective of the long history of inequity faced by Black women and other women of colour.

In 1964, the Civil Rights Act was introduced in the United States (Prather et al., 2018). Despite the focus of the Act on the equal treatment of all people, irrespective of race and ethnicity, the unjust treatment of Black women in health care persisted. In 1972, approximately 20 young, poor, African American women underwent unintended abortions. According to Prather et al. (2018) this resulted from the inhumane use of a "super coil" which caused "uncontrollable bleeding and, in some cases, led to hysterectomies, abdominal pain, and anemia" (p. 252). Roberts (1999) added to this work on the super coil through the interrogation of forced sterilization as a method of birth control. As Roberts writes, "[i]t was a common belief among Blacks in the South that Black women were routinely sterilized without their informed consent and for no valid medical reason. Teaching hospitals performed unnecessary hysterectomies on poor Black women as practice for their medical residents" (1999, p. 90). Shockingly, the forced sterilization of Black women is still practiced within the prison system, as recently revealed in an investigation by the California Department of Corrections and Rehabilitation, which concluded that nearly 150 incarcerated women were forcibly sterilized and/or sterilized without their prior knowledge or consent from 2006 to 2010 (Johnson, 2013).

Scientific and medical racism is maintained through mandatory sterilization. Eugenic science was used to regulate the Black population and forced Black women to endure forceful and painful sterilization without consent or prior knowledge (Prather et al., 2018). In the United

States, thirty states officially supported eugenic programs in the Black Codes and Civil Rights eras. Loretta Ross expands on the eugenics movement, “Based on pseudoscientific theories of race and heredity, [and] evolved into a movement of biological determinism. To promote the reproduction of self-defined ‘racially superior’ people… It was [then] assumed that Black and immigrant women had a ‘moral obligation to restrict the size of their families’” (Ross, as cited in James & Busia, 1993, p. 150). Sterilization was proposed by eugenicists and primarily based on IQ tests and resulted in the sterilization of approximately 10 million Americans due to their assumed innate mental or physical impairment, criminality or promiscuity, or feeble-mindedness. Stern (2020) recounts a decision made in August 1964 by the North Carolina Eugenics Board in which a 20-year-old Black woman was advised to be sterilized. Stern (2020) uses the pseudonym ‘Bertha’ to explain her story:

> She was a single mother with one child who lived at the segregated O'Berry Center for African American adults with intellectual disabilities in Goldsboro. According to the North Carolina Eugenics Board, Bertha had an IQ of 62 and exhibited ‘aggressive behavior and sexual promiscuity.’ She had been orphaned as a child and had a limited education. Likely because of her ‘low IQ score,’ the board determined she was not capable of rehabilitation. Instead, the board recommended the ‘protection of sterilization’ for Bertha, because she was ‘feebleminded’ and deemed unable to ‘assume responsibility for herself’ or her child. Without her input, Bertha’s guardian signed the sterilization form (para. 2-3).

From 1937 to 1966, Black women were disproportionately and discriminatorily targeted in North Carolina for forced sterilized. This overlapped with the time of desegregation in the USA, more broadly. The practice of sterilization was not unique to the United States; in Canada, a separate

yet connected eugenic program emerged (Stote, 2019). This is often linked to sterilization legislation initiated in Alberta (1928-1972) and British Columbia (1933-1973), which:

> …Attempted to limit the reproduction of 'unfit' persons, and increasingly targeted Indigenous women. Coerced sterilization of Indigenous women took place both within and outside existing legislation, and in federally operated Indian hospitals. The practice has continued into the 21st century. Approximately 100 Indigenous women have alleged that they were pressured to consent to sterilization between the 1970s and 2018, often while in the vulnerable state of pregnancy or childbirth (para. 1).

Despite the attempt to represent Canada as a colour-blind or more benevolent nation, it also actively participated in the eugenic movement, which promoted and maintain racial inferiority (see also, Stephen & Strange, 2010). In Canada, similar to the United States, it is evident that Black women have historically faced difficulties in their access to their own bodies in a manner that is similar to and certainly tied with, although not the same as, the call of Indigenous Peoples for their own bodily sovereignty. For Black women, the fight for reproductive justice is historically predicated on their own survival (Gillespie, 1989). To understand contemporary realities of Black women in childbirth, I continue to maintain the importance of (and therefore sought to illustrate) histories of gendered-racial violence in science and medicine. Next, I delve deeper into the idea of anti-black racism as a determinant of maternal health before I examine the diverse strategies of care and resistance that Black women created (and continually refine and create) in response.

2.2. Anti-Black Racism in Maternal Health Care

2.2.1 – Anti-Black Racism as a Social Determinant of Maternal Health

I want to begin this section with an account of two recent stories. First, is that of Shalon Irving, a Black woman in her mid-thirties that died in the week after the birth of her daughter. Shalon delivered her daughter via Cesarean section. Shortly thereafter, she noticed a lump on her incision, which was examined and drained by her doctor. Shalon remained concerned and unwell, yet her doctor continued to undermine her condition and failed to admit her into the hospital—even as she insisted that she was unwell. Shalon died a day later. An independent autopsy concluded her death was due to complications associated with high blood pressure (Taylor, 2020). The second story is that of Kira Johnson, another Black woman, already a mother to a little boy and elated to give birth to her second son. Kira gave birth at Cedars-Sinai Medical Center in 2016, which is recognized as one of the top medical institutions in the United States. However, Kira died of preventable pregnancy-related complications after the birth of her son. I start with the stories of Shalon and Kira to illustrate commonalities between two highly educated women and otherwise privileged Black women. Both maintained access to decent health care and insurance. Shalom and Kira were able to complete their prenatal care and eat well throughout the course of their respective pregnancies (Taylor, 2020). The only factor that distinguished their outcome—and made their outcome so similar to other Black women—is anti-Black racism. This is manifest through the high morbidity among Black women, and in this section, I will illustrate anti-Black racism as a social determinant of maternal health.

The Government of Ontario (2022) defines anti-Black racism as "prejudice, attitudes, beliefs, stereotyping and discrimination that is directed at people of African descent" and continues that anti-Black racism is "rooted in their unique history and experience of enslavement

and its legacy" (para. 3). Anti-Black racism is so deeply entrenched in social realities (institutions, policies, and practices, etc.) that it is normalized or mostly rendered invisible. Social determinants of health (SDH) are defined by Taylor (2020) as the conditions which impact the health and quality of life of individuals in a specific environment, which includes where a person works, lives, or engages. Mikkonen & Raphael (2010) explain race as a social determinant of health, as racialized individuals experience many hostile living situations which often intersect, and thereby intervene in all aspects of their overall health and wellbeing. Taylor (2020) delves into the specific circumstances of Black women:

> … Regardless of social or economic status, [Black women] are more likely to die of pregnancy-related causes. This is even true when compared with white women who never finished high school. The maternal health crisis cannot adequately be addressed without taking account of how racism and bias manifest in the health care system, and in turn contribute to the high rates of maternal mortality and morbidity among Black women. The ways in which a pregnant and postpartum woman interacts with the health care system has implications for her maternal health outcomes. Access to quality care and supports are part of this, but so is how she is treated by health care providers and other health personnel. When a woman is treated poorly, poor health outcomes may follow, including lasting physical and mental traumas that could extend to her infant and family (p. 511).

Anti-Black racism as a social determinant of health is evidenced by the extreme rates of morbidity and mortality among Black women (Prather et al., 2018; Taylor, 2020). The focus on anti-Black racism as a social determinant of *maternal* health is needed to understand the diverse realities of Black women and their encounter within the medical system as more than a single

incident or accidental event, but as resultant from a structure that is continually detrimental to the very existence of Black women and their children.

It is evident that Black women are victims to structural anti-Black racism, and this specific form of oppression directly impacts the health and wellbeing of Black mothers and their children. Taylor (2020) argues, "Historical foundations rooted in reproductive oppression have implications for how racism has been integrated into the structures of society, including public policies, [and] institutional practices… that reinforce racial inequality in maternal health" (pp. 506-507). With anti-Black racism so deeply rooted in North American institutions, policies, and practices, particularly in Canada and the United States, Black women continue to endure several health repercussions at the hands of the maternal health practitioners and providers—that are rarely made visible and often normalized. Maternal death is an egregious consequence; but so too is the denial of Black women from the right to a safe and blissful journey towards motherhood.

The Centers for Disease Control and Prevention (CDC) defines pregnancy-related death as "the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy" (2022). It is found that approximately 700 women die each year in the United States because of complications during pregnancy. Within these maternal death rates, it is also evident that Black women are three times as likely to die from a pregnancy-related cause than white women (2022). Petersen et al. (2019) contend that considerable racial/ethnic disparities in pregnancy-related mortality exist. From 2014 to 2017, the pregnancy-related mortality rates were 41.7 deaths per 100,000 live births for non-Hispanic Black women (2019). Similarly, a Canadian study by researchers Ray et al. (2018),

examined the maternal deaths which occurred from the time of delivery, and up to 42 days postpartum. In their findings, it was reported that of the 181 maternal deaths observed within the 42-day period among a total of 1,211,396 mothers; those deceased were more likely to live in lower-income neighbourhoods and were of Afro-Caribbean descent (2018).

According to researchers Tucker et al. (2007), in the past 50 years, Black women have steadily experienced a three to four times greater risk of death from pregnancy complications than their white counterparts. They rationalise that the increased risk of pregnancy-related mortality among Black women is unrelated to factors such as age, economic parity, or educational attainment. In Tucker et al., (2007) journal, they also note that, "Black women are also more likely to die from complications of pregnancy, including hemorrhage, hypertensive disorders of pregnancy, and cardiomyopathy" (p. 247). That said, their study sought to determine the factors which contribute to the Black–White discrepancy in pregnancy-related death. Tucker et al. (2007) explains:

> We used large, population-based databases to estimate prevalence and case-fatality rates for 5 pregnancy complications: preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum hemorrhage. The prevalence rates of these conditions among Black women were not significantly greater compared to those among white women. However, for all 5 complications, Black women had case-fatality rates that were 2- to 3-times greater than those of white women. This resulted in Black women having cause-specific PRMRs [pregnancy-related mortality ratios] that were 2.5- to almost 4-times greater than PRMRs for white women (p. 249).

The data collected from Tucker and colleagues attests to a clear distinction between the fatality rates between Black women versus white women. Despite having similar prevalence rates of

pregnancy complications, the rates of mortality do not reflect the same results. The unique experience of Black women pursuing maternal care cannot be overlooked. Instead, policies must be developed in consultation with Black women to counter the impact of anti-Black racism and eliminate the fatality rates which are instigated by skin colour.

There are also many implications for infants born of Black mothers that have been widely researched and acknowledged in the United States. In a study that assessed the psychosocial factors and preterm birth among African American and white women in Central North Carolina, researchers Dole et al. (2004) discovered that African American women, regardless of socioeconomic status, steadily demonstrate the highest rates of preterm birth, and their infants have the lowest birth weights of all groups of American women. NCHS researchers MacDorman & Mathews (2011) discuss similar results in their more recent study, as the proportion of very preterm births (being less than 32 weeks of gestation) in non-Hispanic Black women in the United States is 4.1 percent, which is more than twice the proportion for non-Hispanic white women, at 1.6 percent. Infants who are born very preterm also have the highest infant mortality risk, therefore, very preterm births have an immense impact on overall infant mortality rate (2011). This is also evident in the McGill study by researchers McKinnon et al. (2016) who highlight fetal health in relation to Black pregnancies. They originally hypothesised that the health disparities between non-Hispanic Black women and white women in Canada would be less severe given the varying historical experiences of Black women, as well as Canada's universal health care system. However, the adjusted risk ratios of preterm births in Canada were astonishingly found to be slightly higher than that of the U.S., with the crude risk ratio of 1.57 and 1.49, respectively (2016). This demonstrates the lack of data can therefore lead to

misunderstanding of the realities of maternal health care in Canada, as despite having universal health care, the discrepancies are still evident.

McKinnon and colleagues (2016) also determined that in Canada, 8.9 percent of babies born to Black women were preterm, in comparison to the 5.9 percent of babies born preterm to white women. There is also evidence that associates African and Caribbean-born women with higher rates of preterm birth than their Canadian-born counterparts, however, this was only reported in Quebec and Ontario (2016). What can be deduced from MacDorman and Mathews, as well as McKinnon and colleagues, is that the differences in preterm births in Black versus white women are both known and pronounced, and this has not changed much overtime. It is also evident that despite Canada's health care system being universal and its population of Black people being much less in comparison to the U.S., the rates of preterm births are not very distinguishable. Both Canada and the U.S. substantiate high preterm rates in Black maternal health statistics. This proves the significance of addressing anti-Black racism within maternal health care, as the lives of Black infants are frequently at risk before they even enter the world.

Infant mortality is yet another concern that is discussed by MacDorman & Mathews (2011) which they define as the "death of an infant before his or her[s] first birthday" (p. 6). Diverse racial and ethnic groups have varying infant mortality patterns. In analysing the contribution of preterm births and racial/ethnic infant mortality differences, MacDorman & Mathews (2011) discovered that "for non-Hispanic black women, 78 percent of their elevated infant mortality rate compared with non-Hispanic white women was due to their higher percentage of preterm births…" (p. 6). The lives of Black infants lie in the conditions faced by their mothers during pregnancy. Like a chain reaction, a mother's perinatal experience

determines whether her child will be born prematurely, and consequently, whether her child will be able to live past their first birthday.

Throughout this section, I draw extensively from the available literature in the United States. The collection of race-based data with respect to maternal health care and anti-Black racism is better systematised in the United States; whereas, it is not as commonly, nor universally collected in Canada. As described by Davis (2017), Canada is recognized as a culturally diverse nation that is labelled both benevolent and exceptional. The celebration of diversity or multiculturalism in Canada is described as a distraction from the role of genocide, slavery, and persistent violence against Indigenous and Black populations. Boon & Connolly (2022) contend that multiculturalism in Canada is used as a guise to shield the operations of power which produce and maintain structural inequalities. As such, race, ethnicity, and Indigenous identity are not reflected in or accounted for in health data, and thereby maintain a certain level of colorblindness or disregard for racial and biased inequalities in health care services or the broader system. Dayo et al. (2023) argue that the absence of race-based data in health care is able to maintain and promote whiteness as the implicit and continuous norm:

> Canada's lack of race-based data perpetuates systemic racism by evading any responsibility to rectify contemporary health inequities … As such, the real extent of racial disparities in maternal outcomes in Canada are not yet known. Acknowledging the impact of 'Blackness' on health outcomes, healthcare access and delivery, is a needed critical step to improving the quality of healthcare (p. 2).

The lack of race-based data denies possible disparities in health care and fails to inform models, systems, and services that better address unique care needs. To this, James (2020) adds that the collection of race-based data—while beneficial if anti-Black racism is *prioritised*—can also be

severely harmful to Black communities, routinely and frequently subjected and demoralized through surveillance and targeted violence.

That said, there is recent interest from the Canadian Institute for Health Information (CIHI), particularly with the COVID-19 pandemic to understand the disproportionate impact of the virus on racialized communities, as well as contemporary debate about the possibilities for a standardized and consistent approach to race-based data collection in Canada. According to the CIHI (2022):

> To harmonize collection and ensure high-quality data that is comparable across jurisdictions, CIHI is releasing pan-Canadian minimum standards for collecting race-based and Indigenous identity data in health systems, along with guidance on their use. These standards can be voluntarily adopted by health systems that are looking to collect data on inequalities in health care access, quality, experience and outcomes… Canada's health systems need to be able to identify inequities experienced by racialized and Indigenous groups, and to design and implement systemic changes to advance equity in health care. CIHI is on a learning journey, guided by what we have learned, and continue to learn, from racialized groups and Indigenous Peoples, communities, governments and organizations (para. 2-4).

CIHI is focused on the ownership and appropriate implementation of race-based data, as well as appropriate data collection and use.[3] Given the well-documented histories of (anti-Black) racism in medical research and health care, future collection of race-based data in Canada should focus

[3] The collection of race-based data must be collected and protected through law, regulations, and policies (James, 2020) as not to promote the surveillance and proliferation of stereotyping of racialized populations (i.e., Black women), but rather to critique and better inform systems meant to care for their wellbeing.

on ownership and application of this data with the purpose of improving the disparities that exist within the health care gap.

2.2.2 – Black Women Seeking Reproductive Justice

Despite histories of oppression, Black women continue to resist against anti-Black racism in medicine. The African American Women for Reproductive Freedom released a statement, called "We Remember" in 1989 which articulated the persistence of unfreedom after the abolition of slavery and segregationist legislation in the United States. The statement read:

> Those of us who remember the bad old days when Jim Crow ruled and segregation was the way of things, know the hardships and indignities we faced. We were free, but few or none were our choices. Somebody said where we could live and couldn't, where we could work, what schools we could go to, where we could eat, how we could travel. Somebody prevented us from voting. Somebody said we could be paid less than other workers. Somebody burned crosses, harassed and terrorized us in order to keep us down. Now once again somebody is trying to say that we can't handle the freedom of choice. Only this time they're saying African-American women can't think for themselves, and therefore, can't be allowed to make serious decisions. Somebody's saying that we should not have the freedom to take charge of our personal lives and protect our health, that we only have limited rights over our bodies. Somebody's saying that if women have unintended pregnancies, it's too bad, but they must pay the price (Gillespie, 1989, p. 2).

Silliman et al. (2016) recall in the late nineteenth century after the abolishment of slavery, the African American women's club movement allowed for Black women to voice their political views and be heard to uplift their race. Birth control had been on their uplifting agenda, with the

belief that a woman would have a higher quality of life if she was granted the power to control how many she wished to birth and rear. Though birth control was illegal at the time, in 1918 Margaret Sanger aided in the Women's Political Association of Harlem to become the first African American women's club to host lectures on birth control. It was insisted that Sanger's American Birth Control League (ABCL) also place birth control clinics in African American communities for the purpose of aiding Black woman to control their fertility and advance their race (2016). Although many had reasonable fear and distrust of the advocates of birth control, Black women visited clinics which were available to them and made the most of its services.

Methods for birth control taught and provided by the clinics "included abstinence, infrequency of coitus, the withdrawal method, spermicidal douching, diaphragms, rhythm, and underground abortions provided by doctors and midwives operating illegally when other methods failed" (Silliman et al., 2016, p. 59). Most Black women had been proponents for birth control; however, they were mindful of the greater efforts to weaponize it to proclaim white supremacy. Emma Goldman and Margaret Sanger were feminist pioneers of the birth control movement. They stressed the importance of reproductive control for women of all races and classes, as it was an essential steppingstone to gaining power over their lives (2016). Therefore, a woman's choice of what to do with her body was something that had to be advocated by women of all races.

In this way, it is emphasized that Black women played critical roles in supporting for rights over their own bodies (Silliman et al., 2016). For instance, Silliman et al. (2016) discuss few of the many noteworthy Black women advocates:

> Dr. Dorothy Brown, a surgeon from Tennessee, was one of the first state legislators to introduce a bill to legalize abortion in 1967, despite the fact that black Nationalist

> radicals and black Muslims had assailed family planning as a plot against black communities. Frances Beal, who headed the Black Women's Liberation Committee of the Student Non-Violent Coordinating Committee (SNCC), articulated the right of individual women in the struggle to decide whether or not to have children in 1970. Her position was echoed by other women leaders in the civil rights movement, even when distrust of white motives to provide birth control to black populations reached a peak in the 1970s and despite the public rhetoric of many black Nationalist male leaders who attempted to close clinics… Black women leaders like Shirley Chisholm and Toni Cade Bambara insisted that black women's liberation from welfare, poverty, and oppression would begin with their 'seizing control of their bodies though contraception and legalized abortion.'" (p. 61).

Millions of Black women had been organized in socio-political clubs in the twentieth century, many of whom advocated for reproductive rights such as birth control and abortion (2016). Other organizations discussed by Silliman et al. (2016) include *The Sisterhood of Black Single Mothers* was founded in 1972, New York, by Safiya Bandele meant to support the subsistence of teenage mothers, developed with the philosophies of both feminist and civil rights movements. Three Black women, Faye Williams, Linda Leaks, and Mary Lisbon also formed the Black Women's Self-Help Collective of Washington, DC in 1981, and were the first Black women to promote the cervical self-exam in the African American community. Silliman et al. (2016) contend:

> Black feminist thinking and organizing were crucial for reframing the issue of birth control and abortion in the black community. A variety of black feminist grassroots organizations sprang up in cities across the country in the early 1970s. Though many of these groups only lasted for a few years, their critique of the limitations and scope of both

> the black liberation and women's liberation movements laid the foundation upon which contemporary black women's reproductive rights activism is based (p. 62).

The role which Black women play in the advocacy and empowerment of their own bodies and choices is fundamental. Collective feminist action and activism is crucial to their reproductive and rights, as well as disrupting these unjust systems and addressing the disparities within them.

Black women and women of colour have always been innovative in finding ways to manage their fertility outside of the law. Ross & Solinger (2017) discuss a time before *Roe vs. Wade*, when having and performing abortions was criminalized and the death rates were unimaginably high. Black women and women of colour had close relations to community experts, granny midwives, and those with longstanding practices who were able to provide abortions. Ross & Solinger (2017) elaborate:

> These abortionists would have been protected by their own longstanding knowledge about the procedure and also by the fact police did not generally pay attention to their work. These factors may have allowed girls and women who turned to practitioners in their own neighborhoods to make decisions about pregnancy under less frightening circumstances than many whites faced (p. 45).

In addition to abortion in the U.S., there is also a vivid history of Black midwives and midwives of colour who were expert practitioners attending births in their communities, where "As a Black midwife and novice healer, our goals have much to do with the promotion of equity" (Wilson-Mitchell & Herbert, 2014, p. 99). This took place well into the twentieth century, until the American Medical Association influenced state legislatures to outlaw traditional childbirth practices entirely (Ross & Solinger, 2017). Ross & Solinger (2017) note that, "In the first decades of the twentieth century, up to 50 percent of births in the United States were supervised

by midwives; today only about 1% of births are" (p. 262), and Black midwives assisting the births of Black women's babies comprise a very small proportion of that one percent (2017). This is demonstrative of the racism that persists beyond the patients, as Black pregnant women are not even granted the help of other trusted Black women in their time of need.

Ross & Solinger contend that this comes as no surprise, as "white midwifery programs and professional organizations have had a history of racial exclusiveness" (pp. 262-263). To overcome these challenges, founder, president and CEO, Shafia Monroe created the International Center for Traditional Childbearing (ICTC). It all began in 1991 in Oregon, Portland, with intent to "increase the number of midwives, doulas, and healers of colour in order to empower families and to reduce infant and maternal mortality" (p. 261). In 2018, ICTC officially changed its name to the National Association to Advance Black Birth (NAABB), which continues to protect its legacy in endorsing midwives, doulas, and educational programs to improve the care of Black women and infants (The National Association to Advance Black Birth, 2018). However, despite the efforts of so many organizations like NAABB, the experiences which Black women face are yet exasperating.

The vivid realities of Black women in childbirth should be more thoroughly acknowledged in North America. One study conducted by Declercq et al. (2020) completed a secondary analysis of data from the population-based research survey, *Listening to Mothers,* where women were asked questions about their maternal care and birthing experiences in various California hospitals. The study included women with differing races/ethnicities to report their experiences of discrimination during childbirth. These women included Asian and Pacific Islander mothers, Latina mothers, Black mothers, and white mothers. According to Taylor (2020) who also completed an analysis of this data, respondents to the survey were asked about their

treatment by birth attendants and staff during their childbirth and their overall hospital stay. They were further questioned about their treatment based on race or ethnicity, the languages they spoke, details of health insurance, or lack thereof. Taylor (2020) highlights:

> The findings showed better treatment among white women, English speakers, and those with private health insurance. About one in ten women reported being spoken to disrespectfully by hospital personnel. The same women also reported 'rough handling' by hospital personnel and being ignored after expressing fears and/or concerns. These women were also more likely to be enrollees of Medi-Cal, California's Medicaid program. Black women were more likely to report unfair treatment and discrimination within the health care system than white women and Latina women (p. 511).

This study is one of the few which demonstrates the tribulations faced by Black mothers seeking maternal care in the United States.

Taylor (2020) also examined differences in treatment practices. It is evident that Black women are most likely to have caesarean sections at an approximate rate of 40 percent, while white mothers are given c-sections at lesser proportion of only 29 percent. What is alarming about this rate is its consistency with the national rates of c-sections for women of colour. Taylor (2020) emphasises:

> The over-use of cesarean sections in the United States has been a cause for concern by the medical and public health communities for decades. The rates for maternal mortality and morbidity are about three times higher for women who had cesarean sections versus vaginal deliveries. Black women in the *Listening to Mothers* survey also reported high rates of depression and lack of practical and emotional support. Underlining the differences in treatment practices and respect for bodily autonomy for white women and

> Black women are institutional practices that perpetuate racial inequity as a form of structural racism (p. 512).

The inability of medical institutions to justly and properly care for Black mothers proves to have detrimental effects on Black women's overall physical, mental, and emotional health.

Bridges' (2011) book titled, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*, offers a perspective aligned with the analysis from Taylor (2020) and the *Listening to Mothers* survey. Bridges (2011) discusses the racist beliefs of physicians at Alpha Hospital in New York City, and how these ideologies from hospital staff can contribute to the health discrepancies prevalent in Black women. Moreover, she discusses the racial oral tradition in medical care that is comprised of beliefs about the obstetric and gynecologic hardiness of Black women, and its effect on the perception of care that Black pregnant women in the United States require. Bridges argues that the racist beliefs of medical practitioners can be used as grounds to justify why Black people in general do not receive the best procedures, testing, treatments, and therapies for their ailments as white people. Bridges (2011) illuminates:

> Perhaps physicians' devaluation of Black bodies—for no reason other than the fact that that they are Black bodies—explains why Black women die from pregnancy-related causes at three to four times the rate of white women. Perhaps the lesser regard with which physicians hold Black lives explains why Black infants die at more than twice the rate of white infants. Indeed, perhaps racism practiced by the persons who are empowered to care for them partially explains Black people's status as the sickest racial group in the United States" (p. 121).

Physicians, hospital staff, other medical practitioners and caregivers are not immune to racist ideologies and beliefs, despite working in a sector that requires impartiality. It is evident that

Black women and mothers seeking maternal care are continually struggling to receive the support they need due to the perpetuation of anti-Black racism and false beliefs about the Black female body.

Reproductive Justice is deeply interconnected to the notion of Black motherwork. Patricia Collins uses the term 'Black motherwork' to embody the intersection between survival, identity, and power as crucial to the histories, lived realities, and systemic vulnerabilities endured by Black women (2021a). The realities of Black women, specifically, the shared struggle for their children to be valued, is an essential feature of Black motherwork. For this reason, the lack of recognition of Black motherwork in maternal theories is integral to Reproductive Justice. O'Reilly (2004) reiterates the ideas of Collins on Black motherhood as community motherhood; therefore "[redefining] motherhood as social activism" (p. 175). The magnitude of Black motherwork within communities, and as a sense of peoplehood, is understood as the power which Black women have worked to cultivate and maintain (2004). This in turn allows Black communities to assert the personal and communal agency needed to resist the structural violence of racism.

The social activism that stems from Black motherwork therefore empowers Black women. As she describes, "motherhood operates… as a symbol of power" (O'Reilly, 2004, p. 177). To challenge the belief that Black women are not the true standard for mothering, Black motherwork is an exceptional form of community-cultivated power, and more specifically, a highly significant form of maternal power. Collins (2021a) identifies the theme of power as something crucial to Black motherwork, as it is evident that power greatly impacts Black mothers' unique experiences and lived realities. Black motherwork deserves more recognition in feminist theorizing, as it allows for a greater understanding of how power and activism operate in

Black motherhood and highlights its importance to mainstream feminist theories (2021a). Collins argues, "…[unlike] where the sons and daughters of white mothers have 'every opportunity and protection', the 'coloured' daughters and sons of racial ethnic mothers 'know not their fate'" (2021a, p. 167). This demonstrates the necessity for feminist theories to consolidate Black motherwork into their framework, as the fight of feminism and movements such as Reproductive Justice cannot be complete without recognition of the central issues of survival faced by Black mothers and their children.

3. Methodology

3.1 Demographics of the Greater Toronto Area

The Greater Toronto Area (GTA) is comprised of five regions, including Durham region (East of the city of Toronto), Peel Region (West of the city of Toronto), Halton Region (West of Peel Region), York Region (North of the city of Toronto), and Toronto Region. The following statistics regarding population demographics in these regions are according to 2021 Census data (Statistics Canada, 2022). To begin, The Regional Municipality of Durham includes the towns of Ajax and Whitby, cities of Pickering and Oshawa, and municipality of Clarington and townships of Uxbridge, Brock, and Scugog, and has four major hospitals. In terms of population, Durham Region consists of 696,992 residents, with over 66 percent comprised of individuals ages 15-64, 18 percent ages 0 (newborn) to 14, and nearly 16 percent of those ages 65 and older. In 2021, it was found that the second largest racialized group in Durham Region is the Black population, comprising 9.6 percent of the total population. Among visible minority groups, the Black population represents 26 percent, being the second highest behind Asian minority groups. The Regional Municipality of Peel encompasses the cities of Mississauga and Brampton, as well as the town of Caledon, with three main hospitals. Peel consists of 1,451,022 residents, with nearly 68 percent represented in the 15 to 64 age group, nearly 17 percent in the 0 to 14 age range, and approximately 14 percent ages 65 and older. Black residents represent the second largest racialized group in Peel Region, comprising roughly 10 percent of the total population, and nearly 14 percent of the visible minority population.

Halton Region includes the city of Burlington, and the towns of Milton, Halton Hills, and Oakville, with three main hospitals. In terms of population, there are 596,637 residents which comprise 58 percent of individuals ages 15 to 64, nearly 19 percent ages 0 to 14, and 16 percent

ages 65 and older. Of this population, Black residents represent the fourth largest racialized group, at almost 10 percent of the visible minority population. The Regional Municipality of York encompasses the towns of Aurora, East Gwillimbury, King, Newmarket, Whitchurch-Stouffville, and the cities of Markham, Richmond Hill, and Vaughan, with 4 four major hospitals. York Region consists of 1,173,334 residents, including 66 percent ages 15 to 64, nearly 17 percent ages 65 and older, and 16 percent ages 0 to 14. The census release report also states that 55 percent of the York Region population is a visible minority. In terms of Black minorities in York Region, they represent approximately 5 percent of the visible minorities, being the fourth largest racialized group.

Lastly, Toronto Region unifies six local boroughs, being Etobicoke, North York, Scarborough, York, East York, and the city of Toronto, and includes more than 10 general hospitals. Toronto encompasses the largest population in all regions—2,794,356 residents. Of this population, 69 percent are ages 15 to 64, followed by 17 percent ages 65 and older, and 13 percent ages 0 to 14. The Black population represents the third largest racialized group behind South Asian and Chinese, comprising nearly 10 percent of the total region's population. And 25 percent of the visible minority population. Considering that these census data are dated anywhere from two to seven years, it is presumed that the population of visible minorities across the GTA has increased. As a major metropolitan centre in Ontario, it is also crucial to note that Black people comprise 4.5 percent of the population in the province and only 2.3 percent of the physician population (Kralj, 2019). In a study of Canadian medical schools, Khan et al. (2020) found only 1.7 percent of students identifying as Black, even though Black Canadians represent 6.4 percent of the Canadian census population. Therefore, the following research prioritizes

critical theories of race and reproduction in the Greater Toronto Area, with a careful consideration of these Canadian demographics and statistics.

3.2. Theory

3.2.1 Critical Race Theory

This research is theoretically informed by Critical Race Theory (CRT). CRT is premised on the assumptions that: i) racism is embedded in the fabric of North America and thus not readily visible to those in the dominant reference group; ii) experiential knowledge of Black, Indigenous, People of Colour (BIPOC) is critical to understand racism; iii) colour blindness and race neutrality perpetuate the self-interest of the dominant group; and iv) interdisciplinary work is needed to challenge, affirm, and further develop the CRT framework (Crenshaw, 2011). Bridges et al. (2017), explains that Critical Race Theory originated in law studies and was further developed in education, however, there is much significance of including CRT in the health sciences. Bridges et al. (2017) explain:

> A critical race framework would posit that racialized power relationships are a constitutive part of the health sciences… CRT [also] emerged as an intervening theoretical model capable of rejecting essentialist understandings of human identity. In so doing, it captured the multi-layered and intersecting forms of discrimination experienced by Black women and other social groups who exist dynamically across multiple axes of identity… CRT allows us to evaluate how these seemingly progressive bio-political interventions promise to bring solutions that either reproduce the belief that race is genetic or downplay the structural racism that produces and exacerbates inequality (pp. 180-181).

Previously, CRT was employed in health care studies to examine how it can be used to dismantle racism in medicine (Zewude & Sharma, 2021), and help to achieve racial equity in childbirth care (Hardeman et al., 2020). In this way, Critical Race Theory can be used to address the many disparities existing in the health care system, as it considers the specific racial identities and experiences of BIPOC individuals.

Within this research, the implementation of CRT is to understand the factors of racial discrimination and racism prevalent in the normalised practices of maternal health care. By using the principles of CRT as guiding lens, multiple themes were uncovered from the analysis of both semi-structured interview data and the document analysis, including the social constructions of race in the health care system (racial contempt, Black bodies deemed resilient bodies, and perpetuation of the 'bad mother') as well as Black women's reproductive realities (needing a midwife, communication management, and seeking trust and representation). Similarly, a study employing CRT in a maternal care perspective by Adebayo et al. (2022) explains, "Employing a critical race theory perspective to the study of African American women's health is valuable in exploring and critiquing hegemonic ideologies and structures that impact the realities and health outcomes of African Americans" (p. 1135). Therefore, these applications of critical race theory demonstrate its use as a multifaceted model which encapsulates the intersecting systems of oppression faced by Black women, and their specific intersectional experiences as Black women. As such, CRT has theoretically informed and guided this project, through the analysis of the unique experiences of Black women, which further demonstrates how understanding and recognizing race is crucial to addressing racial discrimination in maternal health care.

3.2.2 Reproductive Justice Framework

Reproductive Justice (RJ) is a radical analytical and political framework centred upon stories of Black, Indigenous, women of colour made most vulnerable in reproduction (e.g., via forced sterilization, mass incarceration, premature death, state disenfranchisement or disinvestment, environmental justice, etc.) as the foundation for new knowledge (Ross & Solinger, 2017). Reproductive Justice is premised upon the right not to have a child, the right to have a child, and the right to parent children in safe and healthy environment. Tam (2021) contends that Reproductive Justice is "rooted in Black feminist thought, critical race theory, and critical feminist theory, [it] is an interdisciplinary framework that combines reproductive rights and social justice" (p. 2). One of the goals of Reproductive Justice is to confront white supremacist structures and systems which attempt to "control populations through regulation of bodies, sexuality, labour, and reproduction. The movement is concerned with the day-to-day conditions constituting a person's reproductive decisions including access to resources and the dominant health care system, familial elements, cultural values, educational opportunities, and other familial and community needs" (Tam, 2021, p. 2). It is evident that Reproductive Justice Framework is multidimensional in its ability to consider the reproductive rights of all individuals through an intersectional approach.

Therefore, Reproductive Justice theoretically informs this project, as its guiding principles are demonstrated within the research objectives of understanding Black women's perinatal experiences, as well in as the findings, wherein Black women seek equitable and compassionate care that empowers their bodily rights. It is evident that Reproductive Justice Framework promotes several tenets of Critical Race Theory. Consequently, these theoretical approaches complement and enhance one another, and were therefore used in combination to

effectively analyse issues of reproductive rights in relation to anti-Black racism. Reproductive Justice framework proves relevant as it further enlightens the perinatal realities for all Black women and highlights the importance of birthing a child in a secure, wholesome, and protected environment that is considerate of the intersecting social categories of the participants.

3.3 Methods

3.3.1 Critical Ethnography

The method implemented in this research is known as critical ethnography. With a goal of producing research that addresses social power inequities, researchers are required to maintain active reflection on their selected theories and methods, they must be accountable for any potential concerns of their research, as well as be self-reflexive about their positionality (Allen, 2017). Allen (2017) also explains that "the difference between critical ethnography and conventional ethnography is that the researcher maintains commitments to critical reflection and raising awareness throughout the process" (p. 297). For instance, when producing research questions for a critical ethnography, researchers are urged use their own life experiences and understanding to establish the issues which are significant (as demonstrated in the interview guide; see Appendix 4). A final characteristic of critical ethnography is the relationship between the researcher and the participants. Critical ethnographers are encouraged to communicate using conversation or shared dialogue which promotes relationships with the participants. The criteria for participants included in a critical ethnography is not specific, however, it is concerned with interacting with participants in a meaningful manner and works to inform tangible action within the communities of focus, as well as seeking to change the conditions which lead to these inequities.

Similarly, a study completed by Vaught & Castagno (2008) uses critical ethnography as the methodology in their study which examines teachers' attitudes regarding race, racism, and white privilege following anti-bias in-service training in two well-known urban school districts in the United States. Critical Race Theory was also used to examine teacher attitudes and discover the structural dimensions of racial inequity in schooling and achievement. CRT addresses racism and the structural components of race through its critique of Whiteness and how it is reproduced. In combining the methodology of critical ethnography and CRT, the researchers ultimately examine a series of participant narratives which allow them to relate these narratives to the structural dimension of racial awareness and understanding (Vaught & Castagno 2008). Although not originating from the health sciences, this study demonstrates the compatibility and coherency of critical ethnography as a methodology and CRT as a theoretical framework.

In keeping with the methods of critical ethnography outlined by Allen (2017), I have been selective in using theoretical frameworks such as CRT and Reproductive Justice which both apply to and represent the demographic of interest, and sought to uphold their dignity and respect, foremost. Reflexivity was routinely practiced during my primary investigator position, specifically in a prospective approach during the interviews. During this process of speaking with participants, I maintained the principles of critical ethnography by critically reflecting on the information that was shared with me, thoughtfully crafting, and selecting interview questions, and frequently analyzing my role as both a researcher, as well as an activist. This allowed for a transient relationship to form between myself and participants, as most of them expressed their gratitude for my ability to listen, guide the interview much like a conversation, and make them feel heard. As described by Vaught & Castagno (2008), critical ethnography has also enhanced

the guiding theory of CRT within this research study by simultaneously informing the social inequities of race and racism and its reproduction within health care settings, in relation to the experiences of Black women.

Table 1: Outline of research objectives, questions, and methods

Research Objective	**Research Question**	**Method(s)**
Evaluate processes of racialization within health care—from the perspectives and experiences of Black women seeking care—and how it directly effects Black women and their relationship with the Canadian health care system	How is race, commonly approached as biological in the medical world, socially constructed in the Canadian health care system?	Collection of semi-structured interview data with 7 Black women who recently delivered at a hospital in the GTA
Examine the realities of Black women, the postpartum material distributed, and the quality of care they received which impacted their perinatal experience	What are the reproductive realities of Black women during perinatal care?	Document analysis of written material (i.e., postpartum and discharge material disseminated within the hospital, and intended to support people in motherhood) Collection of semi-structured interview data with 7 Black women recently delivered at a hospital in the GTA
Determine how maternal care could be positively improved for Black mothers' health, including their prenatal, birthing, and postpartum experiences	What would a patient-centred approach to maternal health entail for Black women?	Compare and contrast semi-structured interview data as well as data collected and analyzed in document analysis

3.3.2 Document Analysis

Morgan (2022) defines a document analysis as "…a valuable research method that has been used for many years. This method consists of analyzing various types of documents including books, newspaper articles, academic journal articles, and institutional reports. Any document containing text is a potential source for qualitative analysis" (p. 64). Document analysis is regarded as a form of data selection rather than collection (Bowen, 2009). A document analysis is also frequently used for triangulation, or the combination of approaches, in the study of the phenomenon of interest (Denzin, 1970, as cited in Bowen, 2009). In this way, the qualitative researcher anticipates using multiple sources of evidence to pursue convergence and corroboration of the data collected (Bowen, 2009; Morgan, 2022). For this research project, a document analysis was conducted to supplement the qualitative data collected from semi-structured interviews, as well as allow for the convergence and corroboration of all data.

The document analysis was conducted on material disseminated in a postpartum unit, from a hospital located in York Region. The documents examined included pamphlets, government resources, and brochures about infant and mother health, infant milestones, and safety practices. As shown in Table 1, this has allowed me to address RQ2: What are the reproductive realities of Black women during perinatal care? As such, the document analysis has allowed for the evaluation of the lack of cultural and racial representation within maternal health informational material. The preliminary document analysis data was also used to inform the creation of the semi-structured interview guide (see Appendix 4). As shown in Table 1, the semi-structured interview findings have been examined to address both RQ1: How is race, commonly approached as biological in the medical world, socially constructed in the Canadian health care system? and RQ2: What are the reproductive realities of Black women during perinatal care?

3.3.3 Semi-Structured Interviews

The purpose of this research is to investigate the relationship between race and reproductive justice from the perspective of Black women in prenatal care and childbirth. Therefore, the collection of semi-structured interview data has been analyzed to better attend to the reproductive realities of Black women in prenatal care and childbirth (see Appendix 4). Dejonckheere & Vaughn (2019) describe the semi-structured interview process as a qualitative method often used in health services research that "allows the researcher to collect open-ended data, to explore participant thoughts, feelings and beliefs about a particular topic and to delve deeply into personal and sometimes sensitive issues" (p. 1). Rather than follow a rigid structure of a questionnaire, a semi-structured interview guide will afford opportunities for the interviewer and interviewee to dovetail and elaborate as desired yet also maintain consistency throughout the research. DeVault & Gross (2012) explain the semi-structured interview process as a form of conversation, but also the chance to collect stories, different perspectives, and ultimately amplify the voice of the participant and co-production of knowledge in both academic and public discourse.

I have used semi-structured interviews to collect prenatal, birthing, and postpartum stories from participants to emphasize the expertise of women, particularly as experts of their own bodies as well as the primary voices of their narratives. This method has been used to address both RQ1 and RQ2 (as illustrated in the Table 1), by allowing participants to delve into their unique perinatal experiences, through a conversational style of interviewing. Gluck & Patai (1991) expand this perspective to offer that an interview can be viewed as a chance add to the articulation of Black life. In this way, the interviewees were able to elaborate and offer more nuanced and intersectional stories of everyday life that are not as easily described in more

quantitative and survey method approaches. Given the nature of the research study, the collection of semi-structured interview data maintains a commitment to personal stories but, also, compassion, respect, and inclusion—in that has created an avenue for women to author their own stories. Similarly, qualitative interview data informed the work of Apfel (2016) wherein stories of activist birth communities are offered. This project being a massive inspiration, focuses on birth work to recount unique and descriptive stories from perspective of people involved in perinatal support people.

I submitted to REB in January 2023 and following ethical approval, began to collect interview data in March 2023. Each interview was unique in the length of time, ranging anywhere from thirty-five minutes to ninety minutes. All participants opted to complete the interviews online (via Zoom) and through this platform, only audio data was recorded. To conduct the interview, I first prepared my equipment (cellphone and MacBook computer) to keep time and audio record the conversation, as well as ensured that the informed consent form was signed by myself and the participant and received back to me via email. I first began interviews with an overview of consent and requested that the participant let me know if there was any element of the research that was unclear.

I then completed an overview of the general outline of the interview, and reminded the participant that their involvement was completely voluntary; the participant was not obliged to respond to every question and was made aware that they were free to withdraw at any point, without consequence. The participant was then invited at this point to let me know if there is any topic that I should directly avoid or that the participant might be curious to talk specifically about. I first started with basic identification questions before moving in the interview guide (again, available in Appendix 4). I listened intently and allowed for pauses and breaks as needed.

I did also ask participants to clarify particular words or ideas. At the end of the interview, I thanked the participant for their participation and reminded them that they could contact me if they would like to withdraw their participation or any information they might have shared. I then let them choose a vendor for a virtual gift card which included choices such as Amazon, Sephora and Walmart valued at CAD$25, and the gift card was shared via email. At this point, I reminded the participant that there was still no obligation to proceed—the gift card would not be revoked.

In accordance with York University ethics HPRC protocol, it is also imperative to discuss the potential risk associated with the research. There was the potential for psychological and/or emotional risk associated with this study; particularly for those whose health care experiences were not particularly positive. Throughout the course of the interview, a variety of participants may have felt discomfort, embarrassment, distress, etc. For this reason, it was crucial for me as the researcher to be fully aware and informed in the treatment of sensitive information. As such, I provided a list of potential useful opportunities of support a person may be interested to consult (i.e., Adult Outpatient Counseling and The Stepping Stones Mental Health Day Hospital) (see Appendix 3). As the interviewer and researcher, I also recognize that I have been subjected to information that was at times, emotionally distressing. In this case, I have also sought the available support. All interview data has been strictly audio recorded and transcribed. All data collected was anonymized and stored on a password protected computer indefinitely (as each participant has been made aware through informed consent) as I see this research as the basis for doctoral work.

3.3.4 Inclusion Criteria and Participant Recruitment

Participant inclusion criteria included women/birthing people ages 18 and over, identifying as Black, who were currently pregnant or have given birth at a hospital in the GTA during January 2020 to May 2023. In the beginning stages of the study's proposal, I intended to include participants who had only given birth in 2023, specifically. However, upon facing challenges with recruitment, and getting in touch with women who had given birth so recently, I decided to extend the criteria to women who were currently pregnant (to help emphasize the prenatal perspective on maternal care) or had given birth anywhere from January 2020 to May 2023. To promote participant recruitment, I predominantly relied upon a purposive sampling as a NICU volunteer (see Appendix 2) to inform coordinators in the hospital's maternity units about the focus of this research and distributed the recruitment poster (see Appendix 1) to be shared with people that might be (or know someone that is) interested. The recruitment poster includes printed information including an email contact, the purpose of the research, and eligibility information, and information about compensation (CAD$25 gift card). To begin my recruitment and employ purposive sampling, I visited several maternal health care facilities in York Region and disseminated this poster. I also reached out to Facebook Moms Groups in the GTA to share the poster online, as well as communicated with renowned GTA organizations, such as Black Moms Connection, Black Women's Visions, and Black Birth Project who shared my posters via social media platforms (Instagram and Pinterest). In the end, the study recruited 7 Black women for semi-structured interview data collection (see Table 2)—this number was determined by a similar study that achieved theoretical saturation with a similar number of people (Hayes & Casstevens, 2017). Table 2 illustrates general demographical information that was disclosed by

the participants, including information about their birth settings, chosen/assigned care providers, birth modes, as well as their time of birth (month and year).

Table 2: Participant Demographics

Participant	Age	Ethnicity	Marital Status	# of Children	Birth Setting	Care Provider(s)	Birth Mode	Birth Time
Shewit (she/her)	Not disclosed	Eritrean	Married	2	Hospital	General P./OB	C-section	January 2023
Chanel (she/her)	28	Jamaican/ Austrian/ Canadian	Married	3	Hospital	Midwife/ OB	Vaginal	September 2021
Jasmine (she/her)	25	Jamaican	Partner	1	Hospital	OB	Vaginal	July 2022
Simone (she/her)	42	West Indian/ African	Partner	3	Hospital	Midwife/ OB	C-section	April 2021
Sarah (she/her)	41	Jamaican/ Kenyan	Partner	1	Hospital	Midwife/ OB	Vaginal	October 2020
Shauniqwa (she/her)	Not disclosed	Jamaican	Partner	1	Hospital	OB	Vaginal	September 2022
Jayde (she/her)	Not disclosed	Jamaican/ Canadian	Married	3	Hospital	Not disclosed	Not disclosed	May 2023

3.3.5 Data Analysis

All interview and document analysis data has been analyzed and coded using the qualitative data analysis software tool, NVivo 14. In completing qualitative research, a reliable software such as NVivo, "helps analyze, manage, [and] shape qualitative data" (Creswell & Poth, 2018, p. 213). It offers security by compiling the database and other files into one single file, allows for easy manipulation of the data, and searching features. Using NVivo software also provides researchers with an audit trail of the processes used during the data analysis (Bonello & Meehan, 2019). NVivo keeps a visual account of the coding, annotation, and memoing content, while mapping analytic concepts and themes, as well as locating, selecting, assessing, and

integrating data (Bowen, 2009). Both the document analysis and interviews have yielded data, including passages and/or quotations which have been organised into larger themes and categories through thematic analysis (Braun & Clarke, 2006; Bowen, 2009). Thematic analysis within a document analysis is further explained by Bowen (2009,) as the formulation of pattern recognition within the data. This also allowed for the emergence of themes (and subthemes) derived from more general codes and categories, (Fereday & Muir-Cochrane, 2006, as cited in Bowen, 2009), formulated through the guidance of the research questions (see Table 1).

3.3.6 Positionality & Reflexivity

As explained previously, I am aware that while I do not identify as Black, I am a person of colour, and thus, a visible minority. My own experiences are not expected to be in line with those of my participants, however, this does not limit my own reflection of how my race can affect the research at hand. Emirbayer & Desmond (2012) explain, "The more that race scholars uncover the hidden assumptions in their own scientific unconscious, the more they can strive to undo their effects, thereby making it possible to develop ever-deeper insights into the workings of the racial order" (p. 590). It is important to recognize the role which I have undertaken as both the researcher and interviewer, and as a person of colour. Despite falling into the similar category to those I have interviewed, our experiences within the health care system vary, nonetheless. Ultimately, the findings of this research study can be useful for maternal health advocates and hopefully contributes to the ongoing work towards the racial equity in health and care for Black women in Canada.

4. Racial Reproduction in Reproductive Care

This section aims to identify and discuss relevant themes which emerged from the semi-structured interview data in relation to the RQ1: How is race, commonly approached as biological in the medical world, socially constructed in the Canadian health care system? as well as RQ3: What would patient-centred approach to maternal health entail for Black women? Based on interview data, the social constructions of race in the Canadian health care system (as understood by participants) can be organized in three themes. First, as racial contempt amongst care providers, wherein medical professionals exhibit disdain and discrimination towards Black women due to their life choices and personal circumstances. Second, the reiteration that Black bodies are resilient to fundamental experiences such as pain and exhaustion, which in turn impacts the ways in which Black women are medicated and treated. Lastly, this idea of the Black mother as the 'bad mother', who is treated as incompetent and inadequate, as well as felt threatened by care providers about their decisions. The unique experiences of Black women seeking care from the Canadian health care system can be understood as socially constructed ideas of Black women that originate from biological beliefs of the Black female body.

4.1 Racial Contempt Amongst Providers

Majority of participants found specific interactions within the hospital to be racially-charged, often leaving them with the question: *How might this have gone differently if I was not Black?* For Chanel, despite having given birth to her third child in 2021, her experience from ten years ago still bothered her. Being eighteen at the time, Chanel explains how she was frequently neglected throughout her pregnancy. She recalls, "I was like dismissed a lot… I don't think I was treated that well. Like, I was sent home repeatedly, while I was in labor they were like, 'No, it's

not time'. And then, when I didn't show up, they were like, 'Why didn't you come sooner?' And my daughter was born in like, 20 minutes. So, going into the second and the third [pregnancies], there was a lot of like anxiety [around] like, am I gonna be admitted?... Are they gonna send me away, like is it gonna be a similar situation?". Despite being in active labour and seeking care from medical professionals, Chanel was persistently dismissed and then reprimanded for seeking help while on the brink of delivering her daughter. Only being eighteen and a Black woman, Chanel felt rejected and judged by the hospital staff. Haunted by this experience, in any trip to the emergency room she is worried that "They're not going to take [her] needs seriously".

This is similar to the experience of Jasmine, where upon finding out about her pregnancy, she had hoped to receive care from her family physician who has been her primary healthcare provider since she was a baby. However, she found her physician's contempt for her situation to be unacceptable. Jasmine recounts:

> Another thing I have to mention is my doctor, my family doctor. I didn't have so much of a good experience with him. He basically [could] have been my OB. But he's a more [older] school man. He's very much [an] older gentlemen, and the moment that I got pregnant, I felt judged. And as a Black woman, and you know someone who's also not married yet it, yeah, it just felt like… Oh, my God, and I'm just another typical–hate to say it–but another typical Black woman stereotype: not married, has a baby daddy… He didn't say those exact words, but I could tell, and I could hear it in his voice. Like, I forgot exactly what he said, because it was so long ago. But he did say something that triggered me, and I was like, 'Okay, I'm switching. I'm over it.' I told my family, and they were like, 'You know, he's old school, that's just how they are.'… [But] I do not care. I'm sensitive [and] emotional. You're not going to talk to me that way, like you're a

> *doctor*. Do your job. You're not here to have your personal perspectives… I [also] think he was Italian… He was Caucasian.

What is especially revealing about Jasmine's story is how racist encounters such as this with her family physician had been buried and forgotten about, especially since she prefaced our interview by explaining that she did not have a negative experience. However, Jasmine's experience as a Black woman is undeniable— whether or not she had been married, her race played a large role in the way she was viewed. Having her first baby at the age of twenty-five, Jasmine had been labelled and judged as a young, Black, unmarried woman by a white, male doctor she had known her entire life. In turn, this left Jasmine feeling like nothing more than a racialised stereotype.

In a similar situation, Shauniqwa explains how she felt weary whilst pregnant, not only due to her race, but also her marital status. She explains:

> …My girlfriend gave birth [maybe] about 4 years ago… And she was married at the time… And she was like 'Shin! You wouldn't believe the discrimination that happened. You know I would have received less care if I wasn't married?... The way how [they were] talking to, you know, mothers who were single and giving birth, not married, it's disgusting compared to the way how I was treated and because I was married…' So right off the bat, I had that in the back of my mind… I'm like, okay, I'm going into this single. Are they going to treat me differently? Are they going to, you know, disrespect me? … Or you know what I mean, like, what is to be expected?

Shauniqwa had mentally prepared herself for the discrimination she felt she would most likely face going into her first pregnancy as a woman who was Black and unmarried. While most of her experience had gone well, her negative interaction with one nurse, who she named "Karen", had

her questioning everything. She recalls, “And I was saying that I was good up until I met that *Karen* of a nurse. I believe that also, too. If I wasn’t, you know… If I wasn’t Black, and if I was married, would she talk to me that way? Would she deny me from having [the epidural which] was rightfully owed to me? You know what I mean? Those are the questions that I ask myself.” Shauniqwa’s experience reiterates the idea that race is a determining and intersecting factor that impacts the care Black women receive.

There are recurring instances where these participants knew they were being treated indifferently but had brushed it off out of the fear of overreacting, or with the belief they were flawed or at fault. A basic tenet of Critical Race Theory (CRT) can be applied to gain an understanding of this experience. Particularly, the notion that racism is a blatantly normal, ordinary, and common everyday occurrence for Black, Indigenous and people of colour (Delgado et al., 2023). The ordinariness of racism is exactly why it becomes difficult to address its everyday interactions (2023). As described throughout the perinatal experiences of the women interviewed, their encounters with racism are not easily articulated, and many times, do not feel valid simply because of the widely accepted notions of racism.

In the instance of Chanel, being only eighteen years old at the time of her first child’s birth, she could not understand why she was repeatedly being dismissed and not taken seriously at the hospital, despite being on the precipice of delivering her child. Similarly, Jasmine had been stereotyped and frowned upon by her family physician, who seemed disdainful of her personal situation, being twenty-five, unmarried and pregnant. Shauniqwa, who had also been unmarried and pregnant, felt that her marital status might have played a role in the type of treatment she received from her nurse. Factors such as marital status and age seemed to have a great impact on the type of care these women received, and thus can be described as racial contempt for Black

women. Bridges (2011) articulates this concept of racial contempt, "When we understand that culture can be used to signify fundamental, insurmountable difference (i.e., radical Otherness), then cultural stereotypes and assumptions about the way people from/with certain cultures 'just are' may produce the same effects produced by racial discrimination" (p. 135). The care providers, whether intentionally or not, had labelled these women and grouped them according to cultural stereotypes which directly impacted the type of reproductive care the participants received. As Bridges (2011) describes, this form of racial discrimination, while due to commonly accepted notions about this demographic, is racial discrimination, nonetheless. Racial contempt directly correlates to the historic treatment of Black bodies in systems of science and medicine as resilient and thereby more likely made to endure avoidable pain.

4.2 Black Bodies Are Resilient Bodies

Histories of maltreatment in systems of science and medicine, as well as racist characterisations of Black womanhood have long painted Black women as strong and enduring. Black women are not barred from intrinsically human experiences such as pain and exhaustion and, especially within the context of healthcare, it is harmful to continually labelled or uphold Black women as resilient or unaffected by pain, maltreatment, or anguish. In Shauniqwa's case, she was initially administered the epidural by a seemingly kind and attentive nurse after being induced at the hospital. Unfortunately, the labour and delivery nurses did a shift change and Shauniqwa recalls her new labour and delivery nurse, "Karen", who expected her to move her legs despite being numb from her breast line and downwards:

> She was doing her assessment of everything, and she was like – Oh, right off the bat! 'I have to tell you… You're not going to get no more epidural, girl.' I was like, 'What?'

> And then she's like, 'You're not getting any more epidural. You need to be able to hold up your legs and push' and I'm like, 'Okay, I get that.' She's like, 'Because then, you can dislocate your hip' and all this stuff. She's going through all the risks or whatever… [My baby's] heart rate kept going down, so [this nurse] had to be in my room, moving me every fifteen minutes. And, in fact, I am still frozen—completely frozen… She was just like, 'Okay, can you move your leg right here? You have to move your leg right here. And I said, 'I am completely frozen. I can't move.' She's like, 'You have to try and move. You cannot give birth like this.' And I'm like looking at her, and I'm like, 'What are you talking about?' I have an epidural. I cannot move, like there's no way… My mom is looking at her, and it was just like… Are you kidding me right now like, you're the nurse…?

Shauniqwa felt confused and irritated—her frustration was internalized, at first, and only later did she interrogate the demand of the nurse: how exactly does one gain control of their body whilst heavily medicated? As she spoke, she continued to critically interrogate her frustration.

Following these incessant interactions, Shauniqwa's labour continued to progress. At the three-hour mark, she recalls being able to feel majority of her contractions as her epidural began to wear off. Despite Shauniqwa's doctor having set her up with an epidural drip to help alleviate her pain to her own discretion, her nurse, "Karen", refused to allow Shauniqwa to administer her epidural drip and was dismissive of her pain. Nearing the five-hour mark, Shauniqwa recounts that the pain was unbearable:

> …Why put me through this pain? And there's like an epidural drip where you can actually press a button, and it will just slowly release it. [The nurse] wouldn't let me touch that. Not at all… She fought with me and my mom for me to not touch it… I have

> had no epidural. [It's] pretty much [worn] off, so I'm feeling everything… I didn't care at that point in time, I was screaming, and it was getting to a point where I was like, 'No, I need something for this pain!' Like it's ridiculous…

Shauniqwa was in active labour as her pain medication became increasingly ineffective, and the nurse began to warn Shauniqwa that she would only make things worse for herself if she did not abide to her ways of birthing. She explains:

> [The nurse] is like, 'You're gonna tear… She's telling me all these things. And I'm thinking my head, I'm like, you wouldn't be treating me like this if I was a white… At the end of the day, like you're not giving birth, I'm giving birth. Like you are not having to go through this pain. So why are you stopping me from my own right? So, course it was time to push and stuff, and the way that she was talking to me… Because they come in, they are teaching you how to push. And the way how she's talking to me, she's giving me so much attitude. She's talking to me as… [If] I had to figure this out right now, or my baby is gonna get stuck… I was so hurt. I cried because of the way how she treated me. It was so hard, horrible, the worst bedside manners I could ever expect from anybody, and it's like there's a way of talking to somebody, and you know, getting them to do something, and then there's a way of disrespecting them and talking below them. That's what she was doing. She was expecting…. She was talking to me as if this was my third child… I was exhausted… I was natural, so I was exhausted, tired, like, just out of it.

Shauniqwa describes herself as being vocal—someone who will speak up for herself and others, as well as able to put people in their place if need be. However, being in an immeasurable amount of pain, she was unable to effectively advocate for herself when faced with an awful

nurse, who seemed to take advantage of Shauniqwa's vulnerability. Shauniqwa recounts this experience—now turned an unfortunate core memory— as traumatic and evidently, scarring. To have been silenced and have her pain dismissed during what was supposed to be one of the best moments of her life, Shauniqwa could not believe that a health care provider could be so cruel.

To make things worse, Shauniqwa's nurse had refused to allow anyone to help hold her legs as she delivered her baby. She recollects:

> And now I have to hold my leg up and push, and nobody can assist me. I have to, physically like, hold it myself. My mom can't hold the other leg. [My baby's] father, who was in the room, couldn't hold [my] leg, so it was like, why are you stopping me from this, stopping me from help? So, she ended up getting stuck, and I had, I think, 5 doctors and nurses just jump on my stomach… I mean, I'm just doing what I can do, and I just remember… Just pushing. I didn't care. Just keep pushing, and she finally came out, and it was obviously… I couldn't even enjoy that experience because I was so exhausted. I was ready to just sleep.

The idea that Black women's bodies are resilient in cases of physical pain and exhaustion is affirmed in Shauniqwa's experience with this labour and delivery nurse. Without remorse, this nurse allowed Shauniqwa to labour practically unmedicated, used non-encouraging language and tone, and did not allow Shauniqwa to receive help from her loved ones who could have been there to support her physically. This continued after the delivery of her child. She recalls being sewn up, after suffering a vaginal tear:

> And they're sewing me up, and [doctor's] like, 'Oh, can you feel this? And I'm just like, 'Yeah, I feel everything.' And they're like 'Oh, you didn't have your epidural?' I said, 'No, because [the nurse] didn't let me. They said, 'Oh, you could [of] at least had the

> drip.' So, this whole entire time I could have had the drip! She denied me from my own right… So, he's like, 'Yeah, go ahead, press a drip, like you can. You deserve some medicine, like… Are you okay?' And I'm like, 'Honestly like I can't even speak right now.'

At this moment, Shauniqwa was so extremely exhausted and frustrated by the treatment she received that it overshadowed the happiness one would otherwise expect from a woman that just gave birth to her first child—and possibly her only child due to infertility concerns.

Not even a week after the birth of her daughter, Shauniqwa was forced back into the hospital the same week her daughter was born. She was rushed to an urgent care clinic after experiencing severe lower abdominal pain, where—no more than a week after the horrid experience with the nurse—she recalls her hostile interaction with the urgent care doctor:

> This man was so disrespectful… He didn't want me coming into the room. He spoke out in the lobby about the pain that I was going through… Basically trying to diagnose me outside the office… But the minute that I said I just gave birth… He's like, 'Oh, I don't have… I can't do that.' Right off the bat. 'I can't do that.' And my mom looked at him, and she's just like, 'She's not asking you for that. She's asking you for you to check her blood pressure. Check her out, and what's your best recommendation? But if you don't want to render care, that's no problem. We'll go somewhere else.' And that was a very first time that someone had ever said to me that they didn't wanna render me care.

Despite being in visible pain, this urgent care doctor made it clear to Shauniqwa that he could not and would not help her, specifically because he seemed to be unable or unequipped to help her as a postpartum patient. Regardless of her case, the ability of a medical doctor to refuse to even assess her, given her state, was staggering. She seethes:

> We drove all the way there, and we're like, are you kidding me? You didn't even have the audacity to even bring me into the room to say, 'Let's talk about your case.' You talked— and thank God it was just women that were in in the waiting room— but still, like my patient confidentiality [was] out the window!... And then he is running after us… 'Cause we're packing up and we're leaving, and he's running after us, and he's just like, 'Oh, no, no, no, I can help. What do you want? What do you need?' And it's just like, listen, buddy, I'm not here to sell food, I'm not here to pick up something, like as you can see, I'm in pain, and I just need someone to just check me out, you know?

At this point, Shauniqwa tries to fathom the audacity of this doctor who refused her care, but also, clearly had no regard for her pain, her privacy and confidentiality. He seemed to realize his mistake a little too late, forcing Shauniqwa to seek care from the Emergency Room at the hospital she gave birth at. This is where Shauniqwa found out that she had a retained placenta, but thankfully, she was able to pass it without having to do surgery.

Experiences as complicated and saddening as Shauniqwa's is exactly why both Sarah and Jasmine voiced their concerns about feeling pain as Black women, especially during childbirth. Jasmine explains her fears surrounding having a caesarean section, where she explains:

> Like to have a C-section… I just always have this fear. If you cut me open, I'm gonna die on the table. Sorry, I know that's very dark… And I even express this, like as a Black woman, too, like I've always… You know, I've heard stories, and I've read certain stuff where Black people are not treated fairly when it comes to like giving birth, the pain that they're in and the doctors not listening to them. So, all that stuff ran through my mind. And that also freaked me out along with getting a C-section, so yeah, I was… I did not want the C-section.

Thankfully, Jasmine was able to give birth vaginally and did not have to end up needing a caesarean section. However, her fears are confirmed in the data. According to the CDC, Black maternal mortality rates are the highest among other racial groups; in 2021, it was found that there were 69.9 deaths per 100,000 live births, which is 2.6 times higher than the rate for white women (Hoyert, 2021). Black women's pain is so frequently dismissed, and their bodies are regarded as resilient. However, not in the case that they are not strong and capable of enduring hardship, but that they should not be considered robust and insusceptible to bodily harm, and even death.

In Simone's case, she had been through several exhausting interventions before her son was born via caesarean section. When I asked her about any specific moments that she could recall during his birth, she explained:

> Honestly, no, you know, because of how long the labor was, and then the fact that the epidural failed at a certain point. Honestly, it was all just a blur of pain. By the time they even asked about the C-section, like I didn't even feel [like I could decide] about the C-section… You know, I had to turn to my fiancé, [and say], 'You have to make this decision for us, like I don't feel capable of making this decision. I'm exhausted, and you know, I'm in a lot of pain, and I've been drugged up. And I just don't feel like I can make this decision. So, I need you to tell me what to do.'

Simone had been in labour for thirty-five hours before her son was born. Having experienced inconsistent pain, and prolonged mental and physical exhaustion, her body was so fatigued that she felt incapacitated. In the case of Sarah, she was aggressively approached by a new nurse who had threatened to increase her Pitocin (a synthetic form of the hormone, oxytocin) to accelerate

her contractions and dilation, despite that Sarah's epidural was starting to diminish. She recounts:

> She came on duty, and she matter-of-factly, told me that she was gonna turn up [the] Pitocin, and so I told her [about the epidural] … [She said], 'You know, I'm gonna turn up the Pitocin, I'm gonna double it', and I said to her, 'I do not want to double my Pitocin until I get my epidural because I'm already feeling these contractions and like, I don't know if I'm gonna be able to manage that.' And she pretty much told me like you know, I'm gonna come back in a little while and if you haven't gotten your epidural yet, I'm still gonna turn up the Pitocin…Thankfully for me, the anesthesiologist came and gave me the epidural top up right before the nurse came back to turn up my Pitocin. And to be honest with you, I think if she had tried to do it without me getting the epidural top up, I would have fought her.

The expectation of Black women to fight through unbearable pain contributes to the collective notion that Black women inhabit resilient bodies and are repeatedly objectified and dehumanised (Owens, 2017). In a state of physical, mental exhaustion and pain, they are just as deserving of a high level of care as anybody else.

We can come to understand these participants' experiences of racialization through the major principles of Reproductive Justice (RJ). As outlined by Ross & Solinger (2017), RJ is premised on three major principles: "(1) the right to *not* have a child; (2) the right to *have* a child; and (3) the right to *parent* in safe and healthy environments" (p. 9). The achievement of these principles is dependent on resources such as access to safe environments, high-quality health care and dignified childbirth (2017). It is evident that these principles of Reproductive Justice had not been enacted for the participants, particularly for those with issues such as pain

management. Shauniqwa, who was repeatedly denied pain medication and was instead denigrated and scolded by her labour and delivery nurse, expresses not feeling safe or comfortable during the duration of her childbirth experience. As mentioned in the literature review, Bourke (2014) attributes the exaggerated depiction of Black people's pain tolerances through the historical and scientific notions of Black enslaved bodies. These perpetuated biases of the Black slave as biologically strong and incapable of physically feeling pain has impacted the way in which care providers assess Black women's pain, and especially during childbirth. This is evident in Shauniqwa's experience, as her nurse seemed to believe Shauniqwa could manage hours of labour without the epidural.

In a study examining gendered racial trauma and childbirth trauma for Black women, Markin & Coleman (2023) found that the intersections of sexism and racism during Black women's childbirth experiences were correlated to feelings of trauma and stress, as well as having their pain be consistently ignored or diminished by care providers. This is also demonstrated in the case of Sarah, whose nurse showed no concern or empathy for Sarah's pain as she argued to increase the Pitocin. The nurse had made it clear that her only priority was the progression of Sarah's labour, regardless of if Sarah wanted the Pitocin or not, which Sarah recalls was a traumatic incident. This concept of pain as biologically and racially determined has manifested the 'Superwoman' schema, by which Black women are "…acclaimed for their strength (vis-à-vis resilience, fortitude, and perseverance) in the face of societal and personal challenges" (Woods-Giscombé, 2010, p. 2). As explained by Woods- Giscombé, despite resiliency being known as a positive attribute, this role of 'Superwoman' can be regarded as a double-edged sword with regards Black women's health (2010). Beyond strength, the adversaries faced by Black women have always been about resilience.

4.3 The Bad Mother

Amongst non-white races and cultures, Black women are often (intentionally) characterised as the 'bad mother', being depicted as both unfit and incapable of appropriately raising and mothering a child—this is especially true of women (cis and trans*) that disrupt dominant sensibilities and ideologies intentionally sustained by and reinforced through colonial-capitalistic fantasies of the heterosexual family. We understand this through the experience of the Black single mother who is discursively constructed and positioned as a "welfare queen" or "drain" on the welfare system (Cohen, 2020; Roberts, 1999)—stories through which welfare can then be purposefully dismantled. This is seen in several participants' experiences, as several of them felt threatened that they were not doing right by their children based on the decisions they made during or after birth. As mentioned in the previous section, Sarah's experience with the nurse who wanted to increase the Pitocin regardless of if she had the epidural top-up was extremely overwhelming for Sarah, as she is put in the unfortunate position of wanting to make the best decision for her baby, but also, considering herself and what her body needs. Sarah is essentially shamed by this nurse and made to feel as though her pain is not the priority. She rationalises, "First of all, being told… Being told that my pain didn't really mean anything. And then feeling kind of helpless like I didn't have the ability to really make choices in that moment. Because I was being told, like if you make that choice, then something's gonna happen to your baby." As a mother-to-be, Sarah immediately felt threatened that something could happen to her unborn child because of her decisions and was not granted the grace or consideration of her thoughts and feelings as a mother.

In Jasmine's case, she was made out to be an incompetent mother from the moment her baby was placed into her arms. She recalls:

> I will say, though, right afterwards there was a nurse. I don't remember her name, but she was kind of a little… Egh! Like she was… I don't know, she kind of had a little attitude… And I'm looking at my daughter, and I'm like ahhh what's going on… And so, I had a little moment, and I feel like [the nurse] could see it on my face, and then, when it was time for her to hand me my baby, and I was okay, like, 'How do I hold her?' And she's looking at me like, 'What are you talking about?' Like you can see it on her face… Yeah, very judgemental… She was talking [with a] very like, condescending tone. I didn't appreciate it. And then she was like, 'Okay. Put her on you now.' I'm like, 'Put her on me? What do you mean?' And she's like, 'Breastfeed!'. I'm like, 'I don't know how to do that.' And she's like, 'Okay.' And once again, just the answers, and her tone was very judgmental, condescending. Like she was over it.

Being a first-time mother, Jasmine entered motherhood with an open-mind, anxious, but also very eager to learn the ropes. While she had expected the care providers to be supportive in her journey, this nurse decided to greet Jasmine with hostility, judgement, and allowed Jasmine to feel inadequate as a new mother.

For Shewit, it was after the birth of her daughter that she had felt threatened and depicted as an incompetent and inadequate mother during a disagreement with her nurses about feeding her baby formula. She recounts the nurse's aggression as she checked her baby, "I think she was like treating her and she was like, 'You know your baby has low blood sugar?'" Shewit had not been aware of her baby's low blood sugar at first but had made it clear that she wanted to exclusively breastfeed. When she expressed this, the nurse insisted that she use formula or gel supplements to feed the baby. She explains, "Because they were making it like as if it was my fault, like saying, you know, you don't have enough milk…" While Shewit was trying her best to

produce as much breastmilk for her baby as possible, she was also in recovery from a caesarean section and did not appreciate being blamed for her baby's low blood sugar levels.

In this way, Shewit had begun to feel angry and frustrated with the way she was being treated. Being now a second-time mom, and despite being a newcomer to Canada, Shewit felt that she knew enough to stand her ground on breastfeeding exclusively. However, taunting did not stop there. As Shewit recalls:

> And then the other [nurse] would come in, and she would go like, 'You know, if you don't do this, like we're gonna send your baby to the ICU or something, for the special treatment for the baby.' She was like you have to do this, like, you know, kind of threaten me, and, like the other nurse, would come in and like would go like you know what like you need to do this, this… I said, 'No, I'm not giving her formula, like I don't wanna do that. It's normal, things happen and everything. And [one nurse] was like, 'You know what? If you don't give [formula to] her, like we're gonna take your baby, [and] put her in the special treatment place. She will have an IV if [you] refuse.

After long arguments with the nurses, Shewit eventually gave in for the sake of making sure her baby was okay.

Being a mother already, Shewit was confused about why the nurses were forcing formula down her baby's throat, especially when she had been told previously that breastfeeding is best. When she visited her family physician's clinic for the postpartum check-up, she was told by the nurse that her baby's low blood sugar was due to Shewit's fasting prior to the birth, which was expected. Shewit recalls her relief, "Yeah. I was like thank God; it was not my fault. Her low sugar levels." The postpartum nurses at the hospital had made the baby's health condition out to be Shewit's doing. The disparagement of Black mothers, regardless of their knowledge, skill,

and personal choices, feeds into the socially-constructed notion of Black women being incapable mothers.

The contempt for an individual's life choices and familial structures exceeds racism alone; it also panders to heterosexist notions of what it means to be a 'good' mother, while reinforcing capitalist logics about family. While it may seem normal to place blame on a young and/or immigrant Black mother for her improper and 'poor' life choices and decisions, it further emphasizes the concept of who is the 'good' and 'normative' mother and punishes those who deviate from the socially-acceptable norm. O'Reilly (2023) discusses these ideas in relation to who can be defined as the 'Good Mother' versus the 'Bad Mother'. She writes:

> The term 'normative motherhood' is thus employed to denote and emphasize how the concept of good motherhood operates as a regulatory institution, both discursively and materially, to construct mothers who are not white or middle class as de facto bad mothers… Under normative motherhood, the good and idealized mother is white and middle class, and her dichotomous other is the bad and demonized racialized and working-class or poor mother (p. 10).

The young, Black, inexperienced, single mother disrupts core patriarchal and hegemonic values which are rooted in motherhood and is therefore labelled as the 'Bad Mother'.

Along with the label comes issues with judgement, surveillance and regulation are experienced by racialized mothers (2023). This is demonstrated in the cases of five of the participants, who were all criticized or ill-treated by disapproving care providers who viewed them as inadequate and incapable mothers. Roberts (1999) articles this stereotype of the 'bad mother' using a capitalist lens, where the Black mother is viewed as 'Welfare Queens'. She explicates:

> The myths about immoral, neglectful, and domineering Black mothers have been supplemented by the contemporary image of the welfare queen—the lazy mother on public assistance who deliberately breeds children at the expense of taxpayers to fatten her monthly check. The picture of reckless Black fertility is made all the more frightening by a more devious notion of black women's childbearing (p. 17).

Not only is the Black mother regarded as a bad mother, but also a woman utilizing her fertility as a weapon to obtain welfare and fill her pockets with taxpayers' money each time she pops out a child. This type of logic, while not directly communicated to the participants, is demonstrated in the disdain and dismissal towards them, especially to those who were young, unmarried, or immigrants. Despite being in vulnerable situations, these women were belittled and scolded for their abilities and decisions as mothers and regarded as deviants of 'normal' society who perpetuate a culture of irresponsibility and poverty.

Conclusion: Respectful Maternity Care as Person-Centred Care

How does racial reproduction take place in reproductive care? The experiences documented from the participants have been analyzed and thematically categorized to understand the processes of racialization whilst seeking reproductive care from the Canadian health care system. First, as encounters of blatant racism which can be understood through as racial contempt on the part of the care providers. As outlined by Bridges (2011), the socially constructed notions of Black bodies have allowed for the perpetuation of racist beliefs, and thus disdain towards Black women seeking perinatal care. Black bodies are also constructed as resilient bodies. Specifically, the experiences of these women signify biological (Owens, 2017) and historical (Bourke, 2014), depictions of the durability of Black women, especially in gynecology, which have allowed for their undertreatment during cases of extreme pain and

exhaustion. Lastly, Black women have been long depicted as a threat to socially-acceptable norms of motherhood (O'Reilly, 2023). This is evident through the cases of disparagement directed towards the participants', allowing them to feel inadequate and unfit for motherhood. These social reproductions of race in reproductive care can thus be used to address the final research question: What would a person-centred approach to maternal health entail for Black women?

Person-centred care is a practice in health care, further described by Bridge et al. (2016) as:

> …Patient-based, person-centred, client-centred, or relationship-centred care is not a new concept; however, in recent years it has garnered increasing attention in the research literature and clinical practice. The extensive focus on PCC in the literature and in clinical practice over the past 15 years has helped to foster healthcare environments where there is a focus on individualized care and tailoring of services to meet patient needs and engage them as partners in their care, by providing them with relevant information to make their own decisions.

Person-centred care is a practice that encompasses several other person-dominant approaches. One of the distinct features recognized by the participants is the upholding of respect throughout their perinatal experiences, which can be analysed through the model of Respectful Maternity Care (RMC). Bohren et al. (2020), notes that respectful maternity care is a significant component of quality of care. They contend, "When women feel supported, respected, safe, and able to participate in shared decision-making with their providers, they may be more likely to have positive childbirth experiences. However, when women experience disrespectful care, they may be less likely to use facility-based maternity care services in the future and may be more likely to

have negative birth experiences" (2020, p. 114). Thus, respectful maternity care impacts the maternal experience, and plays a large role in the implementation of person-centred care.

The World Health Organization (WHO) contends that respectful care should be adopted to promote person-centred care for women and their children, as well as tackle health inequalities through a series of domains (as cited in Chinkam et al., 2023). In relation the specific experiences of the participants, Chanel recalls the racial contempt that care providers projected, which allowed for her internal debate of whether to speak up about the injustices that Black women face while seeking perinatal care. She explains, "I think there's like this weird duality of like anxiety over trying to like, be a good patient, and like not be perceived as like the 'angry Black woman', but also like this raging sense of like justice, and like wanting people to do the right thing…" Chanel felt disdain from her providers, as she was repeatedly dismissed and misbelieved as a young, unmarried Black woman during reproductive experiences. Due to this treatment, she explained the fear of being labelled yet another racialized stereotype, but also wanting to demand the respect she rightfully deserved. In this way, enacting respectful maternity care as a form of person-centred care becomes a necessity, entailing safety from harm and mistreatment (2023) against racial reproductions such as contempt.

The way in which Black bodies are viewed directly impacts the type of care they receive and how they are perceived as mothers. In Shauniqwa's case, a person-centred experience would entail respectful care that follows several domains of respectful maternity care, including the upholding of her dignity, continuous access to family support, and the provision of efficient and effective care (2023). Shauniqwa's recalls several negative experiences with her labour and delivery nurse, one being that the nurse had continually denied her use of the epidural drip to relieve her pain. Consequently, she felt that she had not received adequate nor effective care, as

she was coerced into labouring naturally. To make things worse, the nurse had also refused to let Shauniqwa's family assist her during the delivery, forcing Shauniqwa to hold up her own legs and support her body weight alone without any help from her loved ones. Through these interactions, Shauniqwa's dignity was compromised, and all forms of respect had diminished. Similarly, Sarah had been reprimanded by a nurse about her decision to wait for the epidural top up during the labour of her child. By choosing to medicate before the delivery, Sarah was made out to be selfish and as if she was not putting her child first. She expressed the trauma she had felt in that moment because her needs as a Black woman had been disregarded. In this way, having a care provider who would support her decisions as a mother-to-be, but also as a Black woman, was crucial to Sarah's vision for person-centred care. Being another domain of respectful maternity care, it is critical to respect women's choices, as in turn, it strengthens their capabilities of birth (2023). Respectful care is all these women could have asked for during the birth of their children, which had it been enacted, would have enhanced their experiences instead of tainted it. As outlined in the subsequent chapter, the reproductive realties faced by Black women also emphasizes the need for person-centred approaches to care.

It is important to note that although person-centred care (PCC) is often highly regarded, there are several critiques associated with the model. Important to this work is the notion that the PCC promotes autonomy, empowerment, and personal responsibility in the context of consumerism and neoliberalism (Summer Meranius et al., 2020; Tieu et al., 2022). It therefore privileges individual choice and responsibility without adequate acknowledgement of the unique needs and constrains—most particularly amongst vulnerable populations. Tieu et al. (2022) contend that an improved notion of personhood in PCC should regard individuals as socially-immersed subjects, straying away from the understanding that people are individual objects,

unaffected or unafflicted by social, cultural, political, economic, etc. factors. While this research advocates for care models that reflect individual needs, it recognizes these needs within a historically unequal world and the limitations of neoliberal models that perpetuate historic inequalities.

5. Black Women's Reproductive Realities

This chapter aims to recognise and examine relevant themes which emerged from both the semi-structured interviews and the document analysis in relation to RQ2: What are the reproductive realities of Black women during perinatal care? Similar to the previous chapter, I then attempt to articulate this theme with respect to (future) possibilities for more person-centred care, in response to RQ3: What would person-centred approach to maternal health entail for Black women? Based on the interview and document analysis data, Black women's reproductive realities during perinatal care can be categorised into three emergent themes. First, the imperative need for a midwife as their primary care provider, as generally, midwives are thought to provide a sense of comfort and ease, especially for Black women who anticipated having to advocate for their own needs and concerns during their perinatal experiences. Second, challenges with communication management on the part of care providers, as Black women tend to feel misinformed and overlooked throughout their perinatal experiences. Lastly, seeking trust and representation amongst health care providers and resources, as Black women lack trust in the systems meant to care for them, and are misrepresented in the documents meant to support them. As such, the reality of seeking perinatal care as Black women is grounded in the awareness of having to advocate for oneself, because of the simple fact that they cannot rely on the health care system to do it for them.

5.1 Need for a Midwife

Given the oppressive legacies and lived histories of racism in healthcare, more Black women are frequently seeking to secure a midwife to help mediate and manage their perinatal care. Out of the seven women interviewed, five of them mentioned the regret of not having a midwife, wanting a midwife for a future pregnancy, or how having a midwife positively

impacted the level of care they received. In the case of Sarah, as soon as she had learned of her pregnancy, she knew that she wanted to have a midwife to support her throughout her perinatal experience. Unfortunately, the midwives she had selected at first were not available, allowing for her care to be automatically transferred to an obstetrician until she could select an available midwife. During the time that her care was in the hands of the obstetrician, she describes it as a negative experience. At thirteen weeks of pregnancy, Sarah was experiencing cramping and light bleeding and went to the emergency room where she was told to go back to her obstetrician. She recalls:

> So, I made an appointment to see the OB shortly thereafter. And I found her care to be very impersonal. So, like I understand that you know, OBs are very busy and they have several patients that they're seeing and so they tend to be in and out, but it felt really dismissive to me because when I went to see here and I was telling her about my pain and my concern that I was having a miscarriage, you know, she essentially said to me, 'Well, if that's what's happening, then it's what's going to happen and there's nothing we can do about that.' So, I found that to be actually—in the middle of that kind of really scary period—incredibly hurtful. And it solidified to me that I really wanted to have a midwife…

Thankfully for Sarah, she had not been suffering a miscarriage, but she later found out that she was experiencing was growing pains. Being her first pregnancy, Sarah did not have any familiarity or knowledge of what to expect during pregnancy, and her experience with the obstetrician only worsened the situation, as well as her anxieties.

When Sarah was able to transfer her care to midwives who had privileges at her hospital, she explained that the level of care had changed for the better. She describes:

> …It was a really personal experience [with the midwives]. So, like they affirmed my fears, they helped me talk through them. They acknowledged some of the things that I was concerned about… Like some of the conversations a midwife will have with you, the OB won't, right? So, the OB is more so like … Making sure that you're *medically* okay. Whereas with the midwife, what I found is [it's] more like a holistic thing.

Sarah went on to describe the benefits of having a midwife, including mental and emotional benefits as she was able to talk about her feelings, and expand outside of the basic medical questions, such as focusing on methods of self-care. Given that Sarah had given birth in October of 2020, the prime of the COVID-19 pandemic, she felt very isolated and unable to effectively communicate with other moms who were going through the same perinatal experiences. In this way, having midwives helped her build a personal connection with women who were knowledgeable and able to provide her with the comfort and patience that she was different to her experiences with her obstetrician.

The use of midwives is common in North America, specifically in the 1970s when Black women had turned to alternative birthing services due to economic issues (Silliman et al., 2004) and were not granted the adequate reproductive health services (Ross & Solinger, 2017). Currently, midwifery is considered necessary in reproductive care, especially for racialized women, in that a having a midwife is more likely to guarantee a higher level of care, that is culturally safe and trustworthy, as well as upholds the dignity of these women during vulnerable times (Liese et al., 2022). This is demonstrated through the case of Chanel, as being a third time mom, she was cognisant of the benefits of having a midwife as her primary caregiver. She recalls "Yeah, so, continuity of care is really important to me. And when I had the OB, like, I saw him all throughout my [first] pregnancy. But then, when it came time to give birth, like it was just

whoever was on call, I literally don't even remember the name of the doctor. Like, she came in for two seconds, got the baby, signed off on it, and left". Chanel explains that the level of care with an obstetrician and the labour and delivery nurses was extremely impersonal and rough. She recalls:

> [The nurses were] rushing me around. They're like, take off your clothes and like, open your legs. I'm like, 'Bro… What's your name?' [laughs] Right? So, there was just like it just felt so impersonal and rough and like, there was no conversation. [There's this] injection of potassium to help stop the bleeding postpartum, and nobody explained this to me. They just stabbed me in the leg without warning, and just like continued about their life… It was not like a rush, like if they could have said, I'm gonna give you this injection now.

This form of detached care on the part of the providers is exactly what encouraged Chanel to later choose midwifery care for her second pregnancy, and subsequently, her third. With midwifery care, Chanel loved that the midwives were willing to go the extra mile to provide personal care, even if it meant answering her phone calls at two in the morning—Chanel knew she could rely on her midwives to be there to support her, whatever the case.

In their postpartum periods, few women expressed how grateful they were to have received postpartum care from their midwives. Chanel compares the midwifery level of aftercare to that of the obstetrician:

> You go in at six weeks, [the OB] basically [says], like, 'Yeah, you can have sex now. Do you need birth control? See you later.' Like that's it's just so in and out. It's so impersonal… It feels like there's no sense in establishing a relationship with them… But the midwives, they come see you within the first twenty-four hours at home, like in your

> *bed*, they come see you. I think it's twenty-four hours, three days, 5 days, and then every two weeks until that 6-week mark. And they also see your baby, and they come and weigh your baby. They come and help you with lactation support if you need it.… I had a few appointments with the midwives that were literally like—I know I had one for sure—that was a full hour. I think I had a most of them were thirty to forty minutes, and you would never even get a thirty-minute appointment with an OB. There's no way.

Chanel recalls her midwives making home visits in her first two weeks postpartum, and with two children at home already, this made things so simple and convenient for herself and her family. Forming an intimate and personal connection with her care providers was especially important to her, as Chanel and her family felt comfortable and reliant on the midwives to advocate for her and her newborn.

For Sarah, after not having her midwives as active care providers during the birth of her daughter, she was very grateful to have them attend to her during her postpartum period. She recollects:

> So, my midwife came before we checked out of the hospital and then she walked us through it all, [and] she walked out with us. She came the very following day to see us. And I believe my midwife care continued for six weeks post birth. So, she came to the house, saw me, checked on me, checked my pressure, checked the baby, checked her weight. At that point… And again, I am grateful that I had really good midwife care, because to have to get up and go to the hospital or like go to see a doctor who's just gonna see me, you know, for 10 minutes and not sort of talk to you about *you* and ask you about the baby and show genuine interest… [That] would be really, really hard.

Sarah's brief encounter with an obstetrician during her prenatal appointments had greatly impacted the way that she viewed standard maternal care. So much so, that she could not envision herself seeking care from an obstetrician or family physician postpartum. As it turns out, Sarah's midwife was worried she might have developed postpartum preeclampsia (high blood pressure during the postpartum period) at two weeks postpartum—which can occur in women up to six weeks after birth (Powles & Gandhi, 2017). She recalls:

> My blood pressure was so high they were concerned I had postpartum preeclampsia. And so, I spent like a day in the emergency room with them checking my blood pressure and giving me blood pressure medication because they were concerned about that. But that came from the fact that I had a midwife who had monitored my blood pressure, throughout the process, checked my blood pressure, you know, multiple times after, made me buy a blood pressure machine, called me to check in and see what my pressure was like… When [my midwife] saw the pressure was high, [she] told me, you know, in like a gentle but firm way, like 'You need to go get this checked. I want you to be safe. So, I am going to need you to go to the emergency room and then check in with me after.' Like, having somebody who cared that much about my well-being—not just the baby's wellbeing—*my* well-being, after I gave birth… Was a really important experience for me.

Having a care provider who paid such close and careful attention to Sarah made her feel respected and significant. As few mothers have described, once the baby is born, the primary focus is the baby. Sarah emphasizes the importance of being cared for as a new mother, especially because her health was also in the balance.

In a similar situation, Simone, who already had preeclampsia during her pregnancy, had also developed postpartum eclampsia. She remembers the role her midwife played in her diagnosis:

> So, about eleven days after [my son] was born, I went to… My second last midwife appointment. And my blood pressure was so high that they were worried I was going to have a stroke. So, I developed what's called… So, I had preeclampsia and then I developed postpartum eclampsia. So that very day, like within minutes, I was hospitalized again… So basically, what happened is they gave me this very high dose of magnesium and a different blood pressure medication, which was to bring down my blood pressure. If it didn't work, I'd have had to be admitted. I needed it to work because I had an eleven-day-old baby who was breastfeeding. And so luckily, it did work.

Simone was thankful that her midwives had been paying close attention to her blood pressure throughout her perinatal experience. Having caught it just in time, Simone was able to be treated with medication, and return home to her son to continue breastfeeding and bonding. To put this into perspective, Black women experience higher case fatality rates from maternal complications, specifically preeclampsia and eclampsia than non-Black women (Shahul et al., 2015). In this way, having a midwife who had been there to monitor and advocate for Simone might have saved her life.

The advancement of midwifery care in Canada follows a similar history to that of the United States. According to the Ontario Ministry of Health, midwifery became legalized and an official part of the provincial healthcare system in 1994:

> A midwife is a primary care provider who is responsible for all the care necessary for a healthy expectant person and the baby throughout pregnancy, birth and for six weeks

> afterward. Midwives refer clients and newborns to family doctors or specialist doctors like obstetricians and pediatricians if the care becomes complicated. Even if care is transferred to a doctor at the birth, midwives will remain involved in the care as a support to the client and baby (2020, para. 2).

The ongoing support provided by midwives regardless of a patient's medical situation is key to the type of care work midwives prioritize and represent. Reproductive Justice is tied intimately with birth work, care work, and birth justice (Apfel, 2016). As such, the role of a birth worker, such as a midwife, is critical to the fulfillment of the principles of Reproductive Justice, as it "emphasizes bodily autonomy, human dignity, and self determination to counter the pathologizing of black women's bodies and decisions... [And] helps people process the trauma, disrespect, and abuse they experience, but it also helps them envision an alternative, speculative future in which our reproductive decisions are socially and economically supported and enabled" (2016, p. xiv). The decision to choose a midwife as the primary care provider is deeply intertwined with these concepts deriving from Reproductive Justice, such as social support and enablement.

As such, a majority of the women interviewed expressed the desire or need for a midwife as their birth/care worker. They described the care as personal, intimate, and as if they had formed a lifelong relationship with this person who had integrated themselves into their family. A few of these women also articulated their desire in having a Black, or least person of colour, as their midwife or care provider. For Sarah, being a first-time mom, she had her mind set on having a Black midwife and was extremely disappointed when that was not the case. She yearned for a care worker who would understand and relate to her culturally, and therefore familiar with her unique experience as a pregnant Black woman. In a recent study by Karbeah et

al. (2022), they found that Black birthing persons' concerns were focused on culturally-safe birthing experiences and relationship-centered care, as numerous participants had past experiences of medical maltreatment and reproductive racism during previous experiences. It was rationalised that Black birthing people sought care from culturally-informed providers due to mistreatment, dismissal, and neglect within medical care settings (2022). Similarly, Sarah had voiced her feelings of reassurance and trust when she had dealt with Black care providers in the past, reaffirming to her that a Black care provider is exactly who she needed for such a delicate time, such as pregnancy.

For instance, Chanel explained that she had also preferred a Black or person of colour as her midwife. However, having had an exceptional experience with non-Black midwives in her third pregnancy, she was convinced that the midwifery system was progressive in terms of the care work they provided, regardless of race. This is demonstrated in a narrative review by Yoder & Hardy (2018), who found that midwifery-led care programs for Black women promoted support, increased time for educating, less waiting time, improved patient-provider relationships, and enhancement of healthy practices among patients. This is also found in the interview anecdotes from participants, as they noted higher levels of care, forming trust, and ongoing support with their midwives. Specifically, in the cases of Sarah and Simone, their midwives played critical roles in their maternal diagnoses.

Sarah had been in the ongoing postpartum care of her midwife, and it was at the two-week mark that her midwife suspected that she had developed postpartum preeclampsia. Throughout her postpartum journey, Sarah's midwife had been continuously checking her blood pressure, and even made her purchase an at-home pressure kit to test her pressure in between appointments. At the time her midwife had become worried for her blood pressure levels, she

urged her to go to the emergency room where Sarah was treated. In a similar case, Simone, who had already been diagnosed with preeclampsia during pregnancy, had also developed postpartum eclampsia, and was lucky her midwife had caught it before she could have gotten a stroke. In a study conducted by Ross et al. (2019), it was found that Black women and women of lower socioeconomic status (SES) are at a greater risk for preeclampsia, and that Black women were more likely to develop preeclampsia than white women, independent of education. Comparably, a study conducted by Suresh et al. (2022) revealed that the diagnosis of any hypertensive disorders during pregnancy, including preeclampsia, were common amongst Black women. Given this information, the unwavering attention and dedication towards Sarah and Simone on the part of their midwives demonstrates their obligation to their professions as care workers, but also their commitment to their patients' lives and wellbeing.

5.2 Communication Management

During their perinatal experiences, Black women are burdened by having to mediate and manage advice from different health professionals—and this, in turn, can cause people to easily feel frustrated, exhausted, and confused. For Shewit, after having a successful caesarean section she was faced with challenges of miscommunication from her postpartum nurses during her four-day recovery at the hospital. Shewit frequently felt confused by the information received by several different nurses which caused her to be more exasperated and upset in recovery. She explains, "Because like different nurses would come in and like each nurse, would give me her own information. You know, different information, and I was not happy with that. I was getting mad at everyone. You know what I mean? And yeah, so it was not a good experience for me".

Shewit reiterated her frustration as she explained the lack of effective communication on the part of the nurses. When asked about the type of misinformation that was being shared by the nurses, Shewit gave the example about being confused about her medication dosages and the timing. She recounts:

> For me, like [with] my medications, like pain killers, one would say, like, 'Okay, take Advil every 6 hours, and then Tylenol, the other 6 hours.' And then the other one would be like, 'Take both Advil, and Tylenol, mix it [together] every 6 hours' … And I was asking them, 'How are you saying this, and the other nurse is saying this?' And they're like 'Oh, well she meant this… So just do this'.

The lack of effective communication amongst the nurses, and in turn with Shewit, caused confusion. After having gone through a major surgery, Shewit's unspoken need for the correct information regarding her medication was critical—particularly for when she would be at home with her baby, her toddler, and very much sleep-deprived.

On the other hand, Simone described her birth story as a multitude of interventions that she thinks could have been avoided with better communication from her providers. In her initial birth plan, she hoped to give birth to her son naturally at the Toronto Birthing Centre with her midwife as her primary caregiver. Having given birth to her two daughters prior, both via vaginal births at two different hospitals in the GTA, she was really looking forward to being in a calmer environment this third time around. However, due to her high blood pressure, her hopes of birthing at the Toronto Birthing Centre had fallen apart as she had to be induced four weeks before her due date.

When I asked Simone how her birthing experience went, she recalled it was "terrible". The misinformation began from when her midwife induced her using the poly bulb induction. To

ripen her cervix and kickstart contractions, they placed the bulb into her cervix and sent her home in anticipation of the bulb falling out once she was four centimetres dilated. When the bulb fell out the next day, Simone was excited to try and labour on her own as she felt the contractions building. To her dismay, she was informed that due to her elevated blood pressure, she would have to be administered an epidural and her care was now handed to the obstetrician at the hospital instead. She explains, "But you know, I wasn't even told in advance [by any care providers] that I would need the epidural [because of my blood pressure]. Even the night before when I went to get the poly bulb put in, nobody mentioned that. It's only when we went in and I was prepared to labor through it in the hospital and they were like, no, we have to give you an epidural". After being administered the epidural, Simone's labour went on for a total of thirty-five hours where her epidural eventually began to fade, and her doctor realized that her son had not fully descended into her birth canal to be born. It was at this point that Simone was informed of yet another intervention for her son's birth: an emergency caesarean section.

When I asked Simone what she would have liked to improve or change about her experience, she explained, "I think the only thing I would change… Probably the experience… I don't feel like I was given all the information I needed to in order to make the decision to be induced". From the very beginning at her midwife appointments, Simone was aware that her blood pressure was elevated, and she was prescribed a low dosage of blood pressure medication to regulate its levels. However, she felt that as a Black woman, she had been inadequately prescribed medication because her medication did not lessen her blood pressure levels at all. She recalls:

> I think the dose they gave me was too low, and again… My personal opinion is that has a lot to do with the fact that they don't really, you know, there's not a lot of research into

> how medications react with like Black people, right? And so, I think a higher dose would have made a difference, or a different medication because there are two [types] that you could give… I wish I had been given the option to say like, you know, okay, let's try, let's try a higher dose of the medication instead of rushing straight into something that, you know, led into the C-section.

Aside from medication, Simone wishes she had been encouraged to go on bedrest to help her blood pressure levels before resorting to any external interventions, as she "would have preferred, one, not to be induced. Two, for [my son] not to have come so early. And three, maybe all of that would have not led to the C-section, and all of [what] happened… I wish it had been something that had been discussed with us before so that we didn't feel like we were going into it blind". Unfortunately, being put in such a delicate position, Simone instinctively went along with all the medical decisions that were presented to her, despite not being fully aware of how the birth interventions had escalated so quickly.

When Simone was asked about advice she would give to future Black mothers who intend to give birth at a hospital in the GTA, she responded, "Know what to expect, what not to expect, ask questions and advocate for yourself. And if you don't think you can do it for yourself, have somebody there who will be able to do that for you. You know, get everything explained to you". Being prepared and fully informed of her options was all Simone could have asked for during the birth of her son. Despite having a midwife and several other care providers attending her birth, there was still a lack of effective communication which left Simone disappointed, exhausted, and with 'what if?' questions that still linger in her mind, even two years later.

In the case of Jayde, she recalls giving birth to her second child in 2020, the prime of the COVID-19 pandemic, where she was left dumbfounded by the nurses' behaviour when her husband felt sick. She recollects:

> The nurses were good for the most part, but only thing about a hospital that morning…So [the nurses were acting] very weird… So [my husband] walked in, and they just broke my water. He walked in right when they did it, and it made him like, nauseous. So he went straight to the bathroom, and the nurse was like, 'Is he okay?' I was like, 'Yeah he went to throw up, because he probably can't handle it, or whatever.' So, ever since that, I noticed that they all… Every nurse that came into our room started wearing like the gown, like every single thing you could think of… [They would] put on a gown and the mask, like the shield, everything, and I'm like 'What is going on?'… So, after being there for a day and a half, finally… I'm like, 'Is there a reason you guys are wearing this stuff now?' And she said, 'Isn't he sick?' I'm like 'Yeah, because he is a man and he saw what was going on and it made him nauseous for a second. You guys think he has COVID or something?' And they're like, 'Yeah, we did.'

Despite having completed the COVID-19 screening with her husband before entering the hospital, one nurse proceeded to act out of sheer panic because her husband had to vomit. Jayde felt like she was being treated like a disease, as even whilst in active labour, nurses were scolding Jayde to keep her mask on, rather than simply explaining to her that they were worried about a COVID threat. Jayde had to take matters into her own hands, explaining to the nurse that they had done all the screening and neither of them had COVID. She remembers that the nurse was not very happy, "She's like, 'Are you serious? So, no one's sick?' I'm like, 'No!'. So, she's like, 'So… Who put this into protocol for our room to be on lockdown?' And she was pissed off,

too". Jayde felt extremely uncomfortable by the entire interaction as they had gone almost two whole days without any of the nurses attempting to communicate with her about the issue. While their concerns were valid, Jayde felt communication was poorly managed, which made her feel ostracized, a contagion, at the birth of her own child.

5.3 Seeking Trust & Representation

At such a vulnerable but exciting time in a new mother's life, being able to trust their health care provider at every stage of their perinatal journey is critical. The reality of being a Black woman seeking perinatal care is searching for a care provider who represents them, in that they are Black or at least a person of colour, and therefore able to foster trust. Five of the participants mentioned wanting or looking for someone Black or a person of colour as their care provider when they found out about their pregnancy. For Simone, she had opted to have midwives for all three of her children. In all those times, she had midwives who were women of colour, and that had always been her preference. She explains, "I just knew that many times I've been in hospital situations and not felt heard or my concerns have not been addressed. I needed to ensure that the people looking after the baby and I, [and] would hear what I was saying and pay attention to it". Simone stressed the importance of having a woman of colour, as someone who would be able to advocate for her and most importantly, understand her fears as a Black woman.

In Sarah's case, she had desperately hoped to have a Black midwife when she found out she was pregnant with her daughter. Unfortunately, she was unable to find an available Black midwife, but explained her reasoning for wanting someone who was Black, specifically:

> Black women often have negative maternal health outcomes because providers don't take our pain seriously and aren't always trained well to deal with some common health issues for Black people. I felt like a Black midwife would be more likely to understand my needs and advocate for me effectively, and monitor my health… I should say that there's also the issue of Black women's weight being judged by providers, and I felt like a Black provider would be less likely to come in with preconceived ideas.

Despite having a negative experience with a Black nurse, Sarah views her unfortunate interaction with this nurse as an anomaly, as she had always received what she described as "reaffirming care" from Black care providers in the past. She had also been judged previously by non-Black care providers about her weight and felt that someone who was Black would be more open-minded and knowledgeable of her body type and genetics as a Black woman.

In a similar instance, both Chanel and Jasmine explained that while they were unable to choose providers who were specifically Black or people of colour, it was something that crossed their minds. Chanel explains, "And to be clear, all three of the midwives on my team were white, like… That's not my preference. I do want a provider who's a person of color, I do. But it's… You know, the system is also important… The system that midwives operate in, allows them to be better caregivers…" Despite not having midwives who were people of colour, Chanel felt that the midwifery care system was much better designed, specifically in terms of holistic care for mothers and their babies, compared to standard maternal care someone would receive from an obstetrician or family physician.

Representation also plays a large role in the reality of being a Black woman seeking perinatal care. In one of the documents given to new mothers at a hospital in York Region upon discharge with their newborn, there is a consistent lack of cultural representation. In the *1 & 2*

Months – LookSee Checklist by Nipissing District Developmental Screen (NDDS), there are checklists to monitor your child's development in the one and two months of their life to ensure their growth. The list includes startling easily, calming down, sucking well on the nipple, following movement, feeding every 2-4 hours, moving their arms and legs, and several others. At the bottom of the checklists, a note states, "Examples are only suggestions. Use similar examples from your family experience. Item may not be common to all cultures". Aside from Black women, there are a multitude of people of colour and Indigenous folks who are easily excluded from this checklist due to a lack of research about different cultures and milestones for infants at one and two months old that go beyond what is written in the list. Alarmingly, the document also suggests that for those who check more than one 'no' on the survey that parents should follow-up with a health care and/or childcare professional. Alternatively, there are resources such as those created and curated by Fraser Northwest Maternity Hub based in British Columbia, which recognize culturally-safe maternity resources for a variety of communities in New Westminster and Tri-Cities, including immigrants and Indigenous groups (Fraser Northwest Maternity Hub, 2023).

While NDDS recognizes their lack of cultural representation, there are no supplemental resources referred to moms and families. The document then goes on to explain a "Limitation of Liability", which further states:

> While every effort has been made to make the Checklists as culturally, economically and geographically neutral as possible, it must be understood by users that they may still reflect some cultural, economic or geographic prejudices… As such, these prejudices may affect a specific infant's/child's results in a Checklist without actually reflecting a developmental limitation.

Within this document, the LookSee website is also referenced for parents to seek further information and download a variety of checklists (free of charge) for any infants/children up to six years of age. On the website it states that the checklists are Canadian-based, originating from North Bay, Ontario. Despite being Canadian-based, the LookSee resource was developed in Nipissing/North Bay. It raises the question: is this document relevant to new mothers and families in York Region? Does it substantially reflect the demographic of residents in the GTA and list relevant service providers? Delving further into the website, parents and guardians are informed that the checklists are available in English, French, Spanish, Chinese, Vietnamese, Arabic, Russian and Farsi, and is "Easy-to-use for everyone". While this is a diverse set of languages, attempting to make the document available to people of different backgrounds, there are several culturally-relevant considerations which are excluded and therefore do not fairly represent the diversity of Black families.

Conclusion: Transforming Reproductive Realities through Midwifery

What are Black women's reproductive realities? The experiences documented from the participants and collected from the hospital documents have been thematically analyzed to understand Black women's experiences during perinatal care. For one, the reality for several Black women is the shared preference for a midwife as their primary care provider, as described by Liese et. al (2022), midwifery promotes a higher level of dignified care that is trustworthy, culturally-safe, and continuous, especially for racialized women. Seeking improved communication is also a common reality for Black women during perinatal care, as participants felt misinformed, misguided, and even ostracized when challenged with care providers who did not effectively communicate with them. Lastly, Black women found themselves searching for

representation, and in subsequently, trust amongst their care providers. As described by Karbeah et al. (2022), seeking culturally-informed and relationship-centred care increases trust and in turn, minimizes the dismissal and neglect of patients. These reproductive realities experienced by Black women can thus be used to address the final research question: What would a person-centred approach to maternal health entail for Black women?

As discussed, the participants have repeatedly expressed their preference for a midwife as their primary maternal care provider. It is undeniable in the data that the experiences of those who had a midwife throughout their perinatal experience were cared for at a higher standard, which allowed them to feel as though they had made the right decision when choosing a provider. This is specifically demonstrated in the cases of Chanel, Simone, and Sarah, who were appreciative of the continuity of personal care provided by their midwives. In their discussion paper, the Association of Ontario Midwives (2023) explains the integration of patient-centred care as a tenet of midwifery care:

> The midwifery model, for example, puts patients first by: building a partnership with patients; providing continuity of care (so that the patient knows the provider attending their birth); judiciously using interventions; supporting high rates of chest and breastfeeding; supporting choice of birthplace and by following the patient from home to community to hospital as needed.

It is evident that the midwifery model is specially designed to encompass features of patient-centred care.

In the participants' experiences, communication and trust were the most frustrating challenges amongst care providers during the birth of their babies. However, the midwifery model necessitates patient-centred care meant to diminish these issues. For instance, both Sarah

and Chanel describe being continuously cared for by their midwives, and they were especially grateful for the dedicated level of care that they received postpartum. Despite both not having racialized midwives (as they had originally wanted), they affirmed that they had a holistic and satisfying experience being in their care. In the specific case of Sarah, her midwife had been continuously monitoring her blood pressure levels, and when it had become alarmingly high, Sarah's midwife communicated with her in a gentle, but firm manner, recommending that Sarah to go to the emergency room.

According to the Canadian Competencies for Midwives which outlines the knowledge, skills and abilities expected of entry-level midwives across the country, two of the listed midwife roles are the 'Communicator' and the 'Advocate' (Canadian Midwifery Regulators Council, 2020). The role of the communicator emphasizes how communication contributes to patient safety, enhanced health outcomes, and patient satisfaction, two of the tenets being that a midwife, "Demonstrates cultural humility to establish a safe and respectful relationship with others… [And] provides the client and family members with accurate and complete information to assist them in making informed decisions about their health care, treatment choices and symptom management" (2020, p. 15). As a communicator, Sarah's midwife made sure to keep Sarah up to date on her blood pressure levels and provided her with options such as purchasing a blood pressure kit to keep tabs on her own health. Additionally, her midwife made efforts to holistically care for Sarah, in that she gave Sarah a safe space to communicate and share how she was feeling throughout the postpartum period.

As an advocate, midwives are meant to encourage the patient's right to make choices about their care as well as their care environment (2020). In fulfilling their role as an advocate, Sarah's midwife had advocated for her to give birth in the Toronto Birthing Centre and have a

water birth. It was not until Sarah's labour was stalled that she had no choice but to deliver in the hospital instead, for the safety of both her and her baby. Throughout Sarah's experience with midwifery care, she had felt properly informed and trusting of her midwife, being someone who was knowledgeable, culturally-aware, and empathetic towards her experience. As such, midwifery care encompasses approaches to person-centred care, that is geared towards transforming Black women's reproductive realities for the better.

6. Conclusion

To better understand the reproductive experiences of Black women in Canada, there is a need for improved data collection which addresses the disparities in seeking maternal care (Howell, 2018). The careful collection of these realities will enhance both gendered and racial inequities that afflict public health in Canada (Dryden & Nnorom, 2021; Pederson et al., 2010). This research examines the relationship between race and Black women's reproductive realities during in perinatal care in the Greater Toronto Area (GTA) in Canada. This study is thus theoretically informed by Critical Race Theory (CRT) and Reproductive Justice. CRT is premised on the social constructions of race which categorize and subordinate Black, Indigenous and People of Colour (BIPOC) individuals (Crenshaw, 2011) as well as the concept of intersectionality, by which the interlocking systems of oppression shape an individual's unique experiences of discrimination (Crenshaw, 1994). Reproductive Justice is notionally relevant to the understanding of the rights to privacy and choice in reproduction (Ross & Solinger, 2017). Combined, these theoretical frameworks contribute to Critical Ethnography as a methodology through their shared objective to confront power inequities (Allen, 2017), and therefore informed data collection and analysis of this study.

To better address the gaps which exist in Canadian scholarship, an extensive literature review was completed on relevant literature deriving from Canada and the United States in relation to anti-Black racism and maternal health. This investigates literature on the biological premises of race, the historical investigation of gendered-racial violence, and the scholarly work of Black women and gender-diverse folks who are committed researchers and activists working to dismantle anti-Black racism in health care, and further, the inequities faced by Black people in maternal care. To implement this research, I first conducted a document analysis of relevant

material disseminated to women during postpartum care through my hospital volunteer position (Weber & Hilfinger Messias, 2012). The experience from this position further informed the careful collection of qualitative interview data, which emphasizes Black women's lived realities and birth stories (Lucyk, 2018). This led to the formation of three research questions: i) How is race, commonly approached as biological in the medical world, socially constructed in the Canadian health care system?; ii) What are the reproductive realities of Black women during perinatal care?; and iii) What would a person-centred approach to maternal health entail for Black women?

This research study recruited seven self-identified Black women for semi-structured interview data collection (Hayes & Casstevens, 2017). These women were ages 18 and older and had given birth at a hospital in the GTA between January 2020 and May of 2023. Despite my attempt to include gender-diverse perspectives, those that voluntarily participated in the study all identified as women. I am conscious of the fact that people with various gender identities have the capacity to conceive, carry and birth a child, and thus, I believe these experiences are necessitated in future research to further address the intersectional experiences of Black birthing people. The careful collection of these women's birth stories, as well as hospital documents were thematically analyzed and organized into several emergent themes, through the guidance of the three research questions.

The social constructions of race in the health care system were experienced and described by participants as encounters of transparent racism and racial contempt expressed by care providers towards Black women, particularly as related to their life choices and circumstances (see also, Bridges, 2011). Black women are also constructed as inhabiting resilient, Black bodies. Specifically, these women describe experiences of maltreatment and neglect during cases of

extreme pain and exhaustion (Owens, 2017; Bourke, 2014). Lastly, Black women are depicted as a threat to the ideal standards motherhood (O'Reilly, 2023) as they were reprimanded and made to feel inadequate and incompetent as mothers. Black women's reproductive realities include the shared preference for a midwife as their primary care provider, given that midwifery promotes an exception level of dignified and continuous care that is reliable and culturally-aware, especially for racialized women (Liese et. al, 2022). Issues of communication is another shared reality for Black women seeking perinatal care, as some participants felt misinformed, misguided, and excluded during interactions with care providers. Lastly, Black women found themselves searching for representation and trust amongst their care providers, instead of dismissal and neglect (Karbeah et al., 2022).

The social constructions of race and reproductive realities faced by Black women can be used to better understand and inform person-centred care approaches for Black women in Canada. In response to socially constructed notions of Black women, the participants express the need for respectful maternity care to feel better supported, safe, and dignified, which in turn, fosters enhanced childbirth experiences (Bohren et al., 2020). Respectful maternity care is a worldwide approach to person-centred maternal care and is recommended by the World Health Organization to dismantle health inequities in maternal care, as well as promote improved health outcomes for women and their babies (Chinkam, 2023). Respectful maternity care thus promotes the safety from harm and mistreatment, upholding of dignity, continuous access to family support, and the provision of efficient and effective care, as well as respecting women's choices to strengthen their experiences of birth (2023). In this way, the tenets of respectful maternity care can be implemented to better address and impede constructions of race such racial contempt, viewing the Black body as resilient, and inaccurate depictions of the bad mother. Person-centred

care for Black women is therefore grounded in the tenets of respectful maternity care, which allows them to be seen and treated as human beings, deserving of empathetic, deferential, and unbiased care, beyond reproductions of race.

The role of a midwife as the primary care provider is critical to the maternal experience and reproductive realities of Black women. This is evident as the participants who opted for a midwife as their care providers described being satisfied with the level and continuity of care, as well as the fostering of relationships and trust. The midwifery model in Ontario has integrated notions of person-centred care, by which people are prioritized, continuously attended to, and supported in their decisions as birthing people (Association of Ontario Midwives, 2023). Two of the seven roles expected of entry-level midwives include the 'Communicator' and the 'Advocate' (Canadian Midwifery Regulators Council, 2020). The communicator role is defined by a midwife's ability to accurately exchange information with clients in a way that prioritizes their safety, improved health outcomes, and satisfaction, as well as establish a respectful relationship and assisting them in making educated decisions about their health (2020). The advocate role is defined by their ability to encourage the patient's right to make choices about their care as well as their care environment, and advocate for marginalized patients and pertaining populations (2020). The midwifery model promotes approaches rooted in person-centred care, and thus can be used to address Black women's reproductive realities such as communication management and seeking of trust and representation.

Person-centred care is enabled through approaches such as respectful maternity care and the Canadian midwifery model. As such, for future direction towards anti-racist maternal care, enacting respectful maternity care is encouraged (Chinkam, 2023) as well as the decision to opt for midwifery care as the primary provider (Association of Ontario Midwives, 2023). The

findings of this study demonstrate the lived experiences of Black women in Canada, being a marginalized and neglected population with respect to health care, and at a crucial time in motherhood. As such, these findings emphasize the importance of equity-informed prospective scholarship. In being granted the opportunity to understand and disseminate women's stories, I hope to further develop expertise and empirical work needed to address racial inequities in maternal health care through a doctoral program. I am hopeful that this work can be used to better inform conversations on Canadian health strategies from the critical insights of Black Canadian women.

References List

Adebayo, C. T., Parcell, E. S., Mkandawire-Valhmu, L., & Olukotun, O. (2022). African American Women's Maternal Healthcare Experiences: A Critical Race Theory Perspective. *Health Communication, 37*(9), 1135–1146. https://doi.org/10.1080/10410236.2021.1888453

Allen, M. (2017). *The sage encyclopedia of communication research methods* (Vols. 1-4). Thousand Oaks, CA: SAGE Publications. https://doi.org/10.4135/9781483381411

Allers, K. S. (2021). Reclaiming Black Motherhood: Centering Maternal Activism on Birth and Breastfeeding Justice. In A. O'Reilly (Ed.), *Maternal Theory: Essential Readings, The 2nd Edition* (pp. 689–696). Demeter Press.

Apfel, A. (2016). *Birth work as care work: Stories from activist birth communities*. PM Press.

Association of Ontario Midwives. (2023). *Patients First: Leveraging Midwives to Strengthen Maternal and Newborn.* https://www.ontariomidwives.ca/sites/default/files/Midwives%20Submission%20to%20Patients%20First.pdf

Badreldin, N., Grobman, W. A., & Yee, L. M. (2019). Racial disparities in postpartum pain management. *American Journal of Obstetrics and Gynecology*, *220*(1), S206–S206. https://doi.org/10.1016/j.ajog.2018.11.312

Bohren, M. A., Tunçalp, Ö., & Miller, S. (2020). Transforming intrapartum care: Respectful maternity care. Best Practice & Research. *Clinical Obstetrics & Gynaecology*, *67*, 113–126. https://doi.org/10.1016/j.bpobgyn.2020.02.005

Bonello, M., & Meehan, B. (2019). Transparency and Coherence in a Doctoral Study Case Analysis: Reflecting on the Use of NVivo within a 'Framework' Approach. *The Qualitative Report, 24*(3), 483-498.

https://ezproxy.library.yorku.ca/login?url=https://www.proquest.com/scholarly-journals/transparency-coherence-doctoral-study-case/docview/2199790499/se-2?accountid=15182

Boon, S., & Connolly, D. (2022). The Knot Itself: Tangling with Multiculturalism. *Journal of the Canadian Association for Curriculum Studies*, *19*(2), 9–28. https://doi.org/10.25071/1916-4467.40692

Bourke, J. (2014). Pain sensitivity: an unnatural history from 1800 to 1965. *The Journal of medical humanities*, *35*(3), 301–319. https://doi.org/10.1007/s10912-014-9283-7

Bowen, G. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal. 9.* 27-40. https://doi.org/10.3316/QRJ0902027

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

Bridge, E., Law, M. P., & Narushima, M. (2016). Using patient value statements to develop a culture of patient-centred care: a case study of an Ontario, Canada hospital. *Patient Experience Journal*, *3*(2), 87–98. https://doi.org/10.35680/2372-0247.1180

Bridges, K. M. (2011). *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization.* Berkeley: University of California Press.

Bridges, K. M., Keel, T., & Obasogie, O. K. (2017). Introduction: Critical Race Theory and the Health Sciences. *American Journal of Law & Medicine*, *43*(2–3), 179–182. https://doi.org/10.1177/0098858817723657

Byrd, W. C., & Hughey, M. W. (2015). Biological Determinism and Racial Essentialism: The Ideological Double Helix of Racial Inequality. The ANNALS of the American Academy of Political and Social Science, *661*(1), 8–22. https://doi.org/10.1177/0002716215591476

Canadian Institute for Health Information (CIHI). (2022). *Race-based and Indigenous identity data*. Canadian Institute for Health Information. https://www.cihi.ca/en/race-based-and-indigenous-identity-data

Canadian Midwifery Regulators Council. (2020). Canadian Competencies for Midwives. https://cmrc-ccosf.ca/competencies

Chinkam, S., Ibrahim, B. B., Diaz, B., Steer-Massaro, C., Kennedy, H. P., & Shorten, A. (2023). Learning from women: Improving experiences of respectful maternity care during unplanned caesarean birth for women with diverse ethnicity and racial backgrounds. *Women and birth: Journal of the Australian College of Midwives*, *36*(1), e125–e133. https://doi.org/10.1016/j.wombi.2022.05.004

Centers for Disease Control and Prevention (CDC). (2022). *Maternal Mortality.* U.S. Department of Health & Human Services. https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html

Cerdeña, J. P., Plaisime, M. V., & Tsai, J. (2020). From race-based to race-conscious medicine: how anti-racist uprisings call us to act. *The Lancet, 396*(10257), 1125–1128. https://doi.org/10.1016/S0140-6736(20)32076-6

Cohen, C. J. (2020). Punks, bulldaggers, and welfare queens: The radical potential of queer politics?. In *Feminist Theory Reader* (pp. 311-323). Routledge.

Collins, P. H. (2021). Shifting the Center: Race, Class and Feminist Theorizing About Motherhood. In A. O'Reilly (Ed.), *Maternal Theory: Essential Readings, The 2nd Edition* (pp. 167–186). Demeter Press.

Collins, P. H. (2021). The Meaning of Motherhood in Black Culture and Black Mother-Daughter Relationships. In A. O'Reilly (Ed.), *Maternal Theory: Essential Readings, The 2nd Edition* (pp. 151–166). Demeter Press.

Collins, P. H. (2019). *Intersectionality as critical social theory*. Duke University Press.

Collins, P. H. & Bilge, S. (2016). *Intersectionality*. Polity Press.

Collins, P. H. (2006). *Patricia Hill Collins: Intersecting Oppressions*. https://www.semanticscholar.org/paper/Patricia-Hill-Collins-%3A-Intersecting-Oppressions-Collins/a976d21759a3647422ea30252a1997aab5c6cbd5#references

Crenshaw, K. W. (2011). Twenty years of critical race theory: Looking back to move forward. *Connecticut Law Review, 43*(5), 1253-1353.

Crenshaw, K. (1994). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics. In *Living with Contradictions* (1st ed., pp. 39–52). Routledge.

Creswell, J. W. & Poth, C. N. (2018). *Qualitative inquiry & research design: choosing among five approaches (Fourth edition.).* SAGE.

Cronin, M. (2020). Anarcha, Betsey, Lucy, and the women whose names were not recorded: The legacy of J Marion Sims. *Anaesthesia and Intensive Care, 48*(3), 6–13. https://doi.org/10.1177/0310057X20966606

Davis, A. (2017). "The Real Toronto": Black Youth Experiences and the Narration of the Multicultural City. *Journal of Canadian Studies, 51*(3), 725–748. https://doi.org/10.3138/jcs.2017-0039.r1

Dayo, E., Christy, K., & Habte, R. (2023). Health in colour: black women, racism, and maternal health. *Lancet Regional Health. Americas, 17*, 100408–100408. https://doi.org/10.1016/j.lana.2022.100408

Declercq, Belanoff, C., & Sakala, C. (2020). Intrapartum Care and Experiences of Women with Midwives Versus Obstetricians in the Listening to Mothers in California Survey. *Journal of Midwifery & Women's Health*, *65*(1), 45–55. https://doi.org/10.1111/jmwh.13027

DeJonckheere, M. & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, *7*(2), e000057–. https://doi.org/10.1136/fmch-2018-000057

Delgado, R., Stefancic, J., & Harris, A. (2023). *Critical Race Theory, Fourth Edition: An Introduction.* (1st ed.). New York University Press. https://doi.org/10.18574/nyu/9781479818297.001.0001

DeVault, M., & Gross, G. (2012). Feminist qualitative interviewing: experience, talk, and knowledge. *SAGE Publications, Inc*., (pp. 206-236). https://dx.doi.org/10.4135/9781483384740

Dole, N., Savitz, D. A., Siega-Riz, A. M., Hertz-Picciotto, I., McMahon, M. J., & Buekens, P. (2004). Psychosocial factors and preterm birth among African American and White women in central North Carolina. *American journal of public health*, *94*(8), 1358–1365. https://doi.org/10.2105/ajph.94.8.1358

Dryden, O., & Nnorom, O. (2021). Time to dismantle systemic anti-Black racism in medicine in Canada. *CMAJ*, *193*(2), E55-E57.

Emirbayer, M. & Desmond, M. (2012). Race and reflexivity. *Ethnic and Racial Studies*, *35*(4), 574–599. https://doi.org/10.1080/01419870.2011.606910

Ferber, A. L. (1999). *White man falling: Race, gender, and white supremacy*. Rowman & Littlefield Publishers.

Fraser Northwest Maternity Hub. (2023). Resources for Maternity and Newborn Care in New Westminster and Tri-Cities. https://www.maternityhub.ca/

Gillespie, M. (1989). *African American Women Are for Reproductive Freedom: We Remember*. UC Berkeley School of Law. https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=3U3D3H52

Gluck, S. B. & Patai, D. (1991). *Women's words: the feminist practice of oral history (Gluck & D. Patai, Eds.)*. Routledge. https://doi.org/10.4324/9780203819371

Government of Ontario. (2022). *Data Standards for the Identification and Monitoring of Systemic Racism: Glossary.* King's Printer for Ontario. https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism/glossary

Graves, J. L. (2010). Biological V. Social Definitions of Race: Implications for Modern Biomedical Research. *The Review of Black Political Economy*, *37*(1), 43–60. https://doi.org/10.1007/s12114-009-9053-3

Guy, C. (2020). Towards a More Healthy America: Reallocation of Health Care Resources In An Inequitable Health Care System. *Delaware journal of public health*, *6*(5), 74–76. https://doi.org/10.32481/djph.2020.11.016

Hall, S. (2017). *The fateful triangle: Race, ethnicity, nation*. Harvard University Press.

Hammonds, E. M. (2006). *Straw men and their followers: The return of biological race*. Social Science Research Council. http://raceandgenomics.ssrc.org/Hammonds/

Hardeman, R. R., Karbeah, J., & Kozhimannil, K. B. (2020). Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism. *Birth, 47*(1), 3–7. https://doi.org/10.1111/birt.12462

Hayes, C. M. & Casstevens, W. J. (2017). Everyday Racism in Black Mothers Lives: Implications for Social Work. *Social Work Chronicle, 6*(1), 11-27.

Henry, N. (2021). *Racial Segregation of Black People in Canada*. In The Canadian Encyclopedia. https://www.thecanadianencyclopedia.ca/en/article/racial-segregation-of-black-people-in-canada

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

Howell, E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clinical obstetrics and gynecology, 61*(2), 387–399.

Hoyert, D. L. (2021). *Maternal Mortality Rates in the United States, 2021*. National Center for Health Statistics. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#:~:text=In%202021%2C%20the%20maternal%20mortality,(Figure%201%20and%20Table)

Huesch, M., & Doctor, J. N. (2015). Factors associated with increased cesarean risk among African American women: evidence from California, 2010. *American journal of public health, 105*(5), 956–962. https://doi.org/10.2105/AJPH.2014.302381

James, L. (2020). *Race-based COVID-19 data may be used to discriminate against racialized communities.* The Conversation. https://theconversation.com/race-based-covid-19-data-may-be-used-to-discriminate-against-racialized-communities-138372

James, & Busia, A. P. A. (1993). *Theorizing Black feminisms: the visionary pragmatism of Black women*. Routledge.

Jarry, J. (2019). *Are You There Race? It's Me, DNA*. McGill Office for Science and Society. https://www.mcgill.ca/oss/article/health-general-science/are-you-there-race-its-me-dna#:~:text=Race%20is%20a%20real%20concept,from%20race)%2C%20is%20real

Jewell, K. S. (1993). *From Mammy to Miss America and Beyond: Cultural Images and the Shaping of US Social Policy* (1st ed.). Routledge. https://doi.org/10.4324/9780203221440

Johnson, C. J. (2013). *Female inmates sterilized in California prisons without approval.* Reveal. https://revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/

Karbeah, J., Hardeman, R., Katz, N., Orionzi, D., & Kozhimannil, K. B. (2022). From a Place of Love: The Experiences of Birthing in a Black-Owned Culturally-Centered Community Birth Center. *Journal of Health Disparities Research and Practice, 15*(2), 47–60.

Khan, R., Apramian, T., Kang, J. H., Gustafson, J., & Sibbald, S. (2020). Demographic and socioeconomic characteristics of Canadian medical students: a cross-sectional study. *BMC Medical Education, 20*(1), 151–151. https://doi.org/10.1186/s12909-020-02056-x

Kralj, B. (2019). MedicalPost. *Unrecognized physician pay inequities in Canadian medicine*.

Liese, K., Stewart, K., Pearson, P., Lofton, S., Mbande, T., Patil, C., Liu, L., & Geller, S. (2022). Melanated Group Midwifery Care: Centering the Voices of the Black Birthing

Community. *Journal of midwifery & women's health*, *67*(6), 696–700. https://doi.org/10.1111/jmwh.13438

López, C. (2021). *4 top athletes barred from competing in their Olympic events because their natural testosterone levels are deemed too high*. INSIDER. https://www.insider.com/intersex-olympic-athletes-barred-from-competing-in-preferred-olympic-event-2021-7

Lucyk, K. (2018). "It's a tradition of naming injustice": An oral history of the social determinants of health - Canadian reflections, 1960s-present. *SSM - population health, 6*, 178–183.

MacDorman, M. F., & Mathews, T. J. (2011). *Understanding Racial and Ethnic Disparities in U.S. Infant Mortality Rates.* CDC, National Center for Health Statistics (NCHS). https://www.cdc.gov/nchs/products/databriefs/db74.htm

Markin, R. D., & Coleman, M. N. (2023). Intersections of Gendered Racial Trauma and Childbirth Trauma: Clinical Interventions for Black Women. *Psychotherapy*, *60*(1), 27–38. https://doi.org/10.1037/pst0000403

McKenzie, K. (2021). Socio-demographic data collection and equity in covid-19 in Toronto. *EClinicalMedicine*, *34*, 100812–100812. https://doi.org/10.1016/j.eclinm.2021.100812

McKinnon, B., Yang, S., Kramer, M. S., Bushnik, T., Sheppard, A. J., & Kaufman, J. S. (2016). Comparison of black–white disparities in preterm birth between Canada and the United States. *Canadian Medical Association Journal (CMAJ)*, *188*(1), E19-E26. https://doi.org/10.1503/cmaj.150464

Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts.* Toronto: York University School of Health Policy and Management. https://thecanadianfacts.org/The_Canadian_Facts.pdf

Morgan, H. (2022). Conducting a Qualitative Document Analysis. *The Qualitative Report, 27(1),* 64-77. https://doi.org/10.46743/2160-3715/2022.5044

Nelson, A. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the national medical association*, *94*(8), 666. https://doi.org/10.17226/12875

Niles, P. M., Stoll, K., Wang, J. J., Black, S., & Vedam, S. (2021). "I fought my entire way": Experiences of declining maternity care services in British Columbia. *PLoS One*, *16*(6), e0252645.

Nnorom, O., Findlay, N., Lee-Foon, N., Jain, A. A., Ziegler, C. P., Scott, F. E., Rodney, P., & Lofters, A. K. (2019). Dying to Learn: A Scoping Review of Breast and Cervical Cancer Studies Focusing on Black Canadian Women. *Journal of Health Care for the Poor and Underserved, 30*(4), 1331-1359. https://doi.org/10.1353/hpu.2019.0100

Ontario Ministry of Health. (2020). *Midwifery in Ontario: What is a midwife?* https://www.health.gov.on.ca/en/public/programs/midwife/

O'Reilly. (2023). *Normative motherhood: Regulations, representations, and reclamations* (O'Reilly, Ed.). Demeter Press.

O'Reilly, A. (2004). A Politics of the Heart: African-American Womanist Thought on Mothering. In A. O'Reilly (Ed.), *Mother Outlaws: Theories and Practices of Empowered Mothering* (pp. 171-192). Women's Press.

Owens, D. C. (2017). *Medical Bondage: Race, Gender, and the Origins of American Gynecology*. University of Georgia Press. https://doi.org/10.2307/j.ctt1pwt69x

Oyěwùmí, O. (1997). *The invention of women: Making an African sense of Western gender discourses*. Minneapolis: University of Minnesota Press.

Pederson, A., Raphael, D., & Johnson, E. (2010). Gender, Race, and Health Inequalities. In M. Webber & K. Bezanson (Eds.), *Rethinking society in the 21st century: critical readings in sociology* (pp. 291-316). Canadian Scholars' Press Inc.

Petersen, E., Davis, N., Goodman, D., Cox, S., Syverson, C., Seed, K., Shapiro-Mendoza, C., Callaghan, W., & Barfield, W. (2019). *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016.* https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s_cid=mm6835a3_w

Pieper, L. P. (2014). Sex Testing and the Maintenance of Western Femininity in International Sport. *The International Journal of the History of Sport. (31)*13, 1557-1576. http://doi.org/10.1080/09523367.2014.927184

Powles, K., & Gandhi, S. (2017). Postpartum hypertension. *CMAJ: Canadian Medical Association journal, 189*(27), E913. https://doi.org/10.1503/cmaj.160785

Prasad, A. (2022). Deirdre Cooper Owens: bringing context to systemic medical racism. *The Lancet*, *399*(10325), 622. https://doi.org/10.1016/S0140-6736(22)00237-9

Prather, C., Fuller, T. R., Jeffries, W. L., Marshall, K. J., Howell, A. V., Belyue-Umole, A., & King, W. (2018). Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity*. *(2)*1, 249-259. http://doi.org/10.1089/heq.2017.0045

Ray, J. G., Park, A. L., & Dzakpasu, S. (2018). Prevalence of Severe Maternal Morbidity and Factors Associated with Maternal Mortality in Ontario. *Jama Network Open, 1*(7). https://doi.org/10.1001/jamanetworkopen.2018.4571

Roberts, D. E. (1999). *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Vintage.

Rollock, N., & Gillborn, D. (2011). Critical race theory (CRT). *British Educational Research Association*, 1-7.

Ross, K. M., Schetter, C. D., McLemore, M. R., Chambers, B. D., Paynter, R. A., Baer, R., Feuer, S. K., Flowers, E., Karasek, D., Pantell, M., Prather, A. A., Ryckman, K., & Jelliffe-Pawlowski, L. (2019). Socioeconomic Status, Preeclampsia Risk and Gestational Length in Black and White Women. *Journal of Racial and Ethnic Health Disparities, 6*(6), 1182–1191. https://doi.org/10.1007/s40615-019-00619-3

Ross, L., & Solinger, R. (2017). *Reproductive justice: An introduction.* University of California Press.

Shahul, S., Tung, A., Minhaj, M., Nizamuddin, J., Wenger, J., Mahmood, E., Mueller, A., Shaefi, S., Scavone, B., Kociol, R. D., Talmor, D., & Rana, S. (2015). Racial Disparities in Comorbidities, Complications, and Maternal and Fetal Outcomes in Women With Preeclampsia/eclampsia. *Hypertension in pregnancy, 34*(4), 506–515. https://doi.org/10.3109/10641955.2015.1090581

Siddiqi, A. (2015). *Should we routinely collect data on race? Canada at a crossroads.* http://www.dlsph.utoronto.ca/2015/10/should-we-routinely-collect-data-on-race-canada-at-a-crossroads/

Silliman, J., Fried, M. G., Ross, L. J., & Gutiérrez, E. R. (2016). *Undivided rights: women of color organize for reproductive justice* (Second edition.). Haymarket Books.

Smedley, A. (2007). *Race in North America: origin and evolution of a worldview* (3rd ed.). Westview Press.

Statistics Canada. (2022). *Focus on Geography Series, 2021 Census of Population.* https://www12.statcan.gc.ca/census-recensement/2021/as-sa/fogs-spg/Page.cfm?lang=E&topic=2&dguid=2021A00033518

Stephen, J. & Strange, C. (2010). Eugenics in Canada: A Checkered History, 1850s–1990s. *The Oxford Handbook of the History of Eugenics*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195373141.013.0032

Stern, A. M. (2020). *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*. Institute for Healthcare Policy & Innovation. https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st

Stote, K. (2019). *Sterilization of Indigenous Women in Canada*. The Canadian Encyclopedia. https://www.thecanadianencyclopedia.ca/en/article/sterilization-of-indigenous-women-in-canada

Summer Meranius, M., Holmström, I. K., Håkansson, J., Breitholtz, A., Moniri, F., Skogevall, S., Skoglund, K., & Rasoal, D. (2020). Paradoxes of person-centred care: A discussion paper. *Nursing open, 7*(5), 1321–1329. https://doi.org/10.1002/nop2.520

Suresh, S., Amegashie, C., Patel, E., Nieman, K. M., & Rana, S. (2022). Racial Disparities in Diagnosis, Management, and Outcomes in Preeclampsia. *Current Hypertension Reports, 24*(4), 87–93. https://doi.org/10.1007/s11906-022-01172-x

Tam, M. (2021). Queering reproductive access: reproductive justice in assisted reproductive technologies. *Reproductive Health, 18*(164). https://doi.org/10.1186/s12978-021-01214-8

Taylor, J. K. (2020). Structural Racism and Maternal Health Among Black Women. *The Journal of Law, Medicine & Ethics*, *48*(3), 506–517. https://doi.org/10.1177/1073110520958875

The National Association to Advance Black Birth (NAABB). (2018). *History*. National Association to Advance Black Birth. https://thenaabb.org/history/

Tieu, M., Mudd, A., Conroy, T., Pinero de Plaza, A., & Kitson, A. (2022). The trouble with personhood and person-centred care. *Nursing philosophy: an international journal for healthcare professionals*, *23*(3), e12381. https://doi.org/10.1111/nup.12381

Tucker, M. J., Berg, C. J., Callaghan, W. M., & Hsia, J. (2007). The Black-White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates. *American journal of public health*, *97*(2), 247–251. https://doi.org/10.2105/AJPH.2005.072975

Turner, T., Boyce, T., & Butler, A. (2020). *Assessment of the Needs of Black Parents in Ontario.* Toronto, ON: Turner Consulting Group Inc.

Vaught, S. E. & Castagno, A. E. (2008). "I don't think I'm a racist": Critical Race Theory, teacher attitudes, and structural racism. *Race Ethnicity and Education*, *11*(2), 95-113. https://doi.org/10.1080/13613320802110217

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., Declercq, E., & GVtM-US Steering Council. (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive health*, *16*(1), 77. https://doi.org/10.1186/s12978-019-0729-2

Weber, L., & Hilfinger Messias, D. K. (2012). Mississippi front-line recovery work after Hurricane Katrina: An analysis of the intersections of gender, race, and class in advocacy, power relations, and health. *Social Science & Medicine*, *74*(11), 1833-1841.

Wilson, D. R. (2021). Sexual Exploitation of Black Women From The Years 1619–2020. *Journal of Race, Gender, and Ethnicity*, *10*(1), 122–129. https://digitalcommons.tourolaw.edu/jrge/vol10/iss1/13

Wilson-Mitchell, K. & Herbert, V. (2014). Black Motherhood and the Power of the Intersectionality Framework: A Midwifery Perspective on the "New Racism". In *Patricia Hill Collins* (p. 97–121). Demeter Press.

Woods-Giscombé C. L. (2010). Superwoman schema: African American women's views on stress, strength, and health. *Qualitative health research*, *20*(5), 668–683. https://doi.org/10.1177/1049732310361892

Yoder, H. & Hardy, L. R. (2018). Midwifery and Antenatal Care for Black Women: A Narrative Review. *SAGE Open*, *8*(1), 215824401775222–. https://doi.org/10.1177/2158244017752220

Zewude, R., & Sharma, M. (2021). Critical race theory in medicine. *CMAJ: Canadian Medical Association Journal*, *193*(20), 739–741. https://doi.org/10.1503/cmaj.210178

HPRC Appendix

Appendix 1: Recruitment Poster

Anti-Black Racism and Maternal Health in Canada:

an investigation between race and reproductive justice from the perspective of Black women in perinatal care

We want to meaningfully engage with Black women in Toronto, Canada, at a critical point of their motherhood journey. We are looking to **understand**— and hopefully **enhance**— your experience with healthcare!

Participant Eligibility:

- Must identify as a Black (woman or birthing person)
- Must be pregnant or have given birth at a hospital in the GTA during 2020-2023
- Must be ages 18+

Participation includes a 1-hour interview about your experiences before and/or during & after birth. All data will be confidential.

This study is conducted by **Valerie Bhupaul**, MA student at York University & **Dr. Amanda De Lisio**, PhD, Assistant Professor at York University.

Interested to participate?
General questions?
Contact Valerie
T:(416)833-0572
E: vbhupaul@yorku.ca

Appendix 2: Purposive Sampling Script

Hi there,

My name is Valerie Bhupaul, and I am a graduate student working to complete my Master of Arts degree at York University in the School of Kinesiology and Health Science.

I want to invite eligible participants to partake in a one-hour interview. It will be audio recorded. Their participation would be completely voluntary and can be withdrawn at any point, without consequence. Through the interview, I hope to learn more about (i) Black women's reproductive realities with perinatal care in a hospital in the Greater Toronto Area (GTA); ii) how race is socially reproduced through their experience in perinatal care; and (iii) what a person-centred approach to maternal health will entail for Black women.

Participants' involvement in the research will be compensated with a CAD$25 gift card.

It is my intention to start with Black women who have given birth at a hospital in York Region in 2020-2023, before I build outward to people throughout the GTA using a purposive sampling. I have attached a consent form for potential participants to review if they are interested. If you would like to discuss the project in further detail, please feel free to contact me. I would be happy to chat.

Valerie Bhupaul, MA Student

vbhupaul@yorku.ca

Appendix 3: Informed Consent

Informed Consent Form

Date:

Study Name: Anti-Black Racism & Maternal Health in Canada

Researchers: The Principal Investigator is Valerie Bhupaul (vbhupaul@yorku.ca), MA student in the School of Kinesiology and Health Science at York University, and Dr. Amanda De Lisio (adelisio@yorku.ca), PhD, associate professor at York University (Valerie's supervisor).

Purpose of the Research: Hi, my name is Valerie Bhupaul. I am a graduate student working to completing my Master of Arts degree at York University in the School of Kinesiology and Health Science. The purpose of this research project is to meaningfully engage with Black women in Toronto, Canada, at a critical point of their motherhood journey to understand their experiences with healthcare. This research will investigate the relationship between race and reproductive justice from the perspective of Black women in perinatal care. In this project, I intend to use de-identified data in presentations, written papers, as well as creative works (e.g., edited collection of stories which represent the interview data, including powerful passages/quotes to disseminate de-identifiable stories more broadly). The focus of the creative works is the co-production of Black women's perinatal experiences (inspired by the work of Apfel, 2016) and to which a new REB form will be submitted.

What You Will Be Asked to Do in the Research: Your involvement in this research project will entail participation in an interview that will take approximately one hour. You will receive a gift card of CDN$25 in compensation.

Risks and Discomforts: The focus of this research is the lived experiences of Black women seeking perinatal care. That said, you will be asked to detail your unique childbirth experience. I anticipate that there is the potential for psychological and/or emotional risk due to the nature of this project, particularly if your experience of childbirth was not particularly positive. To mitigate this, you will be reminded repeatedly throughout that your involvement that participation is entirely voluntary, such that a question can be skipped or withdraw without penalty. I will overview the interview guide and remind you of the focus of the research before commencing the interview and ask you if any question or topic should be avoided. I will also provide a list of freely available resource supports should you wish to debrief with someone after our conversation:

Adult Outpatient Counseling – Mackenzie Richmond Hill Hospital, Richmond Hill, ON
Local to Richmond Hill: 905-883-1212
Local to Vaughan: 905-832-4554

The Stepping Stones Mental Health Day Hospital – Cortellucci Vaughan Hospital, Vaughan, ON
905-417-2000 ext. 7329

Benefits of the Research and Benefits to You: I anticipate that your involvement will allow for the inclusion of Black women and their interaction with maternal care. I plan to mobilize this critical knowledge through contributing to the scholarship on race-based data in healthcare. I also anticipate that benefits for participants will include the sharing of useful resources related to maternal health, as well as useful knowledge gained about yourself.

Voluntary Participation and Withdrawal: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence your compensation, the nature of your relationship with me, or with York University either now, or in the future. If you stop participating, you will still be eligible to receive the CDN$25 gift card for agreeing to be in the project, even if you withdraw without completion of the research. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. I will keep a master list that identifies you to your coded information, but this master list will be kept secure and available only to me, and selected members of the research team—whom have all signed a confidentiality agreement. Any information that can identify you, such as audio recorded data (which cannot be considered anonymous) will remain confidential. Confidentiality will be provided to the fullest extent possible by law. The data collected in this research project will be stored indefinitely and may be used in a de-identified form by members of the research team in subsequent research investigations exploring similar lines of inquiry. Such projects will still undergo ethics review by the HPRC, our

institutional REB. Any secondary use of anonymized data by the research team will be treated with the same degree of confidentiality and anonymity as in the original research project.

Potential Risks to Data Security: This study will use the Zoom platform to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information. Recordings (audio) will be saved in a password protected file to research team members' local computer, not the cloud-based service. Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact the Principal Investigator Valerie Bhupaul by e-mail (vbhupaul@yorku.ca). You may also contact the Graduate Program Director in Kinesiology & Health Science, Dr. Alison Macpherson by e-mail (alison3@yorku.ca). This research has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Director, Research Ethics in the Office of Research Ethics, 3rd Floor, Kaneff Tower, York University (telephone 416-736-5201 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I_____, consent to participate in *Anti-Black Racism & Maternal Health in Canada* conducted by *Valerie Bhupaul*. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Principal Investigator

Additional consent (where applicable)

You must seek additional consent by including check boxes or requesting additional signatures for the following:

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

2. **Consent to waive anonymity**

I, _____ consent to the use of my name in the publications arising from this research.

3. **Consent to the use of quotes**

I consent to the use of quotations in any final reports/ publications of the research? Y / N

Signature _____ **Date** _____
Participant

Appendix 4: Interview Guide

1. Identity: How would you like to be identified in the documents that are produced as a result of this interview?
2. Is there any other information you deem important to share with respect to your identity?
    a. Pronouns
    b. Race/ethnicity
    c. Education
    d. Employment
    e. Age
3. Why did you decide to speak with me today, and participate in this study?
    a. How did you find out about this study?
4. Which hospital did you give birth in?
5. When did you give birth?
6. How did you come about giving birth at this hospital?
7. What were your initial impressions or experiences of this hospital before giving birth? (i.e., as a maternal patient?)
    a. Did your experience impact you in anyway during preparation for delivery?
    b. What were the first encounters like?
8. How would you describe your birthing experience at this hospital?
9. What are any specific moments or recurring images that you can recall during your birthing experience?

10. How were you treated (by hospital staff, medical experts, etc.) throughout your perinatal experience? This includes before birth, during birth, and after.
11. What did you love about your experience at this hospital?
12. How could your experience have been improved or enhanced?
13. Has your health status changed in any way since pregnancy and/or the birth of your baby?
14. Has your perspective/approach to healthcare been changed or altered in any way since giving birth?
15. Did you find any useful written/printed resources to prepare for your journey to motherhood? If so, can you tell me about these?
16. Can you think of any resources that you would have liked and might have helped you in this journey? You can always email/message me if you remember or think of any.
17. What is your advice to future Black women who intend to deliver at this hospital or any hospital in the GTA?
18. Do you have any questions for me at this time?