Copyright

by

Haile Eshe Cole

2014

The Dissertation Committee for Haile Eshe Cole Certifies that this is the approved version of the following dissertation:

BELLY: BLACKNESS AND REPRODUCTION IN THE LONE STAR STATE

Committee:

____

Joao Vargas, Supervisor

____

Edmund Gordon

____

Maria Franklin

____

Matt Richardson

____

Lorraine Walker

____

BELLY: BLACKNESS AND REPRODUCTION IN THE LONE STAR STATE

by

Haile Eshe Cole, BA; MA

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

May 2014

Dedication

To Nia, Azenia, Arthur, and Lucille

BELLY: BLACKNESS AND REPRODUCTION IN THE LONE STAR STATE

Haile Eshe Cole, Doctor of Philosophy

The University of Texas at Austin, 2014

Supervisor: Joao Vargas

This dissertation begins with the finding that in the United States Black women are four times as likely to die due to pregnancy related complications than their white counterparts as well as the finding that Black children are 2 to 2.5 times as likely to die before their first birthday. Given this, the project examines the intersections between Black women's reproductive experiences and the condition of reproductive health and access in the state of Texas. In order to accomplish this, the research situates the grassroots organizing work of a collective of mothers of color alongside national and state level legislation and data about maternal and infant health disparities. The work not only situates ethnographic experiences within the larger repertoire of quantitative health literature on disparities but it also historicizes the work alongside Black Feminist theories of the body, history, and Black women's reproduction. Drawing from extended participant observations, interviews, focus groups, policy research, statistics, and archival work, this project unpacks the large disparity that exists in maternal and infant health outcomes for African-American women and the ways in which policy, community organizing, and other geo-political factors contribute to, mediate, or remedy this phenomenon. Given the data presented, this projects suggests that (re)creating supportive communities and support networks may be an effective way of mediating stress caused by long-term exposures to racism and ultimately healing the negative maternal health outcomes for black women.

Table of Contents

List of Figures ix

List of Illustrations x

Introduction: In the Belly of the Beast 1

IN THE WOMB OF THE BEAST: WRITING AGAINST THE PATHOLOGICAL BLACK WOMAN 3

KEEPING AUSTIN WHITE: TEXAS, AUSTIN, DEATH, AND ANTI-BLACKNESS 5

WHY REPRODUCTION 15

Interlocking Systems of Oppression 17

Reproduction as a Tool of Genocide 20

ON METHODOLOGY 22

Chapter 1: Blackness and the Political Landscape of Women's Health Policy 30

WOMEN'S HEALTH AND THE AFFORDABLE CARE ACT 36

Maternity Care 37

Access to Communtiy Clinics 38

Sex Education for Teens 38

Abortion 38

Expansion of Family Planning and Women's Preventative Services 39

TEXAS TOUGH 41

Opposing Medicaid 45

POLICY, REPRODUCTION, AND RACE: LARGER IMPLICATIONS 47

Impacts 47

Ideological and Legal Underpinnings of the Relationship Between

Black Women and the Law 49

Women's Health, Race, and Welfare Reform 56

CONCLUSION: FITTING INTO THE FIGHT 61

Chapter 2: Sankofa: (Re) Conceptualizing Black Women's Maternal Health Disparities 66

MATERNAL AND INFANT MORTALITY IN THE U.S. AND TEXAS..................67

CAUSES 74

CURRENT CARE MODELS AND INTERVENTIONS 76

Present Day Midwifery...77

Centering Pregnancy Group Prenatal Care....................................80

Internatal Group Care Model..82

MAMAS Reproductive Justice Model 83

THE GOOD, THE BAD, AND THE UGLY: BLACK WOMEN'S BIRTH EXPERIENCES 86

The Good..88

The Bad 89

The Ugly 91

Identifying Collective Experiences 92

Communication 92

Knowledge 93

Attitudes and Beliefs 94

Stress..95

Access to Care/Care and Treatment..95

Support and Resources 96

LOOKING BACK: MIDWIFERY AND BLACK WOMEN'S CARE PRACTICES..98

Role of the Granny Midwife...100

Decline of the Granny Midwife..101

CONCLUSION INVOKING GRANNY 103

Chapter 3: Not with the Master's Tools: Institutions and the Search for Social Transformation 106

MAMAS WORK AND INSTITUTIONS 109

Employment, Labor, and the Institution 112
Pressures of Institutional Ideology and Structure 118
Profit and the Institution: Capitalizing on the Spectacle 122
Enemies of the State: Institutions and Self-Protection 127
THE MASTER AND HIS TOOLS 133
White Supremacy and Anti-Blackness 134
Considering the Meaning of Hegemony..137
CONCLUSION: INVOKING A RADICAL IMAGINATION 140
Chapter 4: Organizing for Our Lives: Survival and the Politics of Love..145
MAMAS HERSTORY AND ORGANIZATIONAL STRUCTURE 147
Mission and Vision 150
Membership...152
CHALLENGES 155
Collective Capacity and Base Building 155
Acknowledging the White Elephant:Organizing Across Race and Class. 158
Blackness and Anti-Blackness 166
REVOLUTIONARY RELATIONSHIPS 171
Friendship, Love, and Survival 172
Love as Political...175
CONCLUSION: TRANSFORMATIVE WORK 176
Conclusion: Reproduction as Resistance..179
Bibliography 182

List of Figures

Figure 1: Travis County Infant Mortality 72

Figure 2: Travis County Preterm Birth 72

Figure 3: Travis County Low Birth Weight 73

List of Illustrations

Illustration 1: African-American Population Growth/Decline 10

Illustration 2: African-American Map East Austin 1990/2000 11

Illustration 3: African-American Map East Austin 2000/2010 12

Illustration 4: MAMAS Organizational Structure 157

Introduction: In the Belly of the Beast

> *"Then Jonah prayed unto the Lord his God out of the fish's belly, And said I cried by reason of mine affliction unto the Lord, and he heard me; out of the belly of hell cried I, and thou heardest my voice."*
>
> - Holy Bible, Jonah 2: 1-2

When I decided to undertake this project that I entitled *Belly: Blackness and Reproduction in the Lone Star State*, the discernment around the title was immediate. For a project situated in Texas, a state arguably ranked towards the bottom for almost anything positively progressive, the idea of being in the "belly" of the beast seemed to be largely appropriate. Luckily, the beautifully contrived play on words fit squarely into my focus on reproductive health and birth, a phenomenon fundamentally centered on the physical locale of the belly. Alongside the clarity accompanying the name of this work, I carried an inclination to investigate the originations of the phrase "in the belly of the beast."

At its most basic level, the adage "in the belly of beast" denotes a situation in which someone is stuck in the middle of some inordinately grave situation. Probably the most notorious usage of the phrase came from a book written by Jack Henry Abbott entitled *In the Belly of the Beast.* This work published in 1981 chronicled the experiences of an American prisoner via his letters to the famous writer Norman Mailer. This widely acclaimed book articulated Abbott's perspectives and experiences in what he felt was an unjust and problematic system and penal structure. Even after his release from prison in 1981, his subsequent re-imprisonment for manslaughter that same year, and his ultimate suicide in 2002, this expression has sustained as a reference for incarceration and the state of being imprisoned. In my mind, this utility of the phrase

presents an ironic, although incredibly salient, justification for its application in Texas[1]. While Jack Abbot's book has served as a significant source of contemporary popularity, I found a more dated reference to be considerably intriguing.

In its initial conception and early employments, "in the belly of the beast" was in actuality a biblical reference to story of Jonah. As the narrative explains, Jonah disobeys God's directions to go to the city of Ninevah and He (God) sends a great animal, described as a large fish or a whale, to come and swallow Jonah. Jonah then spends three days in the belly of the great fish before being vomited out onto the land to go and fulfill the Lord's directive. The quote cited at the beginning of this section is taken from the book of Jonah and is a portion of Jonah's prayer while in the belly of the sea creature. While the purpose of this explanation is not to provide a Sunday school lesson, I want to draw attention to the language within Jonah's prayer. It not only provides a clearer understanding of what it means to be in the "belly of the beast" but it also directly informs and clarifies my choice to employ it here in this work.

Two words stand out to me in Jonah's prayer. While the scripture does make mention of Jonah's presence in the belly of the fish, Jonah himself names his location as 1) a state of *affliction* and 2) as *hell*. The edition of the bible that I used to examine this verse notated the alternative biblical connotation for the word hell which is the *grave*. While the relationship between hell and the grave is obvious to some, I find it important to draw attention to the explicit connection between hell and death as presented here. While I am no theologian or expert in linguistics, and without delving into the religious doctrine of the afterlife, I would like to draw attention to religious meaning that informs a now secularized expression. If we accept the story of Jonah as a possible

[1] According to a report released by the Bureau of Justice Statistics in 2013, Texas housed the most prisoners in both federal and state prisons than any other state in the United States.

root from which the phrase "in the belly of the beast" originated, I argue that this saying is only partly describing the state of existing in the center of some foreboding circumstance. Instead, if being in the "belly of the beast" is a biblical reference to living in a hell or grave of sorts, then in actuality this statement is about living and *being* in a condition or state of *death*.

This project *Belly: Blackness and Reproduction in the Lone Star State*, even its title, delves into the intersections of Blackness and death. By focusing on the Black reproductive body and the experiences of reproduction for Black women, this project provides an explicit depiction of what it means to exist in a living state of death. More specifically, this dissertation provides multiple manifestations of the *beast* by examining the conceptualizations of the gendered and reproductive Black body and the geographic topographies that serve as hubs for Black death.

IN THE WOMB OF THE BEAST: WRITING AGAINST THE PATHOLOGICAL BLACK WOMAN

In February of 2011, billboards were erected around the country touting the assertion that "The most dangerous place for an African – American child is in the womb." This campaign initiated by an organization called Life Always in New York City was an anti-abortion promotion highlighting the high rates of abortion in the African-American community. This group also wished to highlight the role of Planned Parenthood in targeting minority communities with genocidal abortion services. While the group's position against Planned Parenthood is indeed rooted in an accurate history around eugenics[2], this billboard campaign was met with a significant amount of opposition. Overall, the chosen messaging, instead of depicting a firm stance against eugenics and genocide, failed to contextualize the issue and unsuccessfully directed the blame onto Planned Parenthood clinics. Instead the advertisement promoted the problematic assumption that

[2] Margaret Sanger who was one the foremothers of Planned Parenthood clinics was also a large advocate of the American eugenics movement.

being in the womb of the Black woman was equivalent to the kiss of death and that Black women were to blame for the deaths of their children.

This example recreates and maintains historical conceptions of Black women as the primary culprits for the decline of the Black community. In addition, this Moynihan-esque[3] sentiment also perpetuates ideas around Black women's inability to access ideas around true and legitimate womanhood and motherhood. I mean, what other place is safer than a woman's womb for an unborn child? What *good* mother would be responsible for the death of her own child, right? While the controversy around abortion is a widely debated issue among a diversity of people, Black women have historically and continue to been susceptible to the judgments about their mothering abilities and capabilities. In fact, Black Feminist theorists, have acknowledged the ways in which Black women from the era of slavery have served as the embodiment of inhumanity and the calculating baton in which to measure against the personification of white virtue, womanhood, and motherhood (Spillers 1984; 1987; Roberts 1999). Given this, this 2011 billboard campaign, when couched within its historical precursors and ideological underpinnings, offers another, however repugnant, application of the being in the "belly of the beast." What are the changing meanings behind being conceived in the womb of a Black woman? What are the contemporary repercussions of associating death with the reproduction of Black women? This dissertation seeks to answer some of these questions.

Part of the impetus behind this work is writing against the ideology of the pathological Black mother. Other works have put in significant amounts work to contextualize and historicize this problematic conception (Roberts 1993; 1996; 1999; 2003; Collins 1991; Hartman 1997; Berry

[3] Daniel Patrick Moynihan's 1965 report, fully titled "The Negro Family: A Case for National Action," identified the declining Black family as an important national issue. It blamed the Black female heads of households for recreating a culture of poverty and transmitting pathological behaviors to their children in the home.

2005; Glenn 1993) This work seeks to contribute to this same body of literature. By looking at some of the latest dialogues surrounding Black women's reproduction, birth disparities, and infant mortality, I seek to build upon literature that dispels inaccuracies and appropriately redirects blame away from the Black mother.

KEEPING AUSTIN WHITE: TEXAS, AUSTIN, DEATH, AND ANTI-BLACKNESS

While the geographic focus of this project in its broadest sense is Texas, a majority of the ethnographic data is collected in the state's capitol Austin, Texas. If a premise of this work is evaluating the condition of living in the abdomen of the beast, Texas becomes one form of a "beast." Given this, centering my analysis on the capitol, ostensibly the geographic center and hub of the state's political workings makes sense. Additionally, locating Austin as my primary ethnographic site is particularly useful given its reputation as being a liberal "mecca" of sorts in a conservative state. It is often referred to politically as the blue dot in a red sea. Consequently, accentuating the presence of Black death and inequality in Austin directly challenges this assertion. I argue that this depiction obfuscates the social and political reality of Austin as a polarized, segregated, and racially charged city. It ignores the present reality's pioneering history. Despite its present progressive reputation, the residue of Austin's historical participation in racism as a social, political, and economic system is still visible in its current configuration. In fact, the remnants of this problematic history are most noticeable in the evolution of the city's neighborhood arrangements and continue to be exacerbated by the overwhelming contemporary phenomenon of gentrification. Even a brief geo-spacial analysis of Austin illuminates the impacts of racialized urban planning and in particular the intentional manipulation and migration of Black urban bodies. I argue that the existence of anti-black racism and sentiment as articulated in these various manifestations has created an (im)possibility of Black spaces - let alone safe and healing Black

spaces - in the city over the years. It follows then that this situation can serve as a basis for thinking through the large racially disparate health disparities and can be evidenced in the mapping of the Black migration over time.

The notorious 1928 Austin Master Plan was the first urban development plan for the city of Austin since its founding in 1839 (Busch 2013). This plan, created by the Kock and Fowler engineering firm, has been pinpointed as the primary institutional and government backed proposal to intentionally segregate and specifically relocate Black bodies to a specific section on the east side of town. An excerpt from this proposal states that

> "It is our recommendation that the nearest approach to the solution of the race segregation problem will be the recommendation of this district as a negro district; and that all the facilities and conveniences be provided the negroes in this district as an incentive to draw the negro population to this area. This will eliminate the necessity of duplication of white and black schools, white and black parks, and other duplicate facilities for this area…" (Gregor 2010).

This plan laid the ground work for the current separation of east and west Austin divided what is now major interstate highway I-35. It laid the groundwork for the geographic and racialized unequal distribution of resources around housing, health, education, and basic livelihood necessities. More importantly, the plan specifically aimed to manage the location of Black communities in the city. Even as Latino populations were also confined to certain parts of Austin and condensed largely in the southern part of town, the issue of Latino communities' segregation was not explicitly addressed in the Master Plan.

It is evident from this record that Austin was not free from the political, social, and economic strongholds around race that were so pervasive during that time. In fact, even as late as the 1960's, Austin political leaders, businesses, and residents were still blocking and defeating proposals around fair housing regulation for the city. Austin even its earliest conception was

framed as a progressive and liberal city, free from the urbanization of booming industrialization, and less racially taut than other southern cities. Yet racial tension and inequality was just as present there as other locations in the state and in south. In particular, much of the depictions of Austin as a liberal and progressive city were based on the intent of residents to maintain a less urban feel in the city. Also, the growing intellectual presence due to the increasing enrollment at The University of Texas helped Austin's liberal reputation. Andrew Busch maintains in his 2013 analysis of Austin entitled "Building a City of Upper-Middle Class Citizens" that progressive ideology in Austin was more so about

> "support of New Deal policies, encouraging strong ties to federal government as a source of funding and promoting non-industrial growth, much more than fighting racial inequality or rejecting the sanctity of private property rights…" (2013).

What this confirms is that the intentional movement and placement of Blackness has always been on the agenda as a political, economic, and social tool in Austin.

Given this, it comes to no surprise that movement, migration, and ultimately displacement have become a critical part of the Black experience in Austin, Texas. Combing the history of Austin, one will find that some of the most affluent and prestigious neighborhoods as they exist today in the city were once densely populated communities of Black people. Wheatsville and Clarksville are examples of communities once comprised of mostly Black residents that are now middle to upper middle class and overwhelmingly white[4]. While the 1928 Master Plan initiated the practice of manipulating and relocating Black bodies, a combination of other circumstances

---

[4] David C. Humphrey of the Texas Historical Association asserts that after the 1928 Master Plan, African-Americans in Austin remained highly segregated. This was until the 1950s and 60s when leaders from the community began to protest segregation and demanding more rights and equal access. While African-Americans in Austin remained on the East side of town until the 1940's, Humphrey cites the existence of many Black institutions such as "150 small businesses, more than thirty churches, and two colleges, Tillotson College and Samuel Huston College." While the African-American population continued to grow over the years, the overall percentage in the total population dropped from 33 percent to 17 percent by 1940.

surrounding the changing social and economic landscape in Austin has resulted in an increase in the remaining Black population's migration out of the city.

Over the years, Austin has become one of the fastest growing cities in the nation. It is well known for its large music festivals, multiplicity of outdoor activities, and at one time very successful University of Texas education system and football team. As its popularity dramatically increased and continues to increase, so does the influx of new residents, new businesses and also, as many have seen, the cost of living.[5] Interestingly, as the city of Austin's population continues to grow dramatically, the relative percentage of the Black population is decreasing. In fact, in 2012, city demographer Ryan Robinson lists the African-American wane in population and African-American flight to the suburbs as two of the Top Ten Demographic Trends in Austin (Robinson, 2012). According to data presented by the city as well Travis County, if this trend continues the percentage of Black residents in the area could be reduced to only about 5 percent. Given the current trajectory, it seems that this may end up being the case.

Even more noteworthy is the newfound displacement of Black residents from the core and eastern side of the city. As previously established, this portion of city located on the eastern side of highway I-35 was intentionally and overwhelmingly populated with African-American individuals and families. Yet as more people, and specifically college aged and young professionals began to be attracted to various aspects of the city, they were also attracted to the low housing prices and affordability of the east side. This process, as in many other major cities across the nation, is what is now coined as a process of gentrification. This term in its most basic sense describes the process of displacement that occurs when a once neglected and heavily

[5] According to research conducted by MPF research firm, Austin rental prices rose 4.8% in 2013. Although, a significant amount of construction is occurring around the city, rental prices continue to rise placing Austin in the top ten for annual rental change (Parsons 2014)

minority populated neighborhood becomes desirable, usually due to its affordability and also corresponding rich culture as provided by the original inhabitants. It then follows that this increase in desirability increases "settlement" by more affluent groups and therefore increases the relative profitability of the neighborhood on the housing market. Once this is done, increased efforts to "develop" or "clean up" the area ensues and the original residents are bought out, pushed out, and forced to relocate. It is something akin to a twenty-first century colonialist conquest. The article "Twenty-First Century Globalization: Impacts of Gentrification on Community Health" (2008) states that

> ….In practice, gentrification is a process that up- roots the urban poor by raising rents and taxes and making it impossible for them to stay. Dilapidated and depopulated, yet potentially attractive neighborhoods, with solid housing stock and well laid-out streets in close proximity to the city center, are dis- covered by developers, investors, artists, and other professionals. Block by block neighborhoods change, as newcomers fix up old buildings. As galleries and cafés open, curb stores and mom 'n' pop groceries close. City services improve and the infrastructure is revitalized. In the final phases, wealthy and educated professionals dominate the area. Property values rise, followed by property taxes and rents… (Murphy et al. 2008, 67)

This depiction adequately describes the case for present day East Austin. Illustration 1 shows the population change in areas of Austin for African Americans. This map reveals the sharp decline in representation of Black residents in the city's core and east side and the growing representation in the out skirts of the city. Furthermore, illustrations 2 and 3 also depict the decline of Black bodies from 1990 to 2010 from the city's core and into the outskirts of town. Consequently, this issue is being picked up by a number of people including the city itself, researchers, and the media. Yet, when an anonymous city councilmember was approached about

issues of race in Austin, the individual stated that talking about race was not an option as highlighting racial issues in Austin was not in accord with the way – and to whom – they were marketing Austin as a great place to live.

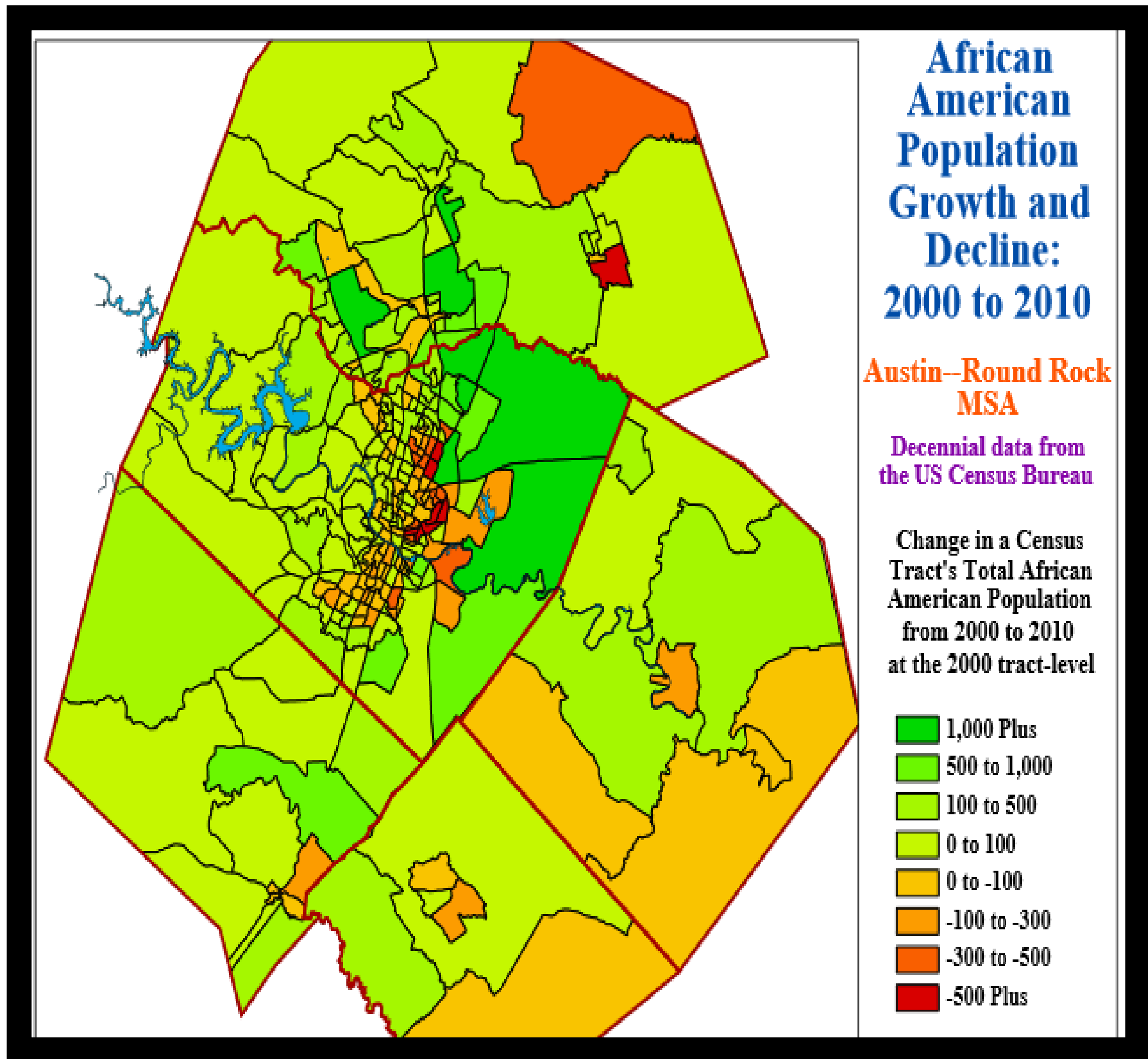

Illustration 1: African-American Growth and Decline[6]

[6] Data Source: City of Austin Planning and Development Review Department Website.

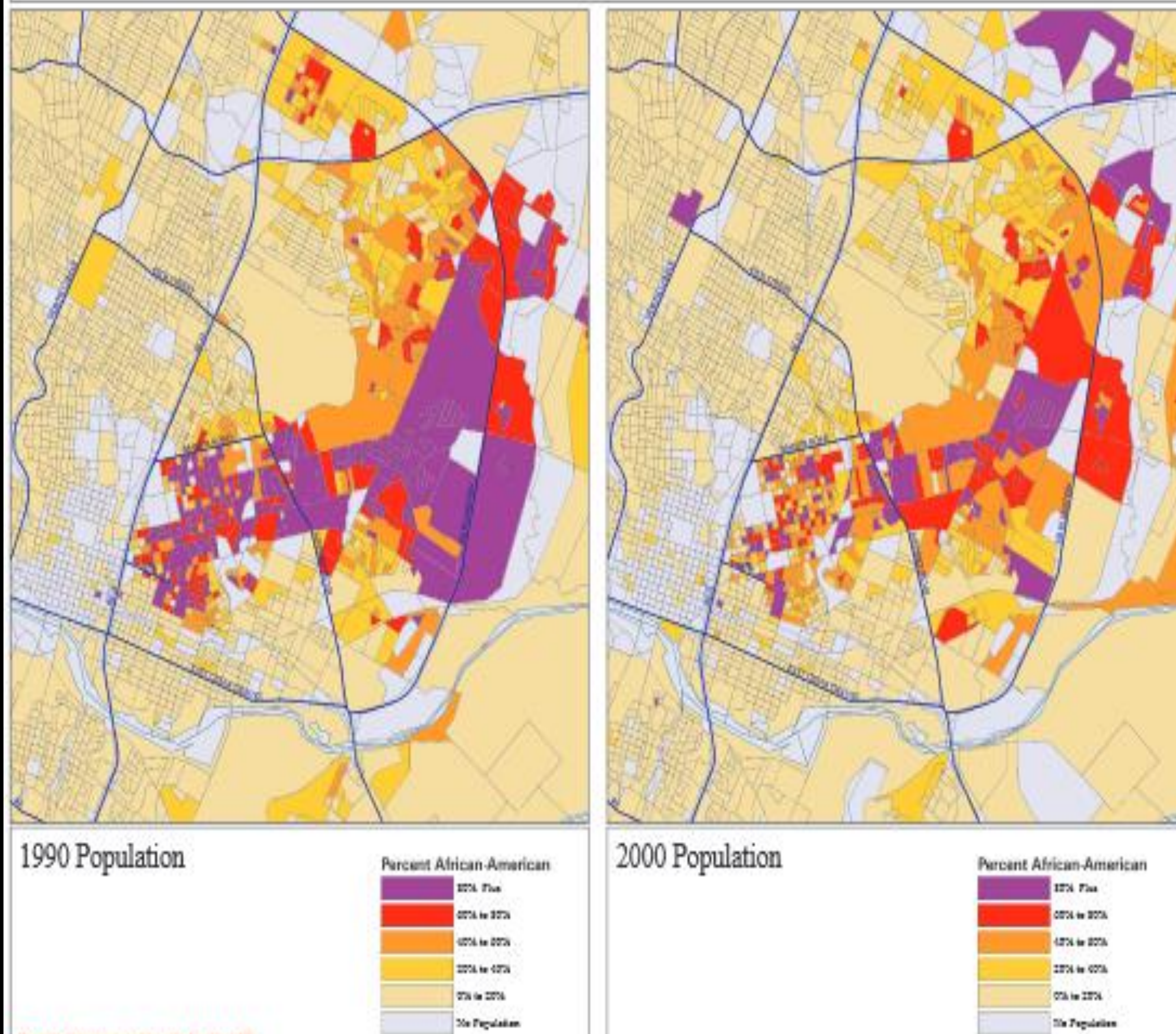

Illustration 2: African-American Map East Austin 1999/2000[7]

[7] Data Source: City of Austin Planning and Development Review Department Website.

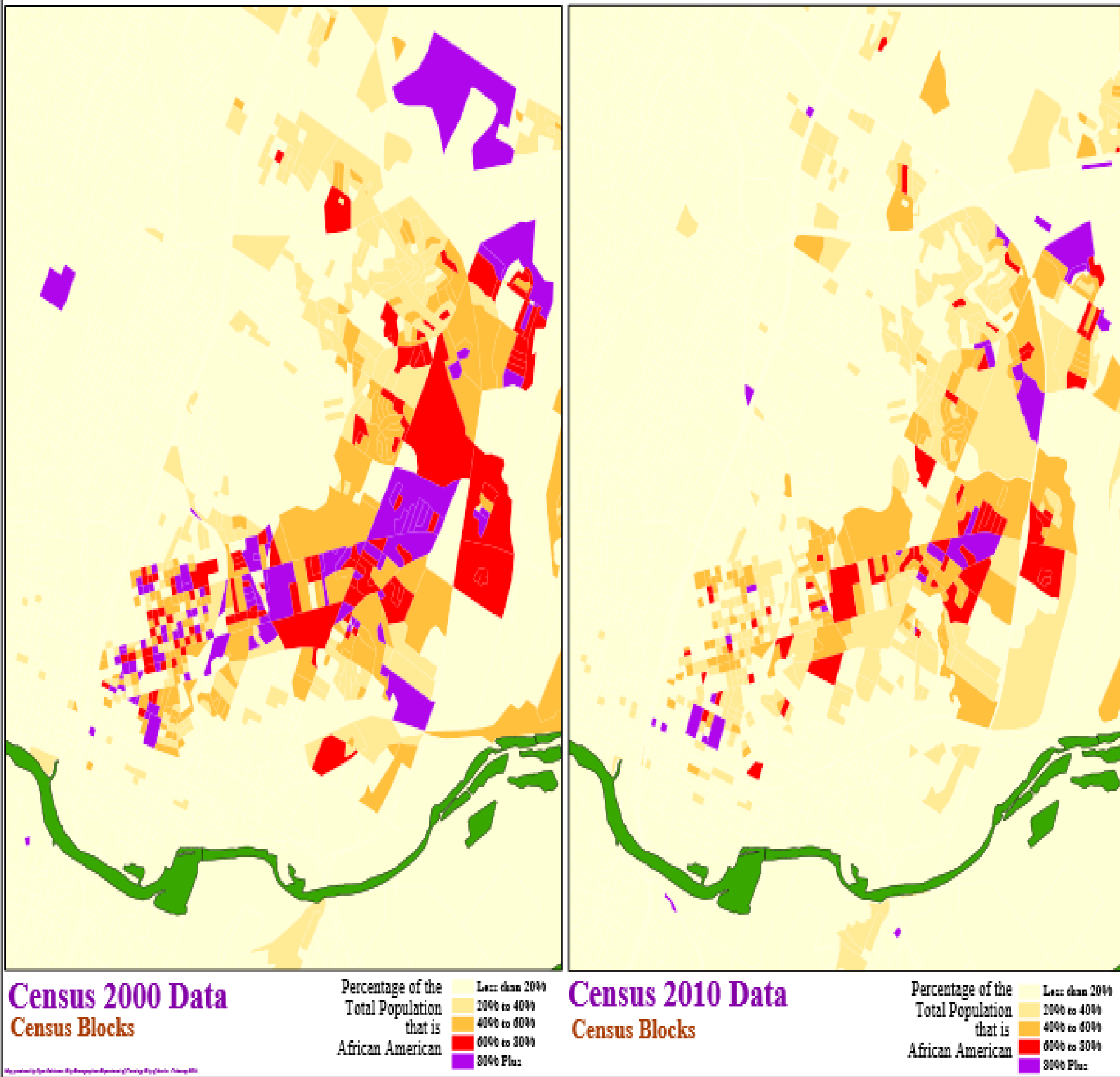

Illustration 3: African-American Map East Austin 2000/2010[8]

[8] Data Source: City of Austin Planning and Development Review Department Website.

Ethnographically, my time in Austin, which spans beyond the contours of this research project, has also provided evidence that supports the notion as exhibited from the urban planning and city management history that Austin is a city rooted in a sentiment that is anti-black. For me and others, it has manifested in various incidences both seemingly minor and notable. They include various instances such as witnessing my Black males friends non-admittance to venues downtown, the treatment and magnified response of the police force during predominantly Black major events such as the Texas Relays, or the fact that a good friend of mine and lifetime resident of Austin often states that "It ain't summer in Austin unless a Black person gets shot by the police." While this fact serves as important context for this project, it further grounds the reasoning and justification for Austin as a critical location for the analysis of Black life and death.

To provide further contextualization around the issue of Black death, I turned to mortality data from the U.S. National Center for Health Statistics. According to the information as presented in National Vital Statistics Reports (NVSR), the overall age-adjusted death rate[9] for all races in the United States was approximately 759 per every 100,000 individuals (U.S. National Center for Health Statistics, 2010). When broken down by race, the death rate for the White, Hispanic, and Black population was 751, 536, and 936 respectively. Interestingly, this national date reflects not only the enormous racial disparities that exist between White and Black communities but also the existence of the "Hispanic paradox" in which Hispanic communities and especially Hispanic immigrant communities exhibit significantly better health outcomes in many instances (Saenz and Morales 2012; Bender and Castro 2000; Hoggatt et al. 2012; Romero et al. 2012; Waldstein 2010).

[9] An age adjusted rate, also known as age standardization, is a weighting process that allows for rate comparisons regardless of age distribution. The mortality rates provided here have been adjusted to include a standardized rate that includes all ages and all causes of mortality and death.

When compared to state data on death rates, Texas' age-adjusted mortality rates are for the most part on par with national numbers. For instance, when evaluated per every 1,000 residents, the Texas mortality rate for all races is about 7.8. This is compared to the 7.6 on the national level (2010). In 2011, the mortality rate for Texas per 100,000 residents was approximately 755.3 (Texas Department of State Health Services, 2011). This is a small drop from 2010. Similarly, when broken down by race, data on mortality is comparable to the national statistics with rates for the White, Hispanic, and Black communities in Texas registering at about 777.3, 615.1, and 918.6 respectively per 100,000 Texas residents.

From here, what becomes noteworthy are the death rates for Travis County. This of course is the county that houses the states' capital Austin. Austin's reputation as a unique, environmentally friendly, outdoorsy, and health conscious city always precedes it. It is the liberal "mecca" in Texas. This demeanor is evidenced even in the overall death rates for the county and in the city. According to the data presented by the Texas Department of State Health Services, the age-adjusted death rate for Travis County in 2012 was 667.4 per 100,000 residents. This is significantly lower than the rate of approximately 780 for the state in 2010 and 760 as the national average. These numbers at first glance seem to be in support of the perception that Austin is a healthy and wonderful place to live. Yet, when examining the data broken down by race you will see that apparently, Black residents in Travis County are not afforded the same live preserving experiences as other residents. When broken down by race for Travis County in 2010, the mortality rates for White, Hispanic, and Black residents was 666.2, 568.2, and 927.1 respectively for every 100,000 residents. This shows that whichever life "protections" are producing these reduced mortality rates in Austin/Travis County are obviously not accessible to the Black residents that reside there. Moreover, while the mortality rates for Black residents in Travis County are similar

to the rates for Black people in both the state of Texas and in the United States, in Travis County the disparity gaps are significantly more pronounced. It begs the question how can such huge racial disparities exist in a city with such a progressive reputation. Although this data focuses strictly on death rates and mortality, the enormous gaps exists in other quality of life and health markers for Black people in Austin/Travis County. This will be explicitly exhibited in chapter 2 around the issues of maternal health and infant mortality. Consequently, these facts dispel yet again the notion of Austin as this liberal, racially tranquil, and progressive city. Instead, it exhumes the ever-present residue of its problematic racialized and ultimately anti-Black history.

WHY REPRODUCTION?

Murphy et al in their article on gentrification highlights the ways in which gentrification causes shifts in the community health. This is particularly true to low-income and displaced populations (2008). When considering mortality rates, and in light of the Austin's quickly evolving formation, I found that looking at issues of health is of grave importance. Nevertheless, I chose to pinpoint reproductive and women's health as my primary focus. This project evaluates the intersections between Black women's reproductive experiences and the condition of reproductive health and access in the state of Texas and in Austin[10]. Other scholars have expounded upon the importance of work on motherhood, reproduction and birth makes to social theory (Collins 1993; Ginsburg and Rapp 1995; Wilkie 2003; Glenn 1993; Davis-Floyd and Sargent 1997). Additionally, focusing on Black women's reproductive health and access allows for a critical examination of not only motherhood but also the various mechanisms and determinants of health that intersect with

[10] In a 2013 study done by Huynh and Maroka, they found that increased levels of gentrification resulted in increased instances of preterm birth for non-Hispanic Black mothers in New York City. This was in contrast with the case for non-Hispanic whites in which increased gentrification served as a protective factor against preterm birth.

race, class, and sexuality and that operate socially, economically, and politically within the terrain of reproduction.

In the fall of 2009, I began work with an organization called MAMAS. This group is a local community organization of mothers of colors and women of color allies who organize around various issues pertaining to poor and working class mothers of color. Their mission asserts that they are:

> …a collective of working class and poor mothers of color based in and around Austin, TX. We are interested in organizing ourselves and other women/mamas of color around issues with accessing needs like food, housing, education and safety, finding out together what our larger ideal community looks like and building it together.[11]

In the MAMAS work, the choice to focus on birth not only grew from the idea that birth was something that all of the women in the group could relate and connect to but it grew more importantly from an important political stance. This stance acknowledged that a woman's experience in birth had longstanding effects not only on her physical and emotional well-being but also for her children. Furthermore, the organization asserts that experiences of discrimination and disenfranchisement for the poor and working class in actuality start in the womb. The collective felt that this work, on a larger scale, took notions such as the school-to-prison pipeline, for example, and extended them to encompass the experiences of birth. MOCR articulated the importance of addressing instead the womb-to-prison pipeline in which the social, structural, and racial variables that direct the lives of Black and Brown people are challenged from birth.

Similarly, while this research project centers on reproduction, birth, and the state of reproductive health and justice campaigns in Texas, it is in actuality not truly about reproduction

[11] Mamasofcolorrising.wordpress.com

and reproduction alone. Instead, this project utilizes and builds upon the study of reproductive justice in order to explicate the ways in which particular bodies and experiences are devalued to the point that their life chances are limited to the point of death. It centers blackness and black women's experiences as a means to reveal the various ways that larger structural mechanisms have and continue to operate ideologically, legally, and physically to maintain a particular social and racial order. Moreover, central to this project is also an attempt to locate reproduction within an interconnected web of many social practices that all work in tandem to maintain a particular legacy of power, control, and domination.

Interlocking Systems of Oppression

Various scholars have theorizes and articulated the ways in which multiple systems of oppression interlock and act upon lived experiences at one time, particularly in the lives of Black women (P. H. Collins 1991; Hooks 1981; Crenshaw 1991; Combahee River Collective 1983). In the same way, focusing on reproduction as a point of analysis allows for a critical investigation of the multiple ways that oppressive systems operate in tandem to dominate, control, and harm bodies. In order to provide one example of how this may look, I would look to draw on some of my previous interests and work around Black women's growing incarceration to make this point. Specifically, I would like to draw on the connection between the history or slavery and mass incarceration and its inextricable link to Black women's reproduction.

Many scholars have theorized about the link between slavery and the present racial dynamics in prisons today (Davis, 2003; Gleissner, 2010; James, 2005, 2007). Joy James in her work acknowledges that use of the term "slavery" to describe a modern day phenomenon is a contested issue. She challenges the inapplicability of the term by stating that "racially fashioned enslavement shares similar features with racially fashioned incarceration…prison is the modern day

manifestation of the plantation" (James, xxiii). This same sentiment can be found in the work of Angela Davis who expounds upon the transition from slavery to the present system of U.S. incarceration. She notes how crime becomes conflated with color and is linked to a historically rooted anti-Black racism (Davis, 2003). This same thread of dialogue has become prevalent among radical prison activists and can be seen in the work of other authors such as Dylan Rodriguez and the more recent work of Michelle Alexander in her book *The New Jim Crow*. Although there are dialogues around slavery, race, and prison, very few scholars highlight the role of the Black woman in this trajectory. This is due in part to the fact that numerically speaking, the number of Black men in prisons today far exceeds the number of Black women. Black women today are the fastest growing incarcerated population and this fact should be considered alongside the historical focus on Black women's bodies and sexuality from slavery and the centrality of violence and subjugation of the Black woman in the maintenance of the state. What I am suggesting here is that the lack of attention paid to black women's incarceration fails to truly reveal the technologies of the state in maintaining power and in particular Black subjugation. If physical and sexual exploitation and violence against Black women's bodies was indeed central to the maintenance of racial order and the "peculiar institution" called slavery, then it would follow that the link between slavery, capitalism, racism and the current penal structure, and the link between Black women's reproductive experiences and the carceral regime, should also be a critical focus of examination. This includes an investigation of violence, sexuality, power, control, and reproduction for example.

Drawing again on Roberts' work and still building upon Spillers and Hartman, it is important to acknowledge the ways in which sexuality, reproduction and motherhood become criminalized in the lives of Black women. For instance, Roberts work discusses the onset of what can be known as "prenatal crimes" or crimes in which the woman is supposedly responsible for the harm of an

unborn fetus. This legality is particularly dealing with the ingestion of illegal substances by a pregnant woman but in practice focuses on the ingestion of crack cocaine and disproportionately targets poor women and overwhelmingly Black women as well. Inherent in this policy is not only an ideology about the incompetence and dangers of poor and black women to their unborn children but also breaks that allow for bias in various levels of its implementation. Yet in furthering this dialogue, Roberts also brings to the light the ways in sanctions that limit the reproductive freedom of the women- such as being sentenced to taking birth control or being given the option of jail or abortion- were at one time the norm. Although she states that these reproductive punishments are not eugenic because they are not directly trying to prevent the transference of criminal traits they still are based on the same premises of eugenic sterilizations laws that assume that

> "…social problems can be cured by keeping certain people from having babies and that certain groups therefore do not deserve to procreate. In either case, reproductive penalties turn offenders into objects rather than human beings that can be manipulated for the dominant society's good" (Roberts, 200).

The above examples, plus others such as the current practice of shackling pregnant women in prison during labor, continue to provide the much needed groundwork to begin marking the link between sexuality, reproduction, and criminality. More importantly, these examples provide for this project the springboard to discuss the relationship that exists between reproduction, sexuality and the criminalization and incarceration of black women in the U.S.

This is particularly important and is considered here in order to begin the dialogue that addresses the question about why it is important to locate reproduction within larger dialogues around racial domination and control. It also strives to reveal how reproduction works in

conjunction with other technologies of racial and gendered oppression. In doing this, I attempt to locate the continuities that may exist between the black female's experiences during slavery, the significance and location of her presence for the maintenance of the racial and social order during slavery and the current phenomenon of the growing incarceration of black women in the United States, and her experiences of reproduction. In other words, including an analysis about incarceration and its links with Black women's reproduction allows for a discussion around the complexity of, and association between, various mechanisms of oppression.

Although, the intellectual stream as presented above provides a more theoretical understanding of interlocking systems of oppression, it does in fact manifest in the ethnographic depictions present in the project and in the following chapter. For example, central to the reproductive work of the MAMAS organization is the explicit assertion to highlight the link between reproduction and incarceration with their "womb-to-prison pipeline" analysis. Moreover, understanding the history of Black women from slavery as well as their reproductive experiences since then, helps to fully contextualize the ways in which various forms of oppression are connected contemporarily to their reproduction. The narratives that arise from the focus groups and conversations with Black women locally as presented in chapter two also provide salient examples of the ways in which criminalization, surveillance, and reproduction concretely manifest around birth, health care, and the participation in state systems including the welfare state. Overall, it is important to try and unpack this association not only in regards to the criminalization of Black women and their reproduction but also to explore the claim that the effects of reproductive experiences has very large and far-reaching social implications.

Reproduction as a Tool of Genocide

If we can recognize reproduction as one piece of a multi-threaded rope of oppression, than it follows that we can also support its conceptualization as a critical tool of genocide. This of course is have been evidence by a number of feminist theorist and scholars who have recounted histories of sterilization and conquest in their communities (Collins 1991; Roberts 1999; Smith 2005). In particular, the role of reproduction in the bio-political power of the state has been evidence in the writing of Foucault (1988), Jacquie Alexander (2005), among others.

According to a document drafted by the UN at the United Nations at the 1948 Genocide Convention:

> … genocide means any of the following acts committed with intent to destroy, in whole or in part, a nationalist, ethnical, racial, or religious group, as such:
>
> (a) Killing members of the group
> (b) Causing serious bodily or mental harm to members of the group;
> (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
> (d) Imposing measures intended to prevent births within the group;
> (e) Forcibly transferring children of the group to another group (United Nations 1948)

Although at first glance, it seems that the obvious and most relevant part of this definition would be the phrase next to letter (d) Imposing measures intended to prevent births within the group. Nevertheless, the issue of reproduction and black women's bodies in actuality encompasses all of (a) through (e). If one recites not only the statistical facts around black women and birth in the United States as released in the Amnesty International report but also the various manifestations of reproductive violence as articulated by Dorothy Roberts (1999) and Saidiya Hartman (1997) to name a few, one can draw a connection between the UN's definition of genocide and the utilization

of the reproduction as a tool of that genocidal project. Moreover, other authors have discussed the relationships between reproduction and genocide by focusing such topics as birth control or abortion (Caron, 2010; Marable, 2000; Weisbord, 1975).

For the purposes of this project, the effects and enforceability of the UN statement is of no concern. Instead, this definition is useful as 1) a theoretical construct to explain the significance of reproduction in understanding the mechanisms of genocide, 2) a means to expound upon the reality of death and suffering in black women's reproductive experiences in the United States, and 3) as presented in the concluding chapter of this work, the ways in which dialogues and work that focus on reproduction and reproductive justice work have the potential to be strategic and powerful acts of resistance against the genocidal project.

ON METHODOLOGY

Irma McClaurin in her edited work *Black Feminist Anthropology* (2001) states that

> Black feminist anthropological theory asserts that by making the complex intersection of gender, race, and class as the foundational component of its scholarship, followers gain a different and, we are convinced, fuller understanding of how Black women's lives (including our own) are constituted by structural forces. The multiplicity of coping strategies and forms of resistance that Black women adopt globally to contend with the structural and psycho-cultural dimensions of racism, sexism, and the other myriad forms that social inequality can assume in people's lives are an essential component of a Black feminist anthropological theorization. In taking on the role of producing meaning, we as Black feminist anthropologists align our commitment, skills, and resources with those of the existing coterie of 'organic intellectuals' that can be found in every community and who '[represent] the interests of the oppressed, raising their consciousness of exploitation, and leading them in the direction of resistance and counter-hegemony…(15)

I consider this dissertation to be interdisciplinary in nature as it draws upon and traverses multiple disciplines such as Anthropology, Black Studies, Gender Studies, and Sociology to name a few. Yet, my methodological approach to this project falls in line with a Black Feminist Anthropological theory and praxis rooted generally in the rich legacy of Black feminism, African-American intellectual tradition, and moving towards an "anthropology of liberation"[12] (McClaurin, 16). I have attempted to weave into my work various aspects of a feminist and epistemology which includes an understanding of the politics of location, an anti-racist and anti-oppression framework, consideration around the rewriting of violence and violent acts, and research that takes careful consideration about the politics of the activist-scholar (Sudbury, 1998; Alexander, 2006; Hartman,2008; Collins, 1999; Mohanty, 2003; Hale 2008)

As a Black woman, conducting research that centers on Black women, I adopt the role of the "native" anthropologist, with all of the complexities and negotiations that come with this location, and have created in this work an auto-ethnography of sorts. Responding against critiques of acculturation and gaze that purportedly and detrimentally influence the critical analysis of "native" anthropologists, McClaurin asserts that

> …'native' anthropologists in general have created scholarship (and new ethnographic interventions) in which our difference, our otherness, serve as valuable points of reference. Black feminist anthropologists, in particular, embody several traditions, all of which emanate from what Foucault calls 'subjugated discourses.' That is, Black feminist anthropologists derive their inspiration from the traditions of women-centered, feminist, African American, vindicationist, and 'native' scholarship that are inherently reflexive and oppositional, and that seek to challenge the historical foundations of anthropology… (60).

[12] This term was originally coined by Faye Harrison in her edited volume entitled *Decolonizing Anthropology: Moving Forward Toward an Anthropology of Liberation.*

Encompassed in this project are the intersections of multiple disciplines, the perspectives of the native anthropologist, the intricacies of lived experience, and the consequences of complex social relations in the field. Nevertheless, the outcomes of this hodgepodge reflect an intricately situated reality that sheds lights on the particularly multifarious Black reproductive experience.

While my impetus for doing this work was in no way informed by a desire to be in conversation with the existing anthropological works on birth, it is important to note the ways in which drawing on this legacy of Black feminist anthropology with a topical focus on birth also provides a critical intervention in the growing literature on birth in the discipline of Anthropology. This compartment of emphasis while growing in magnitude, for the most part excludes Black American birth experiences. Ultimately, my position as a Black anthropologist conducting research on birth, situates me in such a way that I am in direct conversation with these other anthropological texts. As a result, I find it necessary to acknowledge the current literature and indicate where I feel this project intervenes.

The book *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* in its introduction provides an in depth review of the legacy and literature in the field of the Anthropology of Birth. It pays homage to Bridgette Jordan for her work in *Birth in Four Cultures* and honors other anthropologists work such as Margaret Mead Niles Newton (1967), and Sheila Kitzinger (1971; 1981; 1987; 1992; 2000; 2002; 2005; 2006) among others as the foremothers of the Anthropology of Birth (cite). Literature in the field of anthropology and birth has been situated geographical in various settings around the globe such as Egypt (Morsy 1982), Greece (Lefkarites 1992), Sierra Leone (McCormack 1982), Mexico (Browner 1983), and in various places in Europe (Kitzinger 1978) to name just a few. While these various studies helped to grow this

anthropological focus, I feel that my particular interest and contribution fits better in the examinations of birth in Western culture and in particular in the United States.

The introduction to *Childbirth and Authoritative Knowledge* interestingly cites very few studies that focus on the experiences of Black women in America. They reference the work of Gertrude Frasier who examines the history of Black Granny Midwives in Virginia (1998) as well as Molly Dougherty and Debra Susie (1988) whose work also looks at Black Granny Midwives. They also reference one other study by Hahn and Muecke in 1987 that includes in a comparative study the experiences of low-income black women. Laurie Wilkie, in her book the *Archaeology of Mothering* (2003), provides an archaeological perspective on mothering by examining the material culture of a Black midwife in Mobile, Alabama. Overall, even as the research on birth in Anthropology is a growing field, very little work is done and exists on the specifically on the reproductive and birth experiences of Black American women. My research helps to begin filling this critical gap. Furthermore, this project not only seeks to delve ethnographically into Black women's experiences of birth and reproduction in the United States but it also situates the data alongside clinical and qualitative data in other fields. It contextualizes the work historically in order to provide a more comprehensive portrayal of the social, economic, and political complexities around Black women's reproduction and birth.

The research for this project locates the grassroots organizing work of the MAMAS alongside national and state level legislation and data about maternal and infant health disparities. The work not only situates ethnographic experiences within the larger repertoire of quantitative health literature on disparities but it also historicizes the work alongside Black Feminist theories of the body, history, and Black women's reproduction. Drawing from extended participant observations, interviews, focus groups, policy research, statistics, and archival work, this project

unpacks the large disparity that exists in maternal and infant health outcomes for Black American women and the ways in which policy, community organizing, and other geo-political factors contribute to, mediate, or remedy this phenomenon.

MAMAS was created not only with an intent to organize around basic necessities and to work towards creating the just and loving world that the members envisioned, but it was also about acknowledging the oftentimes invisible and political work of mothering and caretaking. This was not only inclusive of biological mothers. It encompassed and articulated a broader understanding of what "mothering" looked like and about who could be involved in the act of "mothering" and "caretaking."

While the focus of (re)conceptualizing the concept of mothering was only one aspect of the work of the MAMAS, this project similarly centers the experiences and perspectives of poor and working class mothers of color in order to revamp the ways in which we see birth and reproduction in the United States. While theorists of the Anthropology of Birth acknowledge the contribution that theorizations of motherhood, reproduction, and birth provides to social theory, the exclusion distinct of the experiences of Black American women limits the ability to forge a comprehensive analysis of reproduction and birth in the United States. As Patricia Hill Collins asserts, centering those on the margins, and particularly the experiences of the (M)Other, (Scheper-Hughes 1992; Rowley 2003) in our inquiries into birth and "motherwork" presents different concepts and themes that drastically change the outcomes of our analysis (Collins 1993). Instead of including the predominant one-liner about disparate racial, ethnic, and classed experiences of birth in the United States, while still basing their analysis on the normalized white middle class experience, this project roots discussions around reproduction in the United States' racialized history and begins a dialogue that reveals the complexity of Black American reproductive

experiences and its impacts on the larger United States reproductive landscape.

Overall, I argue that centering Black women and conceptualizing reproduction in the way described thus far, allows for a broader conversations around the state of American social reality. Specifically, this dissertation despite its focus on reproduction also includes a heavy structural and institutional analysis and as a framework about the larger issue of social transformation. Each chapter, though dealing with various issues impacting reproduction in Texas and Austin, in actuality contributes to these broader and critical dialogues in a complexity of ways.

Given this, **c**hapter one provides a brief overview of both the current national legislation impacting Women's health as well as current controversial legislation around women's health in the state of Texas. I argue that while women's health is framed as a women's rights issue and that the policy decisions around it are supposedly "race-neutral," in actuality the impacts of the policy on the ground and the inextricable link to women's health and Medicaid, expose the racially discriminatory nature of the policy. Moreover, I propose that not only are black women overwhelmingly impacted by these policies but they also fall in line with the historical role of the state and law that 1) renders black women's suffering illegible/invisible and 2) is rooted in racist ideologies around black women, their bodies, and their reproduction.

Chapter two provides relevant information around the current rates of infant and maternal mortality for black women on a national level as well as in Travis County. Given that black women are four times as likely to die from birth related complications and black babies are 2.5 times as likely to die, this chapter explores what the current research says about the root causes of these disparities-including the impacts of stress caused by the experience of long term exposure to racism. With this information placed alongside the information about current healthcare models and information from focus groups with black women in Austin, I argue that drawing upon the

legacies of Black Granny midwives and building stronger relationships and creating loving supportive communities to combat the impacts of racism stress could be our best immediate solution to these maternal health disparities.

Chapter three examines how the inherent nature of institutions hinders the preservation of counter-hegemonic work and radical social transformation. Using the examples of the MAMAS and their various engagements with various institutions around the reproductive health of Black bodies, this chapter provides concrete examples of why engaging in institutional collaboration around reproductive health is counter-productive and rarely provides the potentiality for progressive work. In the end, I assert that we must a radical imagination that creatively concocts alternative way to exist, work, and operate outside of established systems and institutions and is courageous enough to believe our utopian and radical imaginings are boundless and feasible.

The final chapter gives insight into the inner workings, relationships, and organizing structure of MOCR. I argue that organizing around blackness within this structure proves to be difficult given the hardships that arise in trying to organize around challenging race, class, and color dynamics. Ultimately I maintain that the process of relationship building, love, and support proved to be the most transformative and critical part of the organizing work.

Finally in the conclusion, I argue that reproduction is not only significant as a tool of genocide but is critical as a means of resistance and rebellion against death. Incorporating love, hope, support, desire, pleasure and community into our blueprints for social transformation and may be a way to incorporate resistance into our day to day and ultimately serve as our primary means of survival.

While this dissertation offers many critical interventions, it is not without its shortcomings and gaps. In particular, while this project does acknowledge some of the geo-spacial and geo-

political contributions to black displacement in Austin, the reach of my geo-spacial and geo-political analysis only goes as far as an examination of gentrification and the declining population rate of Black individuals in the city. In other words, it fails to examine the many other aspects of the historical and changing black political economy that exists (or not) in this local setting. Nevertheless, a more in depth analysis of Austin's history as well as more specifics and around urban planning, political circumstances and representation, and Black political economy would significantly bolster my argument and deepen the insight provided thus far.

Chapter 1: Blackness and The Political Landscape of Women's Health Policy

"The notion of incorporation is intended to specify more precisely the extent to which policies in fact offer benefits and protection to minorities and enable them to attain a measure of status within the national community. Incorporation is thus the obverse of the idea of "social exclusion," or a concept that denotes not simply chronic poverty or unemployment or even exclusion of social benefits but social marginality and isolation…Incorporation is more than just the lack of discrimination in awarding benefits and protecting rights; protection against deliberate, overt discrimination-differential treatment of individuals explicitly because of racial or ethnic characteristics-is a necessary but not sufficient condition for full incorporation. Incorporation also encompasses rules and procedures that allocate benefits, rights, and status. This may happen in such a way that some groups are systematically favored while others are systematically deprived. Such group imbalances may occur even in the absence of discriminatory intent through the unconscious operation of program administration, as when uniform, apparently race-neutral rules are applied unevenly to different groups. One group may be less inclined to seek benefits, for example, whether because of fear, lack of access, or cultural differences among groups. This kind of administrative discrimination also occurs within a political setting, and policies themselves can encourage such discrimination by shifting discretion over the rules and their application to lower levels of government and to front-line administrators or by adhering to standards of policy "success" that bias implementation and evaluation. Policies may thus be discriminatory even if they are applied in scrupulously neutral ways."

-Robert C. Lieberman, *Shaping Race Policy* (2005)

I sat in my bed with my legs crossed and my back propped up against two flimsy and flattened out pillows. I gently resituated my body trying to get into a more comfortable position while also attempting to not disturb my sleeping four year old whose body was curled up and nuzzled against me with one hand resting on top of my left thigh. It was around one o'clock in the morning. This was way past my usual 10pm knock out time and my eyes were burning with exhaustion and the desire for sleep. I continued to stare entranced at the screen of my laptop. I could feel my heart drumming against my chest as my emotions jumped from anger, to sadness, to disgust, to joy, to exaltation, and even to utter disbelief. My eyes strained as I continuously flipped between my twitter timeline, Facebook, and the live streaming of Texas State Senator

Wendy Davis's attempt at a thirteen hour filibuster in the Texas Senate to impede the passage of HB2/SB1. This bill would ban abortions occurring after 20 weeks of gestation as well as require that all abortions- even non-surgical ones- be performed at a Licensed Ambulatory Surgical Center (ASC). If passed, given the requirement for all abortion clinics be up to standard with ambulatory surgical centers, this bill would effectively cause the closure of all but five abortion clinics in the state of Texas (Texas Policy Evaluation Project 2013).

I observed the pictures flooding the internet of orange clad protestors inundating the capitol and the materialization of what later would be coined by the participants as the "people's filibuster." I gapped in awe at what I perceived as a public display of legislative disarray and blatant procedural manipulation by the president of the house. "At what point must a female senator raise her voice to be recognized by her male colleagues," stated San Antonio democrat Leticia Van de Putte. As I heard the swelling voices of the crowd chant in collective rebellion my eyes welled with tears of inspiration and yet overflowed in globules of sorrow and rage.

A part of me wished I was there. In that moment Texas was making national news and I wished that I could be there in the flesh witnessing it all go down. Earlier, while sitting on my mother's couch, I had contemplated whether or not to head down to the capitol with my daughter to participate in the demonstration. Even though I hadn't quite figured out how to explain the significance of what was happening in four year old terminology, I wanted her to see it. I wanted her to understand what happens when politicians delegate over bodies, oblivious or unconcerned with the real life implications of their decisions. I wanted her to see the potential power of the people and feel the energy that circulates in collective political actions. Yet, when I saw the heaviness in those big brown innocent eyes I decided to head home instead. Stroking her sleeping head, I wept for her and for myself. I wept because the need to fight for full autonomy over my

body still existed. I wept because as a black woman this fight over my body has been and continues to be etched into my existence and while I stood inspired by what was transpiring before my eyes, I knew that even if this fight against HB2 was won, it would have little to no impact on my struggle. It was only a small piece of what justice looked like to me. I knew that when large groups similar to the one converging in Austin rallied around "rights" and "access," they rarely acknowledged the specificities of my black woman struggles- let alone the history behind it. I knew from past experience that even these supposedly progressive political spaces were in actuality quite exclusive and rarely made space – intentional or otherwise- for the involvement and prioritization of the marginalized groups overwhelming impacted by these decisions-liberal whiteness fighting consciously, or subconsciously, "on behalf of" the plight of the other or effectively erasing it with the rhetoric of the collective "all."

As the confusion around the final vote ensued, pictures, videos, and social media updates heralded the procession of state troopers to the capitol. News of protestor's arrests began to surface on the social media scene and my usual and considerably justified fears around policing took over my imagination. I conjured up images in my head of Texas state troopers ripping my child from my arms for daring to enact my "right" for political expression. I envisioned screaming and wailing while a musical mash up of the Star Spangled Banner and Texas Our Texas played triumphantly in the background; flags waving. *Nah…I'm good,* I thought. I closed my computer sure that I would hear the final verdict on the vote in the morning. I rolled over, clicked off the lamp on my night stand, and embraced my daughter snuggly, grateful that I had another night with her and wishing my arms could always shield her from the perils of the world.

The next day, news would break about the Republicans' attempt to the change the timestamp on the vote and the people's success at momentarily stopping the bill. HB2 of course

would later be revived and ultimately pass during the subsequent special legislative session called by Governor Rick Perry. This occurred in the face of the considerable mobilization against it.

***

This chapter draws a connection between current conceptions of women's health policy and blackness to explicate the way current policies function to maintain and contribute to established racial formations via black women's reproduction. It will begin by providing a brief overview of the impact of recent federal legislation on women's health policy nationally as well as Texas's response to this legislation and its own controversial contribution to women's health policy at the state level. Next, the chapter delves into the larger implications of these various policies, contextualizes them alongside other writings about race and policy, and historicizes them against writings that illuminate the role that law and policy has played in relation to the black female body. Finally, the chapter will explain the ways in which purportedly race-neutral policy is discriminatory is nature based on the prevalence of disparate impacts, how these policies are rooted in a history that perpetuates the invisibility of black female experiences, and how public perceptions around welfare and blackness also influence women's health policy decisions.

In the 2012 presidential election year, the media was riddled with controversial commentary surrounding reproduction and women's health from the conservative right. From U.S. Republican Representative Todd Akin's comments about "legitimate rape" to Indiana State Treasurer Robert Mourdock's comments asserting that pregnancies resulting from rape were "what God intended," the controversial nature of issues surrounding women's health began to rocket to the forefront of the political terrain. While many of these comments were met with strong opposition and seething critiques from the general public and both Democrats and Republicans alike, the foundational ideology underscoring these problematic comments still managed to

manifest in proposed legislation at the state level. While much of the most controversial legislation coming out centered on conservative attempts to restrict access and availability to abortion services, a lot of the push back was and is also a response to the passage of the Patient Protection and Affordable Care Act also known as "Obamacare". This piece of groundbreaking legislation, signed in 2010, not only made significant strides towards opening access and improving women's health care and preventative health services nationwide but it included provisions that would change the eligibility requirements and ultimately significantly expand the enrollment and availability of Medicaid.

Inherent in this push back from Republican run states is the age old debate about the role of the government and whether it is the responsibility of the government to provide for the "deserving" or as some would coin it the "undeserving" and "able-bodied" poor. From the inception of the Social Security Act signed by President Franklin D. Roosevelt in 1935 to "Reaganomics" and into Bill Clinton's 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), welfare and its reform has been a politically divisive and overwhelmingly partisan issue that seems to linger on the frontline of the political agenda. Recently, discussions around welfare have also managed to manifest within current dialogues around women's health.

What is noteworthy about the current debates around women's health is the way in which conversations tend to focus on issues of access, agency, rights, and choice and frame it as a women's rights movement. While these dialogues do manage to bring gender inequalities and inequities to the forefront, this primarily gendered narrative fails to adequately acknowledge the racial implications as well as the underlying ideologies that inform much of the political and legislative decision-making around this issue. In other words, framing issues around women's

health as merely a "women's rights" issue in essence helps to erase the way that these policy decisions have unequal impacts across race, class, and even sexuality. This erasure obfuscates the discriminatory nature of women's health policy that has broader reaching implications outside of gender. It also perpetuates and recreates historical transgressions and consequences of policy that failed to adequately address issues of race. This includes both examples of explicitly racist policy during the era of slavery and Jim Crow for example, to the more present constructions of policy where race functionally operates underneath the surface. Generally, women's health policy is not categorized as "race policy." In fact, it is more likely to be categorized as a "race-neutral" or even "color-blind" attempt at managing issues pertaining to women's health. Yet, I argue that given the relationship between the architects and practitioners behind these policies and the nature of the individuals and communities most impacted by them, it seems that drawing the association between women's health policy and race is essential. In particular, the inextricable link between access (and lack thereof) to women's health services and Medicaid in these conversations is glaring. It begs to consider a few critical questions.

Given the uproar around women's health that stems from politicians attempts to limit access and choice, how is it that race remains only an undercurrent or even afterthought in these political debates? This is in lieu of the republican run states push back against Medicaid expansion which would in turn increase availability and access to care for poor and underserved communities and in particular women. How is it possible to talk about limitations to access and choice without also talking about which populations have the least amount of access and choice and therefore the most overwhelmingly effected by these decisions? Some lip service is given to the impacts of Medicaid expansion on the poor as well as the impacts of the ACA on services for poor women of color. Yet, it begs to question how welfare remains in the political imagination as an issue almost

inseparable from race, yet current debates around women's health--now linked to the expansion of the welfare rolls--fails to include race in it's the framing. While current women's health debates are oftentimes strictly conceptualized as a gendered issue, it is important to also acknowledge and evaluate the subtle and overlooked racial underpinnings of current legislative decision making and women's health policy and agenda setting.

WOMEN'S HEALTH AND THE AFFORDABLE CARE ACT

Federal legislation has had a huge impact on women's reproductive health. Presently, one of the major and also controversial pieces of legislation is the Patient Protection and Affordable Care Act (ACA). The ACA, at its essence, is an attempt by the federal government to implement market driven health insurance reform through the creation of exchanges that would widen and diversify the participant risk pool and therefore lower the cost of insurance. Central to this intervention is the "individual mandate" that requires that all individuals either obtain the minimum insurance coverage (whether that be through an employer or by participation in the exchange) or pay a monetary penalty. Consequently, after President Obama signed the ACA into law in March of 2010, a joint lawsuit, spawned by the two court cases *National Federation of Independent Business vs. Sebelius* and *Florida vs. Department of Heatlh and Human Services*, was filed by 26 states challenging the constitutionality of the act. Although the law was upheld as constitutional by the Supreme Court, including the individual mandate piece, the Court's decision on another even more controversial piece of the law left a door open for state discretion (Cortez 2013). While much push back arose against the compulsory nature of the individual mandate, even more dissention arose at the state level in regards to ACA's proposal to expand the Medicaid. Although this expansion was not intended to be elective, the Supreme Court ruled that Congress could not impose this measure on the states, cited as "unconstitutionally coercive" by the filing

parties ("Defending the Affordable Care Act" 2012). Given this ruling, state participation in the Medicaid expansion was rendered optional. Nevertheless, the expansion program by the federal government is being offered as an incentive by promising to cover 100% of the expansion costs for the first three years and then covering at a declined rate for the following four years. This would mean that the program would ultimately be backed by federal government for six years ("HHS Finalizes Rule…" 2013). Yet even given this support, many states-predominantly red- are opting out.

Much controversy surrounds the enforcement of the ACA. Many provisions attempt to fix benefit issues, pre-existing condition and maternal care issues in particular. For example, under the ACA there will be more affordable health insurance options that allow for women to choose from a variety of selections or stay with their current health insurance and provider. Furthermore, the ACA includes provisions that prohibit denial due to pre-existing conditions as well as gender bias in coverage and denial for conditions such as breast cancer. These new provisions, including the requirement for all insurance providers in the exchange to cover maternity, are a significant step toward providing adequate care for women in the U.S. According to the National Partnership for Women and Families (2013), here are some of the specific women's healthcare issues addressed by the new provisions put forth in the ACA.

Maternity Coverage

Under the ACA, insurance policies, both public and private, will now have to cover Maternity Care as part of their insurance packages. Yet, The Department of Health and Human Services has left the responsibility of outlining the specific services that will be provided under the umbrella of "maternity care" at the discretion of each state. The ACA also proposes access to home visitation

services for new mothers, post-partum depression, smoking cessation services, as well as a requirement for employers to provide appropriate time and space for breastfeeding mothers.

Access to Community Clinics:

Due to the large number of individuals who are currently uninsured in the country, it follows that this same population must rely on resources and services provided from free or community clinics, known as essential community providers (ECP). With the changes under the ACA, all individuals must be insured yet most private insurances do not cover services at ECP's. Therefore, legislation under the ACA requires that private insurance companies contract with ECP's. This will assure that women will not have to change their providers under the new legislation and it also allows for women to seek services from clinics in their own neighborhoods and communities.

Sex Education for Teens:

The ACA is providing a significant amount of funding for states to implement sex education classes for youth under the Personal Responsibility Education Program (PREP). The funds will be used to support education around abstinence, pregnancy, STIs, and HIV/AIDS. This funding also continues to support present abstinence-only education programs as well.

Abortion Coverage:

While the ACA allows for insurance companies to cover abortions it does place restrictions on that coverage. The ACA does not allow The Department of Health and Human Services to label abortion as an "essential health benefit" and it requires that all funds and payments for abortion services be handled separately from any monetary exchange for other health services. Furthermore,

the ACA allows states to prohibit insurance companies from covering abortion services and does not require any health facility or company to provide or pay for abortion services.

Expansion of Family Planning and Women's Preventative Services*:*

With the proposed Medicaid expansion under the ACA, more women will be insured and therefore will have access to family planning services otherwise inaccessible without insurance. Furthermore, the ACA requires that "preventative services" be provided without any cost to the woman. This includes access to contraception. The term "preventative services" has been divided into the following sub-sections: 1) Screening for gestational diabetes, 2) HPV testing alongside cervical cancer screenings for women over 30, 3) Counseling for STIs, 4) FDA approved contraceptives and supplies, 5) Breastfeeding counseling and equipment, 6) Screening and counseling for intimate partner violence, 7) Screening and counseling for HIV, and 8) Well woman visits.

Although these strides in women's healthcare have been championed by many, red states are not the only ones requesting to "opt-out." This is particularly true when the issue of contraception becomes central to the conversation. The ACA brings with it many dilemmas and it also received particular push back from religious institutions. Given this, the ACA includes an opt-out clause for "religious institutions" so that they do not have to provide coverage for contraceptives to their employees. Religious institutions were those groups who met the following criteria: that their purpose is to inculcate religious values, they primarily employ and serve people who share their religious tenets, and that they are nonprofit groups under federal tax law (Bronner 2013). There was also considerable pushback from religious *affiliated* institutions that for many reasons did not meet the criteria for a religious institution. Initially, and in response to the pushback by *affiliated*

institutions, an opt-out clause was also included that allowed for a one year period of transition and preparation. This concession was still met with a large degree of opposition. Finally, in February of 2013, the decision was made that the burden of providing coverage for contraception would be placed on the insurance companies rather than on the institutions themselves. While many were content with this compromise, some are still unsatisfied with the decision (Pear 2013).

While the opinions and responses of individuals, insurance companies, and other institutions to the passage of the ACA have been the source of much debate, what is most glaring in these dialogues is the issue of federalism- state versus federal power. At the root of this contention is whether or not the ACA oversteps its jurisdictional boundaries with the passage of the ACA. The Supreme Court found that it was important that the federal government not proceed in a dominating and coercive manner in regards to implementation of the ACA. Consequently, many states have made it abundantly clear that they do not plan to expand Medicaid nor participate in the exchange. This ruling is unfortunately rendering a critical component of the ACA, the expansion, ineffectual.

A recent New York Times article highlighted the fact that the 26 states who have decided to reject the expansion are 1) overwhelmingly located in the south, 2) are home to over half of the country's population, and 3) house approximately 60 percent of the uninsured poor in the U.S. (Tavernise and Gebeloff 2013). The additional impact of this according to the article is that around two-thirds of the countries black populations as well as single mothers and in particular black single mothers, live in these 26 states and will be left ineligible for both the benefits of the Medicaid expansion as well as any subsidies offered under the ACA. Ultimately, despite the seemingly honorable intentions of the ACA, the structure of the U.S. political system that reverences the dynamics of the shared power of federalism leaves the door open for legislative

discretion that perpetuates historical and geographical patterns of gendered and racialized disenfranchisement.

In Texas, various justifications for rejecting the expansion have been asserted such as the lack of long-term sustainability or the logistical struggles for participating in the exchange on a state level. Yet, many have felt that opting out of the expansion is passing up on an opportunity to increase adequate healthcare for poor Texans and in particular increasing access to critical services for women in the state. Interestingly, this decision seems to align with a history of restrictive legislative decisions that have negatively impacted women's health in Texas.

TEXAS TOUGH

The state of Texas has had a long history of enacting laws that place them on the conservative side of the public and political discourse but have also proven to have a negative impact on women's health in the state. Reproductive rights, and in particular abortion, continues to be a debated issue in state legislature. Since its legalization in 1973 with the Roe vs. Wade decision, abortion has remained to be a contentious issue in the legislature, with advocacy groups, and amongst individuals. Interestingly, amidst the tussles around the ACA, Texas has also managed to enact various anti-abortion laws that extremely impact and limit access to abortion services for women in the state.

In 1999, the Texas Legislature passed S.B. 30, the Texas Parental Notification Law. This law requires parental notification for any minor seeking an abortion (Texas Senate Bill 30 1999). The repercussions of this bill were a decrease in the number of abortions by 11% for 15 year olds, 20% for 16 year olds and 16% for 17 year olds (T. Joyce et al 2006). In 2003, the Texas Legislature passed H.B. 15 also known as the Woman's Right to Know Act or the "Sonogram Bill". Rick

Perry first brought this bill to the forefront by declaring it an "emergency item" at a Texas Right to Life rally (Hoffman 2011). The bill eventually passed and became effective on September 1, 2011. It states as a requirement that all physicians must administer a sonogram 70 to 24 hours before an abortion is performed so that patient is able not only see images of the unborn child but also listen to the fetal heartbeat. Furthermore, this law also requires that the physician must provide information and printed materials describing the unborn child and stages of development, listing resources for alternatives to abortion, and also discuss informed consent. After receiving the required information, the woman is then sent away and must wait at least 24 hours before the procedure will be done (Texas Department of State Health Services 2012).

While this bill was framed as an attempt to inform women of their rights and increase knowledge around the decision of abortion, many viewed this bill as an attempt to decrease the prevalence of abortions and ultimately strengthen some of the already existing barriers to accessing these services. Interestingly, much of the push behind this bill was fueled by powerful conservative anti-abortion interest groups in the state such as the Texas Right to Life. Ultimately, Texas's incessant obsession with limiting abortion in the state unfortunately also had larger impact that effected the ability for women to access general health services in the state. This was done with the passage of The Affiliate Ban Rule in 2012 that single handedly dismantled the federally funded Woman's Health Program (WHP) in the state.

The Texas Medicaid Women's Health Program (WHP) was established by S.B. 747 during 79th Texas Legislative Session and was first implemented on January 1, 2007 (Health and Human Services Commission 2010). The WHP, authorized by Section 1115 of the federal Social Security Act, is a Medicaid demonstration waiver that allows some standard Medicaid eligibility requirements to be waived to expand access to preventive health and family planning services to

low-income women meeting certain criteria. This Texas Health Care Transformation and Quality Improvement 1115 Waiver allows states to try out programs that would help meet the objectives of the Medicaid statute. The waiver applied to Texas women below 185 percent of the federal poverty level (FPL), or the level they would be covered by Medicaid if they became pregnant and therefore increased their family's size by one child. The federal match rate of this the WHP was 9:1, with the federal government contributing around $36 million of this program (2010).

In 2009, DSHS Rider 69 was established. This prohibits state funds from being used to pay the costs of abortions provided by centers contracted with DSHS and asserted that organizations that provide abortions must be separate from entities contracting with the Women's Health Program. With the passage of the Affiliate Ban Rule, state agencies were prohibited from providing funds to any organizations affiliated with abortion providers. Organizations affiliated with an abortion provider would have to separate into two entities in order to receive state funding: one that provides family planning services and another that provides abortions. This division would further ensure that no state funds were linked to abortions.

Consequently, when the WHP was due for renewal in January 2012, the enactment of the Affiliate Ban rule led to the loss of federal funding. Ultimately, the Affiliate Ban Rule authorized the exclusion of organizations affiliated with abortion providers from participating in the state Medicaid waiver program (the WHP). Given this, the renewal was declined by Centers for Medicare and Medicaid Services (CMS) because it went against the Social Security Act and restricted patients' rights and ability to receive services from the family planning provider of their choice. Prior to the passage the rule, CMS encourage the Texas government to reconsider and even granted a temporary extension of the Medicaid waiver. The Affiliate Ban Rule passed anyway (Attorney General Greg Abbot 2011). Texas has now taken over the WHP, renaming it the Texas

Women's Health Program. This program allows the state to exclude such organizations as Planned Parenthood who provide abortion services but also knowingly forgoes the 9:1 federal funding match rate.

Finally in 2011 during the 82nd Legislature, the budget for family planning services was also cut. This further exacerbated many of the already mounting women's health access issues in the state. Funding for family planning services was reduced by two thirds, with the budget decreasing from $111.5 million to $37.9 million (HB 1 2011). The remaining funds of $37.9 million were divided into the following three tiered system:

- Tier 1 funding is available to public entities providing family planning services (e.g. Health departments).
- Tier 2 is available to non-public entities (e.g. non-profits) that provide comprehensive primary care in addition to family planning services.
- Tier 3 is available to non-public entities that exclusively provide family planning services (Joseph Potter et al 2012).

Recent Texas legislation has quickly proved to have serious repercussions in Texas. Cuts to family planning have caused 24 family planning clinics to shut their doors and approximately 57 other clinics were forced to reduce their hours. The Tier 3 Clinics which originally served approximately 41 percent of women receiving services through the WHP or other public funded family planning programs, have experienced the most closures and reduced hours. The Texas Department of State Health Services reduced the number of family planning organizations funded from 76 to 41 and the number of providers in Texas that accepted Medicaid dropped from 3,500 to 2,449 providers and many would not accept WHP patients at all. What was significantly

detrimental about the cuts was the fact that nearly half of all services provided through the WHP were provided by entities that the Affiliate Ban Rule prohibits (Mann 2012). Overall, recent legislation is decreasing the women served in Texas and increasing the number of unintended pregnancies in Texas. These changes in legislation endanger women's access to health services in Texas. Moreover, past and present reproductive rights legislation has drastically impacted the high number of Medicaid births and uninsured residents in the state. Texas is home to the highest number of uninsured residents in the nation, with one in four Texans lacking an insurance plan (Jones 2012). Moreover, Texas has the highest birth rate in the U.S. and over half of babies born have mothers on Medicaid (Kaiser Family Foundation 2010; Swartz 2012; "Texas Medicaid in Perspective" 2013). Given this, consideration of Texas' additional rejection of the Medicaid expansion under the ACA is also significant.

Opposing Medicaid Expansion

According to the National Partnership for Women and Families (2013), under the ACA approximately 19 million more women will become eligible under Medicaid. This is in part due to the fact that the ACA expands Medicaid to single individuals and families whose incomes are up 133 percent of the Federal Poverty Line. In a report released by the Perryman Group, an economic and financial firm in Texas, the ACA and particularly the provision to expand Medicaid will in actuality save Texas millions of dollars. According the analysis of the Perryman Group, expanding Medicaid provides three primary benefits: 1) expanding health spending and therefore increasing business activity, 2) reducing spending on uncompensated care and 3) health insurance reduces mortality and morbidity therefore increasing productivity (Perryman 2012). Furthermore, under the ACA, spending is matched by the federal government and reimbursement rates are at 90 percent. In other words, the state would only have to reimburse 1 dollar out of every 10

for Medicaid spending while the federal government would reimburse the remaining 9 dollars out or every ten. Ultimately, expanding Medicaid actually increases productivity for the state and basically pays for itself with the support of the federal government. In addition, when considering the specifics of contraceptive coverage, the changes under the ACA would save women approximately 600 dollars a year and employers who provide coverage actually save money in the long run.

The citizens and politicians of Texas are varied in their support of the ACA and Governor Perry's decision to deny Medicaid expansion. Many democratic state representatives were in support of the ACA and the new provisions that it was offering. In regards to women's health, two aspects of the ACA, birth control and abortion coverage provided by the law, were being directly challenged in Texas and was evident in some of the proposed legislation during the 83rd session. For example, as it is written, the ACA provides access to prescriptions for generic birth control will be available to women through their insurance at no out-of-pocket cost. Nevertheless, House Bill 649, also known as the Hobby Lobby Bill, was proposed in opposition to this mandate and would allow the state to exempt any "religiously-based" company (for example "Hobby Lobby, the store from which the name of the bill originated) from sales and taxes up to the amount that the company would pay in federal fines for not offering birth control coverage to their employees. According to the law, companies could potentially be fined $100 per employee per day for not adhering by this portion of the ACA. This could add up to the amount of $25,000 per year per employee (Aaranson 2013). Another example is the proposal of House Bill 997. This was another bill introduced to the Texas legislature that aimed to exclude abortion coverage from health care plans now required to cover them by the ACA. According to the Hyde Amendment (which became law in 1977), federal funds can be used to cover abortions in three distinctive circumstances: 1)

when the pregnancy is a result of rape, 2) when the pregnancy puts the mother's life in danger, or 3) when the pregnancy was a result of incest (Dept. of Health and Human Services 2013). Due to the fact that Texas does not offer funding for elective abortions, the bill's intent was for the state to be exempt from paying federal fees due to ACA requirements. The bill, however, also seeks exemption of minimum Medicaid insurance coverage for abortions of pregnancies resulting from rape or incest and does not provide a thorough definition of when an abortion may be performed to save the pregnant mother's life.

POLICY, REPRODUCTION, AND RACE: LARGER IMPLICATIONS

In beginning to unpack the most recent policy decisions around women's health both nationally and in Texas, it is first important to look at its impacts. Important to note is the particular focus on "discriminatory impacts" as opposed to "discriminatory intent." Research has shown that today explicit expressions of racist ideology have been consistently on the decline (Lieberman 2007). Given this, proving racist intent becomes increasingly difficult. Nevertheless, lack of demonstrable intent does not negate the fact that policy can still have disparate outcomes and therefore is inherently discriminatory despite its supposedly neutral conception. Regrettably, much of the full impact of the more recent legislation has yet to be seen and will reveal itself over time. Nevertheless, there is existing data that begins to examine the effects of current women's health legislation.

Impacts

As previously established, the implementation of the new ACA legislation holds promise in terms of making some significant strides towards improving women's healthcare access and coverage throughout the country. Although this will not apply to women who are non-citizens or to those

who are incarcerated, the new provisions around maternity care, preventative services, and the Medicaid expansion are said to increase the overall health of approximately 19 million women nationwide (National Partnership for Women and Families 2013). In particular, this legislation has the potential to impact poor women of color significantly (Ridley-Kerr et al 2012; National Partnerships for Women and Families 2013). Yet, as we have seen, the ACA is not free from complications and the Supreme Court's ruling on the Medicaid expansion has acute impacts and undercuts the power of the ACA. Moreover, individual state's autonomy to govern abortion services has played a major role in defending state's rights to manage women's health as they see fit. Much of the detrimental policy decisions as seen in Texas, for example, are a direct result of this allocated discretion.

Many of the measurable impacts thus far have manifested in increased barriers to accessing care. This of course, is in addition to many of the already existing barriers to adequate health care services such as transportation, childcare, health coverage, and the systematic and structural hindrances that make navigating the health care system problematic and difficult for many women in these marginalized groups. The extreme cuts to family planning effectively overruled all of the other barriers by replacing it with the biggest barrier of all-eliminating the availability of healthcare facilities and providers. Texas Policy Evaluation Project (2013) cites that after the cuts to family planning funding women 1) found it extremely difficult to locate a provider in their area, 2) found it more difficult to access information about contraceptive options, and 3) were no longer able to access free services and therefore would forego preventative treatment due to costs. Furthermore the Texas Policy Evaluation Project (2013) also found that as a result of the new abortion restrictions of HB 15 women1) experienced impacts on emotional well-being due to longer waiting periods, 2) they experienced both financial and logistical barriers to accessing abortion services,

and 3) the changes to the bill increased barriers but rarely altered the woman's decision about her choice to abort. The larger impacts of this on women's health generally as well as birth rates in the state has yet to be seen. Overall, these cuts more significantly impact those women who are low-income, women of color, and women who live in a rural setting (Texas Policy Evaluation Project 2013).

What is also a significant impact and repercussion of most of these restrictive policy decisions is the attack on reproductive agency and choice for women in the state. While patriarchy functions in oppressive ways that place non-male gender identifying people and their interests at the margins, race, class, and other markers of privilege can either relieve or exacerbate that experience. I argue that ANY discussion around choice and access is inseparable from the experiences of those groups who have historically been blocked from exercising choice and having access and their respective (in)abilities to perform such tasks. Therefore, with or without attention given to race and class in rhetoric, the agency, access, and choice of poor non-white women is at the core of the matter of women's health and what is ultimately at stake. Yet, more often than not, this reality does escape the narrative in both policy implementation and responses to it.

Ideological & Legal Underpinnings of the Relationship between Black Women and the Law

The process of subconscious and reckless politicking over the lives and health of non-white women is at the root of much of women's health policy decisions. Yet attempts at "color-blind" policy in a "race-conscious" and racially stratified society continues to be the chosen and yet ineffectual approach (Lieberman 2007). While much work is needed that addresses the repercussions of "color-blind" policy decisions, it makes sense that the lack of attention paid to race within these policies continues to result in racially disparate outcomes. If indeed prioritizing

the experiences and well-being of marginalized groups were on the forefront of decision making for most policy makers, one could argue that we would not have half of the disparities, inequalities, and inequities that exist today. This sentiment would be something akin to the application of the Combahee River Collective's notion that "if Black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all the systems of oppression" and applying it to policy design (Combahee River Collective 1983). Instead, what we see transpiring is policy design that perpetuates established social hierarchies. Part of this replication process is rooted in historical practices of serving the needs of the dominant group. In this case, the dominant groups refers to those individuals, groups, or institutions holding clout, position, money, resources, and consequently political power. Even despite the "browning[13]" of the nation, the historical and present conditions of our political structure are such that political activity continues to be dominated by the interests of white men.

To be clear, this is not to say that agenda setting cannot and has not in the past asserted the interests of marginalized groups. If this was the case, this country would not be able to tout in its history the civil rights movement or the strides that affirmative action made over the years. It can happen – usually with the correct political ingredients mixing in an ideal political moment. More specifically, these political shifts can also be attributed to the existence of multiple political issue champions and a large amount of political will and pressure from the ground. While these more successful examples are important to make note of, history shows that they were not without extreme opposition and continue to be challenged to this day. Consequently, it is safe to say that marginalized interests are rarely championed on the forefront of the political agenda. This is even despite the fact that addressing the issues of marginalized groups has overwhelming social,

[13] According the Census Bureau demographic projections, more than 50% of the United States population with be "minority" (i.e. anything other than non-Hispanic white) by 2050.

economic, and political impacts and consequences for country, state, and local communities. This supports the notion that policy making is in actuality rarely a logical or a linear process. Instead, it oftentimes manifests as a mixture of timing, political climate, people, and places that result in a new issue on the agenda and ultimately a new policy decision (Kingdon and Thurber 2011). Additionally, it is important to note that while policy making is oftentimes a non-rational process that ignores the needs of those on the margins, support for particular policies is never clearly cut across race, class, gender, or sexuality. Even those who have been historically marginalized can be supportive of repressive policies.

Useful for understanding this concept is Cathy Cohen's concepts of secondary marginalization (1999). Inherent in this notion are the ways in which intra group power dynamics result in internal processes of marginalization. In particular, Cohen references the subscription to politics of respectability in the black community, criticisms when there is a violation of social norms and behaviors, as well as the role of Black elites and the Black church in intra group marginalization. Consequently, these intra group variances, highly influenced by the growth of a Black middle class, play out in interesting ways in regards to policy. In fact, studies have shown that the population of Black people in the U.S. show varying degrees of support for race based policies such as affirmative action and towards welfare reform. More specifically, surveys have shown that a number of Black people are just as critical of welfare and its respective recipients as their white counterparts (Gilens 2000; Tate 2010; Price 2009; *Pew Research Center's Social and Demographic Trends Project* 2007) What this speaks to though, is the deep rootedness and wide-ranging investment in racialized, gendered, and sexed ideologies that inform the very structure and fabric of U.S. politics and society at large. Equally important to understanding the process of policy making is also examining the foundational ideologies that underscore the structure and day to day

processes of our political system. Policy does not exist in a vacuum. Specifically, given the absence of non-white narratives within women's health policy making, the foundational ideologies and historical underpinnings that govern the policy making process must be explored. Moreover, Black women have had a particular historical relationship to the law, policy, and how it related to their bodies and reproduction. Given the nature and focus of this work, it is important to pay specific attention to this particular history.

Hortense Spillers in her work "Interstices: A Drama of Words" (1984) cites the slave ship and the middle passage as the initial site of subjugation for the Black female body and Black female sexuality. She states that it is at this point that social and cultural attributes of enslaved Africans in the middle passage become suspended, ultimately erased, and then refashioned to fit the needs and culture of colonial society. Moreover, Spillers maintains that the discursive and ideological depiction of the enslaved black female situates her existence in a state of "non-being" meant to be the measuring stick and foil for white humanity. For instance, she states that Black women

> "…became instead the principal point of passage between the human and the non-human world. Her issue became the focus of a cunning difference- visually, psychologically, ontologically- as a route by which the dominant modes decided the distinction between humanity and 'other'" (Spillers 1984, 155).

This understanding of inhumanity had large ramifications on conceptualizations of Black female sexuality. For instance, Spillers maintains that the state of "non-being" then rendered the Black female as both hyper-sexed and unsexed due to the supposedly unbounded and boundless nature of her sexuality. She states "…the unsexed black female and the super sexed Black female occupy the same vice, cast the very same shadow since both are an exaggeration of the uses to which sex might be put…" (Spillers 1984, 164) leaving Black female sexuality open to be imagined by and fashioned for the usage of the dominant culture. This undefinable sexuality left the Black woman

open to the physical violence and sexual whims of the slave masters and their family and served as the measuring stick in the valuation of white female sexuality and virtue (1984).

Spiller's argument serves as a starting point in which to discuss the various ways that this classification of the Black female set the precedent that would continue in the United States for years to come. This argument lays the groundwork for understanding how the ideological serves as the foundation for conceptualization of the law. Saidiya Hartman asserts that the inhumanity and illegitimacy of Black womanhood and motherhood not only operate ideologically but more importantly within the legal context. Ideologically classifying Black women as an entity of non-being laid the necessary foundation to then establish legal precedents that would secure the status of Black women as property and legally unrapeable. For example, Hartman states that although the crime of rape was indeed written into 19th century common law, in actuality "rape of an enslaved black woman was an offense neither recognized nor legislated by law" (Hartman 1997, 79). Imbedded within this practice were not only ideologies about the lasciviousness of Black women but also the non-existence of Black humanity and the propertied entity's inability to participate in social comportments such as giving consent. In other words, if Black women were neither women, nor mothers, and if they were non-human and ultimately the white slave owner's property, then how can a Black woman be raped? Furthermore, given the statutes that declared that the child's status be determined by that of the mother, all children born to enslaved mothers were in turn enslaved and the property of the white slave master. Hartman asserts that

> "Motherhood was critical to the reproduction of property and black subjection, but parental rights were unknown to the law. The negation was effected in instances that ranged from the sale and separation of families to the slave owner's renaming of black children as a demonstration of his power and domination. The issue of motherhood concerned the law only in regard to the disposition

> and conveyance of property and the determination and reproduction of subordinate status…The law's concern with mothering exclusively involved questions of property… (Hartman, 98).

Ultimately, Black women's existence, centered on her reproductive potentials and sexual autonomy and only mattered in relation to her status as property (1997). In other words, "the essence of Black women's experience during slavery was the brutal denial of autonomy over reproduction" (Roberts 1999, 24). This "sanctioning of sexual violence against slave women by virtue of the law's calculation of negligible injury, the negation of kinship, and the commercial vitiation of motherhood as means for the reproduction and conveyance of property and black subordination" as stated by Hartman speaks not only to the specific ways in which the law managed the reproduction of Black women but more importantly its use in maintaining racial hierarchies (84).

Numerous examples of the continued acceptance of the illegitimacy of Black motherhood and womanhood as it is supported by law can be found even in more contemporary examples. This is evidenced in the histories of sterilization and eugenics targeting Black women in the U.S., the stereotypes of the Black welfare queen, the disparate number of referrals of black children into the child welfare system, and even into the 1965 Moynihan Report entitled "The Negro Family: The Case for National Action" in which "pathological" Black mothers were charged with the decline of the Black community (D. Roberts 1996; 1999; 2003; United States. Department of Labor 1965). Additionally, Dorothy Roberts works exhibits how the unacceptance of Black motherhood develops into the criminalization of Black women. She references the use of legal sanctions to either force when to have elective abortions, implant the dangerous drug Norplant as a means of birth control, or be punished for having additional children (1999). Another striking example that resonates in many ways with the current women's health debates was/is the unknown drug testing

of pregnant Black women in the hospital and the respective punishment of those mothers found to have ingested drugs during pregnancy. Similar to the example of changing abortion policies in Texas and other states, this is done so under the pretense of protecting the unborn fetus. Nevertheless, Robert gives an example in which a woman faced "…up to ten years in prison for ingesting drugs during pregnancy…but can have an illegal abortion and receive only a two year sentence for killing her viable fetus" (Roberts, 171). From this, it becomes apparent that fetal protection in actuality is not an accurate depiction of the motive behind the implementation of these punitive laws. Finally, the Welfare Reform Bill of 1996, which also included The Personal Responsibility and Work Opportunity Act of 1996, marked policy changes that not only limited the amount of time that families could receive assistance but also incorporated welfare-to-work programs where poor mothers were required to work and participate in trainings without the institutional support to take care of their children in the process. This, in turn, resulted in the further economic stratification of poor families and many times poverty and lack of economic resources was interpreted as neglect and child abuse.

All of these examples allude to the ways in which Black women's reproduction and ultimately motherhood continues to be a target and point of scrutiny for law and policy. These examples of the abuses and violence inflicted upon Black women in the U.S. speak to the ways in which the law has never been a protective measure for Black female bodies and how Black female experiences are only useful in both social and ultimately political narratives when they support established stereotypes that vilify Black women. This being the case, the erasure of Black women's narratives from the women's health political agenda, even despite the centrality of numerous consequences of the policy on Black female experiences, falls directly in line with historical practices of policy and law that are built upon the racial structures imbedded in U.S. society.

Centering within the dialogue of women's health the detrimental impacts on Black women or centering them in the solution directly goes against the traditional role that policy and law has played in relation to Black women. Interestingly this same context is useful for explicating the problematic and racialized implications of the linkages between the conversations about Medicaid expansion manifesting alongside and within the dialogues about women's health.

Women's Health, Race, and Welfare Reform

Within the recent policy debates and policy decisions, push back against Medicaid expansion is happening alongside and in tandem with restrictive women's health legislation. While these two issues seem separate it is no coincidence that both of these political shifts are happening at the same time. Given the phenomenon coined as the "feminization of poverty" which recognizes the overwhelmingly gendered and racialized makeup of the population of poor in this country, healthcare coverage and access for women has become an increasing burden on the state. As mentioned previously, in Texas, more than 50% of all births are covered by Medicaid. Given this, I argue that women's health is inextricably linked to conversations around Medicaid, its expansion, and therefore also impacted by racialized perceptions about welfare. Herein lies an additional entry point into racial ideologies that underpin the current women's health conundrum.

Many citizens in the United States perceive the purposes of welfare, and in particular Medicaid, to be a means for which the state can offer various forms of assistance to the poor. Few are knowledgeable about the history of welfare and Medicaid and the transition into their present configurations. Generally welfare encompasses various mechanisms of support that can be divided into categories such as education, social insurance programs such as social security, Medicare, retirement plans, and unemployment, and means-tested support programs for the poor. While

welfare is oftentimes only associated with assistance for the poor, in actuality aid to the poor only makes up a small portion of the welfare spending in comparison to more universal programs that fund education and other segments of the general population (Gilens 2000). Consequently, public perception of welfare programs is often associated directly with spending on programs that assist the poor such as Medicaid, Temporary Assistance for Needy Families (TANF), and the Supplemental Nutrition Assistance Program (SNAP) the current form of food stamps.

The origination of this aspect of the federal welfare program can be attributed to the Social Security Act of 1935. It was within this piece of legislation that the Aid to Dependent Children (ADC), later known as Aid to Families with Dependent Children (AFDC), was established. This legislation allowed for the provision of cash assistance to single mothers and their children. At its inception, this program possessed a plethora of problems. Approximately, two thirds of the spending for the program came from the states. Moreover, eligibility requirements were also determined by the states which resulted in the exclusion of non-white women and also white women who were seen to be unfit or "unworthy." In other words, in the beginning this aspect of the welfare program was implemented as a safety net for "virtuous" and oftentimes widowed white women. After the growth of "night raids" and intrusive investigations into the morals of the applicants, the federal government stepped in to limit the state's power in establishing eligibility requirements (Piven and Cloward 1993; Lieberman 2007; Béland and Waddan 2012).

Coupled with the large industrial boom and the mass migrations into urban settings, this resulted in a monumental growth of enrollment on the welfare rolls. This also meant a growth in non-white and particularly Black families becoming eligible for government assistance. The largest jump in enrollment numbers has been cited to have happened between the 1960s and into

the 1970s. Interestingly, as the racial demographics of those becoming eligible for assistance began to shift, so did public perceptions and seething political critiques about welfare spending.

Over time, perceptions around Medicaid and welfare have transitioned into a more negative light. This is particularly apparent in the tense political debates around whether or not to cut welfare spending that continue to persist. Generally, research has shown that in measuring public perceptions on this issue, in actuality most U.S. citizens support allocating government funds to assist the poor and needy (Gilens 1995; 2000; Shapiro and Young 1989). This does not contradict the widely help opinion though, that currently the government spends too much on welfare programs. If the general population supports some degree of public assistance programs, then where does the negativity surrounding Medicaid and welfare stem from? The answer to this question can be found not in the program itself but who the public perceives to be the recipients of that assistance and whether that assistance is warranted (Gilens 1995; 2000; Cook and Barrett 1992). In one study looking at welfare and public perception, it found that there were two main reasons that most of the pubic, and in particular white members of the public, had a dissatisfaction with current Medicaid programs. The study asserts that dissatisfaction with welfare spending from the public is largely built on the following two assumptions: 1) that most Medicaid recipients are black and 2) that black people are lazy and have less of a work ethic than other races (Gilens 1995; 1996; 2000). This perception, also reflected in media representations of welfare recipients, exists even despite the fact that numbers show that this widely held opinion is far from the reality. Black people numerically do not make up the largest portion of the impoverished population (Henry 2004).

Implementation decisions around relief and assistance have always been associated with the conditions of work. In fact, Cloward and Piven maintain that in actuality welfare operates to fulfill

two primary functions: 1) quelling social unrest and 2) governing labor and work (Piven and Cloward 1993). Cloward and Piven's work highlights the historical correlations between fluctuations in relief spending and the civil unrest of the depression or the political upheavals of the 1960's, for example. Interestingly, it is during these times of social disorder that some of the most dramatic shifts in welfare and relief spending occur. Their work illuminates the ways in which welfare can be used not only as a political tool but also as a way to enforce work. This tactic was particularly apparent at the inception of the social security act when states could determine the eligibility requirements that 1) forced poor Black individuals and particularly Black mothers into low level jobs and 2) kept them ineligible for public assistance. Although in this particular case welfare serves as the labor enforcing mechanism, it falls in line with other legal tactics such as the black codes and sharecropping during reconstruction that sought to maintain a subservient and yet enduring black workforce. Overall, these tools, overwhelmingly practiced in racially taut southern states, allowed for the continued maintenance of racial hierarchies. Building from an understanding of welfare as a mechanism of social control that seeks to regulate the poor and the Black as opposed to a mechanism of relief, provides an understanding of how welfare design and its respective public perception continues to reflect welfare's racialized foundations. As mentioned previously, Bill Clinton's 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) is another example of policy that reflected perceptions around welfare and race and supported the relationship between welfare the regulation of work.

Bill Clinton's Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) implemented work requirements, imposed time limitations on assistance, and ultimately sought to "end welfare as we have come to know it." It mirrored the larger perception about public assistance and ultimately the work ethic and abilities of those individuals on the

welfare rolls. This piece of legislation at its core bolstered the growing idea that people who receive public assistance should work and should not remain on assistance forever. Similar to its predecessors, this law promoted returning to traditional family values such as marriage and was buttressed by largely accepted American values such as individualism and hard work. Although it would have been politically incorrect for Clinton or any politician to address race explicitly in his attempt to dismantle the welfare "as we know it," the rhetoric behind this legislation fit lock and key within the racialized narratives and public perception around Blackness, welfare, and work ethic.

In an attempt to further disclose the connection between welfare, Black women, and women's health policy, it is important to connect all of the pieces. Central to slavery was an investment and preoccupation with legally and ideologically defining and managing Black womanhood and Black motherhood. Moreover, Black women's value and ultimately their "work" centered on the profitability of their reproduction. Managing the labor of Black women has always been inextricably linked to also managing their reproduction. This is apparent in the racist eligibility requirements of early welfare programs of the 1930's and into the restrictive work requirements of Clinton's 1996 legislation. Therefore, if 1) welfare is actually about social control and enforcing work, if 2) the current debates around women's health policy are unavoidably built upon the conditions of poor non-white women, and if 3) Black women have been historically disenfranchised by the law via their reproduction and work then it follows that the parallel between Medicaid expansion and women's health policy is not at all unexpected nor coincidental. This trajectory in which racial stereotypes are projected into opinions about welfare recipients is directly linked to Medicaid, its expansion, and ultimately into narratives around women's health. This

directly impacts the process of ensuring access, choice, and coverage for those who don't already have it.

Policy making and agenda setting is a phenomenon inseparable from one important thing: people. Regardless of status, role, or position, no person is without biases, perceptions, opinions or assumptions. More importantly, given the tense and pervasive racial history in this country, there also exist intense racial assumptions that not only play out at the micro level with individual interaction but more importantly these racial ideologies play out at the macro level in the systemic and institutionalized processes that govern the structure and function of our society. Policy is no different. Perception is largely guided by already established schemas around gender and race for example that guide our understanding of other complex -or not so complex - societal occurrences. In other words, people make associations using already established mental "frames" to analyze new sets of information (Winter 2008). Linking this with politics, public perception, and race, "people understand political issues by analogy with their cognitive understanding of race or gender" and ultimately racial stereotypes continue to inform their understanding and support of various political and policy decisions (Winter 2008, 19). This means that given the link between Medicaid expansion, the push back against it, and its inextricable link to women's healthcare, racist ideologies around welfare also ultimately impact how women's healthcare policy is framed and what decisions are made. On the one hand, I am not arguing that policy makers sit around conniving ways that they can try and limit reproductive access to poor Black women. Nevertheless, I am asserting that while the public narrative and general framing erases the experience of women of color and poor black women, these problematic assumptions about them not only translates into lack of concern for their needs but informs and is at the root of women's health policy decisions.

CONCLUSION: FITTING INTO THE FIGHT

"If we think about the history…our herstory of how we got here and reproduction in this country and how this country is built on the back of the reproductive control of black and indigenous women…literally… right? If we know that how we have the wealth that we have is built on their backs literally, how can we not link the forced sterilizations that still happens today in this country and why it makes sense that for many of us, yes, we want to fight for the right to not have a baby but actually oftentimes it is our right to be able to keep our tubes from getting tied from under us that we have to fight for just as hard. Day to day. Today and every day. So these are the dots. Not to make any less of the potential of this moment but unless we can figure out how to connect the dots in this moment and really build a movement that's representational of our population, of who we are and our experiences and how we've lived reproduction, then we are not going to win the war against women…"

- Laura, Collective Member at the Women's Healthcare Access in Texas Panel, August 26, 2013

***

Unlike myself, a few individuals from MAMAS were able to attend the rally the night of the Wendy Davis filibuster. During our subsequent conversations around how we fit (or not) into this conversation and whether we wanted to collectively participate (or not) in the actions planned to combat the additional special session called by Governor Rick Perry, I found that many of my fears and assumptions about the previous rally were share and confirmed. The original turn-out, though impressive, showed a lack of participation by a people of color contingent. Even in the planning meetings, acknowledgement around this absence was met with disdain by many of the participants and organizers. This of course came as no surprise to many of us. Nevertheless, we decided to make a showing with our children at an evening gathering in front of the capitol steps.

Approaching the rally with the lights of the capital not far in the distance, a gathering of orange shirts and blue shirts came into my purview. There of course was an inherent segregation of bodies with the orange shirts overwhelming the capitol lawn while a few blue shirts loitered around the outskirts of the crowd or congregated under the trees to our left passing out juice and

water to children. “This juice came from Jesus,” they told the children who approached asking for refreshments.

The low murmur of conversation lingered in the air and various pockets of people hugged, laughed, talked, and passed signs from hand to hand. It seemed that much of the energy around rallying was already subsiding. At least until the next big push for a vote that would be happening soon at the capitol. We gathered together with our children to take a picture to commemorate our time together that night. It had been a while since we all had gotten together as a group with our children for some political action. Even our social gatherings had become intermittent and dispersed over time. As we grouped together to take a picture, one enthusiastic orange clad stranger came up to snap a shot of our group. We all shook our heads and exchanged glances of unspoken yet shared discernment knowing the way in which our brown bodies in that space were being consumed in a tokenized photo-opt.

Although, many of us agreed that the organization of the political response to the HB2/SB1 was problematic, we also felt that this could be particular moment to intervene and challenge the way that these problematic racial dynamics were playing out. Coincidentally, a member of MAMAS was asked to speak at a press conference the next morning to help and represent the interests and perspectives of women of color in this fight. Later, after the passage of the bill, another one of our members was invited to speak on a panel about the upcoming changes to women’s healthcare access in Texas. As a more concrete statement, together, we decided to draft a written response that explained our stance on HB2/SB1, the rallies happening in Austin, and our larger perspectives on the importance of reproductive justice in the lives of women of color. Below is an excerpt of that collective statement:

"…We are heartened to see the tremendous outcry from the public to defend women's rights to abortion in the state of Texas, and it is an important fight for us as women of color. However, fighting for abortion rights as a single issue is particularly complicated for communities of color, in part because people of color in the US have a different historical connection to the question of ending pregnancy.

Beginning with the enslavement of Africans and the colonization of indigenous communities, this country was FOUNDED on stripping the reproductive control of communities of color and generally attempting to maintain control over OUR bodies.

These practices have continued well into the 20th and 21st centuries with forced sterilization of black and brown women in many different instances. The most recent headline on this came out THIS WEEK, about the coerced sterilization of possibly hundreds of women incarcerated by the state of California.

These coerced sterilizations in California and the anti-choice bills here in Texas are part of the same system of reproductive control that aims to maintain the historical existence of a racist, classist, sexist, genocidal, and hierarchical order that fatally impacts the life chances of people of color. In particular, we are talking about legislation and attacks on reproduction that are directed right at working class and poor women of color.

By and large, our feeling is that mainstream abortion-rights struggles do not even see this history and its living legacy, which has been very alienating to many of the communities who will be most affected by the legislation that our Senate will hear today. The right to abortion is only one small slice of our full struggle for control over our reproduction and our bodies

We would like to call on each and every individual who has shown their passion over the last several weeks about abortion rights to extend that commitment to fighting for full reproductive autonomy and self-determination for every woman, not just those who can afford it, where the option of ending a pregnancy and the full option of keeping a pregnancy are both truly available. We call on each of you to not only recognize the fact that reproductive justice is a matter of racial and economic justice, but that those who live the experience of racial and class marginalization should be part of the leadership of guiding a movement for reproductive justice.

For us, the struggle that matters is not what gets decided in this building over the next few weeks. What matters to us is the continuous struggle against all violence against women of color until no government ever faces a political landscape in which our rights to self-determination over all aspects of our lives and our bodies could be taken away…"

The next chapter further examines the intersections of race and women's health but outside of the policy realm. Instead it delves into the issues around maternal and infant mortality rates. It expounds the large racial disparity in maternal health that exists presently and begins a conversation not only about the speculated causes for the outcomes but also by drawing upon historical health practices in the African-American community, makes a claim for ways in which these issues could potentially be addressed.

Chapter 2: Sankofa: (Re) Conceptualizing Black Women's Maternal Health Disparities

"It is not wrong to go back for that which you have forgotten." - *African Proverb*

"The question is, what are we supposed to do about all of these dead black babies? It's an outrage!" My mouth dropped open as those three words echoed in my ears like a resounding bell. Dead. Black. Babies. Each word struck me like a shot in the chest. I looked to my left at my coworker sitting next to me who was also a black woman and realized that her eyes were welling up with tears. From across the room another gentleman, a doctor from a local community clinic, parroted the sentiments of the researcher's previous comment. "Yes! Something should be done about all of these dead black babies…" There they were again; those painful, agonizing words. In my head I could see small, brown, lifeless bodies piled up like a scene from the movie Rosewood. I saw the little faces of beautiful brown children who would never make it to see their first birthday. While these men bellowed about the outrage of the deaths of these black children I was not convinced. They talked as if speaking about inanimate objects. Numbers. Things without families. Things without stories or any connection to people or the living world. I was horrified. Listening to them, you would think someone dropped a bag of marbles on the floor. "What are we supposed to do about all these damn marbles rolling all over the damn floor? I'm outraged!" Maybe what bothered me the most was the fact that their ire reeked of the eagerness and motivations of a stumped scientist rather than a concerned and compassionate human being. Despite their supposedly indignant responses to the fact that an overwhelming number of black infants will die before their first birthday, it was apparent to me that their declarations lacked even an inkling of sensitivity around the issue and were devoid of any material connection…

***

This chapter in its broadest sense examines the significantly disparate maternal and infant outcomes that exist for African-American women in the United States. It situates data on infant and maternal mortality rates as well as current literature addressing root causes within the context of local efforts and experiences of Black women in the Travis County/Austin, Texas area. While this chapter also examines some of the proposed interventions and existing models of care, it locates these practices alongside the literature around black women, racism stress, and the historical practices of midwifery and Black women's support networks. Overall, I argue that (re)creating spaces of support and traditional practices of care, as they existed historically and prior to the obliterating impacts of a colonialist medicalization processes, could be the primary way to mediate experiences of racism induced stress for child-bearing Black women.

Central to this chapter is the presentation of information gained from both my time organizing at the grassroots level around maternal health in Austin, Texas with MAMAS as well as my more recent experiences working with a governmental entity to improve maternal health outcomes for Black women in Austin/Travis County. In particular, this chapter draws upon both formal and informal conversations with Black women over the years as well as responses collected from three focus groups (one with MAMAS and two with the government group) around the needs, wants, and reproductive experiences of Black women. My primary aim here is to provide a more qualitative and ethnographic illustrations that will (re)humanize and reframe how we conceptualize maternal health disparities for Black women and ultimately how we seek to remedy the outcomes.

MATERNAL AND INFANT MORTALITY IN THE U.S. AND TEXAS

It was a Saturday morning around 11:00 am. For the past hour, around 25 of us, Black and Latina women and children sat in the lobby of an office space located on the historic east 11th

street. The air teemed with the constant murmur of conversation and the chatter and thunderous footsteps of playing children. After making small talk and feeding ourselves and our children the larger group separated into two smaller groups – one Latina and Spanish-speaking and one Black. The purpose of this convening was to conduct small groups to discuss our particular experiences of pregnancy, birth, and prenatal care in Austin, TX.

We, a group of eight black women including three members of the MAMAS, congregated around a small round wooden table in the center of a tiny back office space. The walls were lined with personal desk tables, each connected to white shelves that sat atop the back of the desk. A long rectangular brown table sat adjacent to room's entrance covered with a plethora of office supplies and a row of sample flyers for MAMAS Pregnancy Clinic that we planned to "field test" as part of today's gathering. In the far left hand corner stood a stack of about 8 large plastic bins storing gently used women's and children's clothing, accessories, and toys that MAMAS had collected over the years. The conglomeration of bulky objects lining the grey walls resulted in the reduction of the already small space and forced us all to squeeze tightly at the center of room. While this wasn't the most ideal or most comfortable arrangement to talk about such intimate experiences as pregnancy and childbirth, as an all-volunteer community organization we were oftentimes forced to work with both the time and space constraints that we had at our disposal.

Sitting together with other Black women who had attended that day, we went through a round of introductions. Name. Where are you from? How many children do you have? What have been your experiences of pregnancy, prenatal care, and birth? The brief stories spanned the gamut of experiences. Some had insurance and some did not. Many had cesarean sections. There was a 17 year old who lost her fallopian tube due to the neglect of a local clinic and one woman, Shonda, who had 6 consecutive miscarriages. I, as well as Ashley, another member of MAMAS, scribbled

rapidly on scratch paper in order to try and capture as best we could the information being shared in the circle. After the introductions had ended, I looked to Lois, one of my fellow members who would be facilitating the focus group as she began to describe the reason for inviting everyone out to participate today. "Thank you all for coming out today," she said. "So…. Radiant Woman/Mama, which is a project of MAMAS, is attempting to start a free prenatal clinic for Black and Brown women here in Austin, TX." *But why are we really here?* I thought. *Tell them why we are really here.* My eyes met Lois' gaze. My thoughts must have been inked all over my face. "Should I just tell them,'" she asked. I nodded. "So…in the United States pregnant Black women are four times as likely to die than white women…and not only that but our babies are more likely to die than white babies…" Silence. I glanced around looking at the brown faces of the women in the room. No one said a word. The small room seemed even smaller in that moment and the stuffiness of the clutter seemed suffocating. Everyone looked lost as if trying to fully understand and comprehend the statement that had just fallen on everyone like a heavy mortar brick. No one asked why. No one asked for explanation. For what was seemingly an hour but actually spanned only a few minutes, eight black women, six black mothers sat there staring at each other in silence.

***

In 2009, Amnesty International Released a report entitled "Deadly Delivery: The Maternal Health Care Crisis in the USA." This report not only shed light on the inadequate and fatalistic maternal care in the United States but it also provided a racial and class based assessment of the conditions of birth and reproduction for women here in the U.S. According to this report, the U.S. out spends any other country in health care expenditures. Yet, it has one of the highest rates of infant and maternal mortality (Amnesty International 2009). This report cites that U.S. women have a greater risk of death than forty other countries in the world. These same fatal statistics are

exacerbated by race. While maternal and infant mortality rates are extremely high in the United States compared to other countries, Black women are four times more likely to die due to birth related complications than their white counterparts. Additionally, black infants are approximately 2.5 times more likely to die than their white counterparts (2009). Data as presented by the Annual Vital Statistics Report also supports this national phenomenon. In the most recent report released in 2013, the data showed that the infant mortality rate for black infants born in the United States, was approximately 12.4. This is compared to the 5.3 for non-Hispanic white infants and the 5.29 for Latina infants (National Vital Statistics Reports, 2013).

In Texas, rates of infant mortality mirror that of the national statistics with the infant mortality rate of Black women being more than 2 times that of white women. In 2010, the infant mortality rate was cited to be approximately 11.4 deaths per 1,000 live births for black women as opposed to 5.5 for their white counterpart (Healthy Texas Babies Infant and Maternal Health Data 2010). Similarly, preterm birth rates for Black women in Texas also exhibit this robust disparity with a rate of 17.5 and 11.6 per 1,000 live births for Black women and white women respectively (2010).

Travis County, host of Austin the state's capitol and the primary geographical focus of this study, actually reveals a slight increase in the outcomes gaps compared to state averages. For example, the average infant mortality rate from 2007-2009 for Black women, Latina women and white women in Travis county were 11.7, 5.0, and 4.6 respectively for every 1,000 lives births (March of Dimes 2013). Similar disparities can be found during this time in the rates for preterm birth as well as low birth weight which were 16.8, 10.7, and 9.5 for Black, Latina, and white women and 15.3, 6.9, and 6.7 respectively (2013). (See Figures 1, 2, and 3)

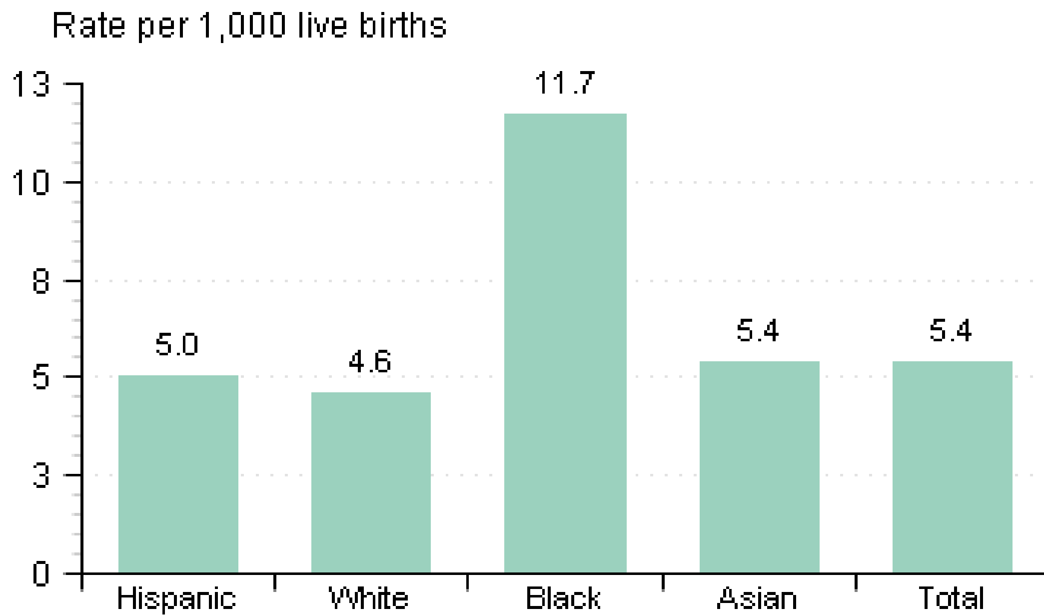

Figure 1: Travis County Infant Mortality Rates[14]

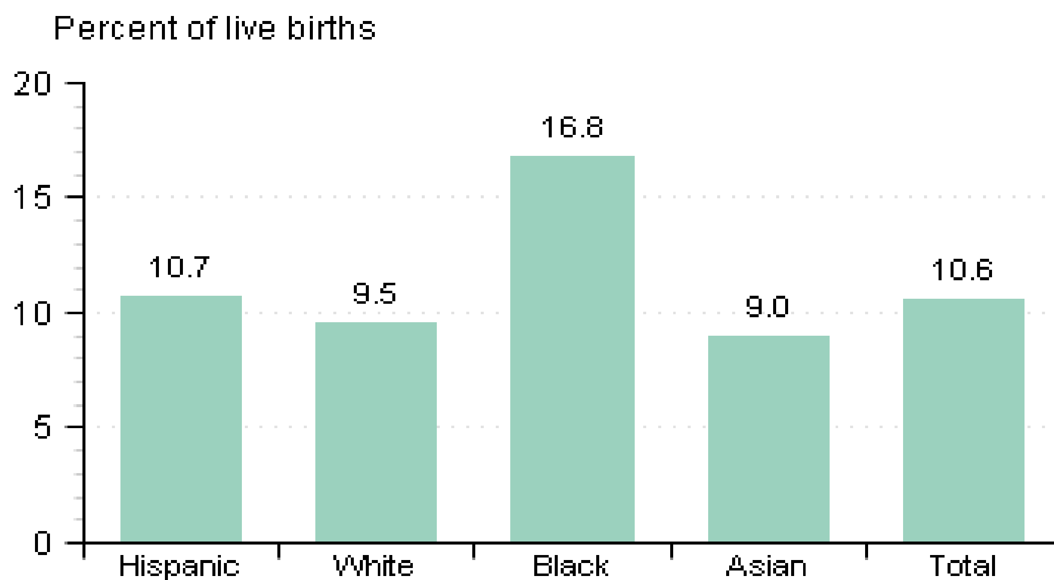

Figure 2: Travis County Preterm Births[15]

[14] Data Source: Source: Infant mortality rates by race/ethnicity Travis | PeriStats | March Of Dimes
[15] Data Source: Source: Infant mortality rates by race/ethnicity Travis | PeriStats | March Of Dimes

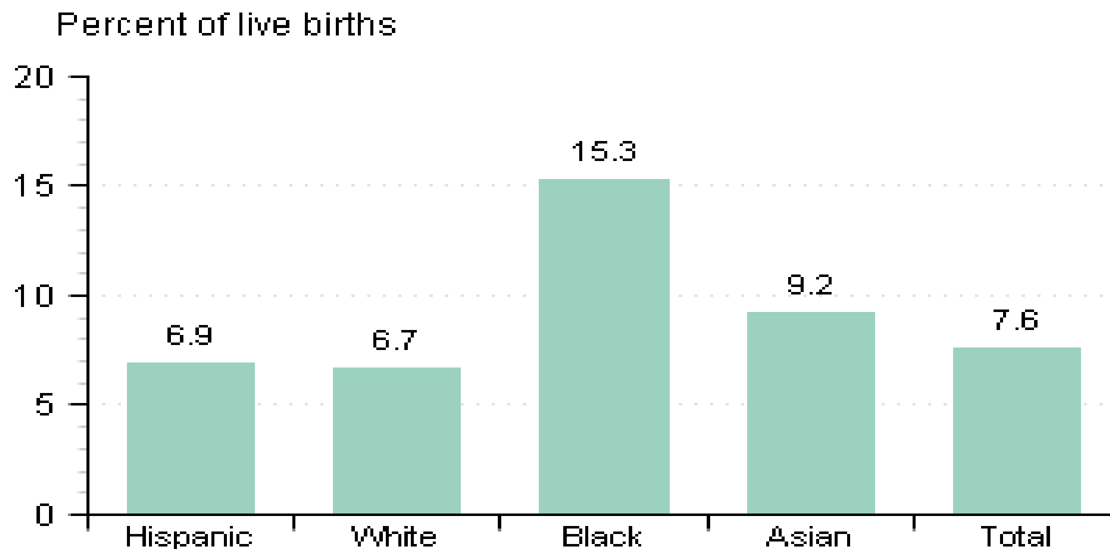

Figure 3: Travis County Low Birth Weight[16]

In 2013, Children's Optimal Health, a local research non-profit, released a new report entitled "Travis County Birth Outcomes as Related to the Physical and Social Environment." According this recent report, Black women make up approximately 8 percent of the total births and yet account for 12 percent of the infant deaths. This is in comparison to other racial and ethnic groups in Travis County whose percentage of infant deaths are proportional to their representation in the county population. Specifically, this reports cites the infant mortality rate to be approximately 9.6 for Black women. This is compared to 6.4 for Hispanic women, 4.3 for Asian women, and 5.4 for white women. Additionally, of the 2 percent of births in Travis County that occur prior to 32 weeks of gestation, 44 percent of those are of Hispanic origin, 35 percent are

[16] Data Source: Source: Infant mortality rates by race/ethnicity Travis | PeriStats | March Of Dimes

Black, 5 percent are Asian, and 16 percent are white. While Hispanic women make up the largest proportion in the subset, this percentage still correlates well with their representation in the total number of births. Consequently, given that Black women are only 8 percent of the total births in Travis County, their representation in the subset of births that occur prior to 32 weeks is grossly overrepresented. Unfortunately, the data in this report also reflects the ways in which this pattern of disparity continues to subsist in rates of low birth weight and very low birth weight in Travis County. For example, for every 1000 live births, Black women's rate of low birth weight is 114. This is compared to the rate of 57.5 for Hispanic women, 76.9 for Asian women, and 57 for white women. Of the 3 percent of births that are *very* low birth weight in Travis County, Black women make up 32 percent of that population with a rate of 34.6 for every 1,000 live births. This is compared to 42 percent, 6 percent, and 20 percent and rates of 11.8, 11.1, and 11.7 for Hispanic women, Asian women, and White women respectively.

While the National Vital Statistics data is recognizing a drop over the years in infant mortality rates nationwide, the racial discrepancies that locate black children at the height of mortality remain constant. Given this, the state of maternal health outcomes and in particular the impact on the Black community has gained a significant amount of attention and newfound interest has been sparked in trying to pinpoint the causes of the disparity. Additionally, and despite the even larger disparity related to race and maternal mortality in the United States, less attention is given to this particular topic. The National Vital Statistics report cites the lack of reporting standardizing as one reason for inadequate attention paid to this issue.

CAUSES

Generally, much of the literature acknowledges access to prenatal care, adequate care, education, socio-economic status and financial barriers, behavioral risks such as smoking and even social support as factors that can significantly contribute to maternal and infant health outcomes.

In contrast to this more clinical and behavioral approach, there has been an interesting shift that has occurred in the literature regarding the particular outcomes of Black women and infants. For example, new studies have shown that even when controlling for education, socio-economic factors, and behavior, Black women still experienced higher rates of preterm birth, low birth weight, and maternal and infant mortality (Giscombé and Lobel 2005; Dominguez et al. 2008; Dominguez 2010; Buka et al. 2003; Colen et al. 2006; J. W. Collins, Herman, and David 1997; Ferré et al. 2011; Collins, J W and David 1990). In other words, when compared to a white woman with the same education level, income, access to care, and behavioral practices, a Black woman is still more likely to have negative birth outcomes. An article in the New York Times asserted that even highly educated Black women with higher socio-economic statuses were more likely to have worse birth outcomes then a lower income teenage white mother (Rothstein, 2002). Given this, practitioners, providers, and researchers have begun to investigate other mechanisms by which the disparity is manifesting. After eliminating education, income, behavior, and socio-economic status for example, race becomes an apparent "last man standing."

In line with this strain of thought, theories have begun to surface that articulate a broader life course perspective on the topic of maternal health (Lu and Chen 2004; Lu et al. 2006). Although these studies, including the data presented in the Healthy People reports, are leaning toward a more life course perspective on health that addresses social determinants, issues pertaining to high levels of stress and particularly racism induced stress have begun to rise to the forefront of maternal health conversations. For example, research has found that 1) Black women

are more likely to experience stressful life events (Dominguez et al. 2005; Lu and Chen 2004), 2) socio-economic conditions, societal/institutional structures and pressures, neighborhood, intimate partner relations, and experiences of prejudice and discrimination are some of the sources of stress for Black women (Holland, Kitzman, and Veazie 2009; Rich-Edwards and Grizzard 2005; Rosenthal and Lobel 2011), 3) higher instances of perceived stress has been linked to instances of LBW (Caldwell et al. 2002; Dominguez et al. 2008; Sable and Wilkinson 2000), 4) experiences of racism and discrimination, particularly introduced at a younger age, were found to be associated with instances of LBW(Carty et al. 2011; Dominguez et al. 2008; Giscombé and Lobel 2005; Hogue and Bremner 2005; Jackson et al. 2001; Dominguez 2010; Rich-Edwards and Grizzard 2005; Rosenthal and Lobel 2011), and 5) terms such as "weathering," increased "stress age," and "allostatic load" have used to denote the continuous exposure to life stressors that subsequently and over time erode the overall health of the individual (Buescher and Mittal 2006; Holzman 2009; Geronimous 1991; 1996; Love et al. 2010). These concepts were found to be particularly useful when describing the accumulation and impact of stress in the lives of African-American women, the impact of this process on pregnancy, and the way that it contributes to negative birth outcomes including LBW(Hogue and Vasquez 2002; Geronimous 1999; Rich-Edwards and Grizzard 2005).

Returning to the 2009 Amnesty International reports offers a unique analysis that strays away from the focus on behavioral interventions in the maternal health crisis. This is particularly important given the new direction and focus of social determinants and the significance of looking at racism as a determinant for negative outcomes. The Amnesty report cites a number of things including lack of quality healthcare, inaccessibility, financial barriers, and race discrimination as primary causes for these unequal figures around maternal health and mortality (2009). Moreover, the document asserts that these statistics stand as evidence of the United States' violation of three

basic human rights: 1) the right to life, 2) the right to health, and 3) the right to freedom from discrimination (2009). What is most significant about this stance is the fact that for the first time, inequality and discrimination that directly affects infant and maternal mortality outcomes are being recognized as larger human rights issues. This lens on maternal health drastically changes the conversation from focusing on the behaviors of the women but instead deflects the blame and responsibility away from the women and onto societal structures and institutions. This analytical shift situates the conversation around maternal health disparities into the realm of social justice, rights, and activism and moves from critiquing the behavior of the individual to placing a critical lens on institutional and structural "behaviors". I find this focus to be much more relevant when discussing the African-American community in particular and when combined with the scientific literature that points to a life course perspective and proffers a dialogue around the fatal impacts of racism and stress reconfigures the ways in which interventions around this issue should be developed. Ultimately, if accepting stress induced by racism as the primary cause of these fatal impacts, then if follows that it is yet again the *condition* of *being* black that leads to these large disparities. In addition, research has also acknowledged the decline of health and birth outcomes for immigrating Black women to the United States (David and Collins 1997). Given this, it is not only stress and the condition of being Black but the particular experience of anti-Black racism in the United States that impacts maternal and infant health outcomes. This being the case, how can prenatal care models and interventions truly intervene?

CURRENT CARE MODELS AND INTERVENTIONS

Thus far we have established that prenatal care is not the primary cause nor it is the primary remedy for the birth disparities that presently exist for Black women. Nevertheless, it seems like

a lucrative practice to examine existing care models and to assess their strengths, weaknesses in these areas, and places for improvement. Although the American Congress of Obstetricians and Gynecologists (ACOG) *Guidelines for Perinatal Care(*Riley, Laura E.; Stark, Ann R 2012), the primary goal for maternal care is a safe delivery for both mother and child while also delivering patient and family centered care. In addition, the guidelines suggest that this model of care includes counseling and conversations around the desire and/or readiness for pregnancy, overall health, the social, environmental, occupational, and economic circumstances' effects on pregnancy, as well as the patient's support system. While we know that there is a lot of variability in traditional obstetric and gynecological care dependent on location and physician, we also know that given the statistics, this model has not been effective in preventing the high rates of mortality for Black women and infants. Given this, the following depictions reflect existing models that present an alternative to the traditional obstetric model.

Present Day Midwifery

Midwifery practices exists today and remains largely utilized as an effective model of prenatal and women's health care. While this practice maintains some of the historical stereotypes of being unsafe and not as "good" as hospital or obstetric care, much of these notions are rooted in opposition by Obstetricians and large medical institutions. This is in contrast to the racially motivated attacks that existed in the mid-1900s. Nevertheless, midwifery and the growing acceptance of alternative and natural birthing practices is becoming more and more mainstream. In fact, midwifery as it exists today has become a signifier of wealth and privilege whereas in the past it signaled the evidence of racialization, poverty, and access deficits. Interestingly, midwifery today has evolved so far past its historical roots that it has overwhelmingly become a middle to upper-middle class white practice. While there are Black and other women of color practicing

midwives as evidenced by professional organizations such as the International Center for Traditional Childbearing (ICTC), their representation in the overall group of practicing midwives in the United States is nominal. Even with this, midwifery as a model is presented as a supportive and caring alternative to traditional obstetric care.

The Midwives Alliance of North America (MANA) asserts that the Midwives Model of Care™ is a model different from contemporary obstetrics given that it is "uniquely nurturing" and "woman-centered." In particular, MANA asserts that the Midwives Model of Care™ includes: monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support minimizing technological interventions and identifying and referring women who require obstetrical attention[i]. Overall, the midwifery model of care is a supposed attempt at providing care that aides in a safe pregnancy, labor, and delivery for the mother and baby while also delivering emotional, mental, and spiritual support to the woman and her family. This model professes a woman-centered approach that prioritizes patient based decision making and provides the necessary structure to encourage the natural process of birth to occur without unnecessary medical interventions. This model promotes continuity within the relationship between patient and provider and offers the continuous support and presence of the provider through pregnancy, labor, and post-partum.

In rhetoric, this model exemplifies much of the historical practices and care exhibited by the Granny Midwife. In this, the model offers the potential for the empowering, woman-centered and supportive care that not only would be supported by research but also as expressed in the requests of the women in the focus group. Nevertheless, the practice of midwifery as an institution

that is situated in the racialized society that is the United States is not free from its own structural and systematic quandaries.

In 2012 the women of color board members of MANA released an open resignation letter asserting their exhaustion with the lack of commitment and attention to the needs and issues of women of color. Here is a brief excerpt from that letter:

> *"MANA continues to spout canned responses in support of: various race, gender, social justice issues; 20,000 midwives by 2012; more midwives of color to serve communities of color; end racial disparities in health care, etc..., while not actually developing workable strategies and expending resources (and if so, begrudgingly supporting after endless negotiations) to achieve any of them…*
>
> *Having suffered through the CPM Symposium, we Sisters have spent too many days trying to help MANA, its leadership and the leadership of the other AMOs "get it". And they still do not. We have committed ourselves to our local and global communities we serve first and foremost, doing the best we can with dignity and character knowing that our communities and our children are watching. We can no longer continue to participate in MANA's disrespect of us as a group, a race, as the Women our community respects. We cannot keep our heads held high and take this shit. Our view of ourselves will suffer and eventually the young ones will look at us with less than admiration. We are not "The Help -2012 Version". This treatment is not good for us, mentally, physically, emotionally and psychologically –this is the stress that's kills us in so many ways, drains our energy and distracts our focus…*
>
> *These issues and these organizations distract us from our true mission; we have become myopic, focusing on these groups and not exploring global approaches to maternal and infant health care, increasing the number of MOCs, and better serving our communities…"*

Below is MANA's public response:

> *"It is with heavy hearts that the Midwives Alliance today received the resignation of several key members of the MANA Midwives of Color (MOC) Section, including the Chair. MANA is fully aware of its history of privilege and the issues related to cultural and systemic hierarchies in decision-making. We are committed to working towards a structural change in the way our organization operates in light of the repeated failures to address the needs of our midwives of color. We recognize the disproportionate impact of perinatal disparities and poor outcomes for women, infants and communities of color. MANA has an ongoing responsibility to address these issues in order to fulfill our mission of providing a professional organization for all midwives."*

While the included evidence of this public dissension may seem disconnected from an examination of effective maternal health care models, I argue that it is directly related and relevant. The particular component of the midwifery model of care are significant in regards to revamping how we care and support pregnant women. Nevertheless, the internal dispute that erupted publically is a testament to the pervasive nature of racism that plays out in the daily lives of Black women, within our care systems, and with our providers. Therefore, as supported by the growing literature and the experiences of women, if negative outcomes are results of lifetime exposures to systematic and institutional stress, then in order to remedy these outcomes there must also be an effort to address the manifestation of the problematic processes at a systematic and institutional level. This dispute is an example of this much needed work.

Centering Pregnancy® Group Prenatal Care

This model of care coined as Centering Pregnancy® was developed by nurse-midwife Sharon Shindler-Rising and combines aspects of traditional obstetric prenatal care into a group-based setting. The practice of group prenatal care is actually not a new concept. In fact, a local Black physician stated to me in at a community meeting, "We have been doing this for a long time. Way before Centering." Nevertheless, Sharon Shindler-Rising was the first to package it, create a standardized curriculum, and market it to become the rapidly growing group prenatal model that it is today.

Its primary purpose is to provide prenatal care as well as education that covers topics pertaining to pregnancy, labor, delivery, and post-partum. The curriculum also includes various topics on contraception, general health, and healthy families and parenting that is useful during the interconception period.

The care begins with a traditional exam with the care provider and is followed by ten group sessions comprised of eight to twelve women who are at similar points of gestation. Each session is approximately 90-120 minutes and women partake in self-assessments and self-monitor their weight, blood pressure, and even urine analysis with the assistance of the nurse or clinician. At each of the group sessions, each individual is pulled out of the group to be examined by the clinician. Each group session is facilitated by a clinician and usually a nurse trained in the Centering method. It is structured in a group based discussion format as opposed to a lecture format dominated by the interests of the instructor. Spouses and other support persons are permitted to attend. Although curriculum does exist for each session, the more discussion-based and patient inclusive structure allows for greater flexibility as well as the opportunity for the concerns and experiences of the participants to be shared with one another.

The Centering Health Institute identifies three primary components to their model- 1) risk assessment, 2) education, and 3) support. The following thirteen essential elements have also been identified by the Centering Health Institute: 1) Health assessment occurs within the group space, 2) Participants are involved in self-care activities, 3) A facilitative leadership style is used, 4) The group is conducted in a circle, 5) Each session has an overall plan, 6) Attention is given to the core content, although emphasis may vary, 7) There is stability of group leadership, 8) Group conduct honors the contribution of each member, 9) The composition of the group is stable, not rigid, 10) Group size is optimal to promote the process, 11) Involvement of support people is optional, 12) Opportunity for socializing with the group is provided, 13) There is ongoing evaluation of outcomes.

Overall, advocates of this model contend that its strength is in its empowering potentiality for participants, the delivery of a built in support network, increased time in prenatal appointments,

increased opportunity to address maternal health issues and educational content, and greater opportunity for scheduling flexibility. More recently, this model has been shown to be able to reduce preterm birth and low birth weight for Black women but cites behavioral change as the primary reason for its impacts (Ickovics 2003; 2007; Picklesimer 2012).

Internatal Group Care Model

The Internatal Model of care is built upon the presumption that prenatal care alone is not enough to reduce instances of low birth weight and preterm birth. Instead, this model proposes an "internatal" approach that addresses preconception care and wellness in between pregnancies. Championed by Michael Lu, this model is built upon a life course understanding and merges with community in order to provide a framework that can adequately address the needs of child bearing age women and ultimately impact maternal and infant outcomes. Risk assessment, health promotion, clinical interventions, and psychosocial interventions stand as the core contents put forth in this model.

While the core contents as laid out above are applicable and beneficial to all women, the internatal model is particularly useful in addressing the needs of high risk women. In particular, this model emphasizes the needs of women with: 1) chronic hypertension or a history of hypertension during pregnancy, 2) pre-gestational or gestational diabetes, 3) women or are underweight overweight, or obese, and 4) women with a history of preterm birth. The primary assumption underlying this model is that addressing wellness and risk during the post-partum period and into the next pregnancy allows for timely interventions that not only promote better health but that can also prevent and decrease the risk for complications and negative infant and maternal outcomes.

While the internatal model predominantly addresses the time in between pregnancies, the model is meant to be a connect process that continues into the following pregnancy. The early interventions, monitoring, and support provided prior to birth ideally will have a positive impact on the woman's experience, general wellness, readiness, and ultimately birth outcomes. Furthermore, this model advocates the use of group prenatal care as a way to provide additional support networks and community engagement for the women involved.

The Internatal model not only suggests care and assessment during the period between births but it suggests an alternative schedule of visits directly after birth. Instead of the traditional six week post-partum appointment, this model proposes instead three or four internatal appointments beginning at the two week post-partum mark. This is a critical intervention that helps to alleviate certain issues that may arise far in advance to the six week appointment and helps to encourage breastfeeding or address in early arising concerns. This would be then be followed by a 6 week, 6 month, and then annual appointment.

What is useful about this model is the amount of attention and supervision implemented during care. It is more comprehensive and also encourages direct community engagement and involvement. Nevertheless, this model remains to the overwhelmingly clinically focused and does not necessarily address issues of stress reduction, racism, and culturally based peer support.

MAMAS Reproductive Justice Model

This model was written and developed over the years by Laura, one of the members of the MAMAS organization. It takes a community organizing approach to preconception and prevention. While some individual preconception work can potentially be done in the routine well woman checks, this model proactively addresses preventative care through consistent and continuous community education and awareness work. Community health workers actively play

the role of doing outreach to recruit women to participate in the model of care as well as women from the community to participate in the community education piece as well. Furthermore, the community health workers serve as a primary liaison between agencies and institutions and the community and raise awareness in the community about important maternal health issues. Furthermore, general wellness practices and resources such as nutrition counseling and education as well as exercise are on-going.

This model also implements a group model of prenatal care. Similar to other group formats, the women will participate in prenatal group sessions facilitated in a popular education and discussion format. While curriculum does exist, the topics will be tailored to the needs of the women in the group. Each woman will manage and contribute to her own self-assessments such as weight, height, and blood pressure and will be examined individually by the care provider during the group sessions. Group meetings will be approximately two hours in length and additional wellness components such as healthy food preparation and education and prenatal exercise and dance are offered on-site and alongside the group sessions.

In addition to the group prenatal sessions, each woman during the pregnancy will be supported by a community health worker. This individual will not only be trained as a community health worker but will also help with systems navigation and be trained as a birth education and birth support specialist. This way, the woman will have an individual in which they can directly refer to for physical, mental, and emotional aide.

This model of care builds upon the practice of midwifery. Women will be visited by their provider at 1 day, 3 days, 7 days, and 14 days post-partum. This would then be followed by a 6 week appointment. In addition, the group prenatal sessions would reconvene and approximately 6 weeks post-partum and continue until 3 months post-partum. The groups are encouraged to

continue to meet even after the 3 months are completed. Furthermore, community health workers would continue to provide post-partum support, breastfeeding assistance, and any other assistance necessary during the post-partum period. Women will continue to have access to the on-going nutrition and group exercise classes. It is important during the implementation of this model to consider the effects of service coordination and integration. This model proposes a single site of operation for all of the services. This is done in order to alleviate barriers to care and access.

Most critical about this model is the fact that it proposes culturally-*based* as opposed to culturally- *sensitive* care. In order to accomplish this, prenatal group sessions are divided by racial/ethnic/cultural background. For example, there may be one group specifically for Black women. This is done in order to address directly in group discussions the needs and concerns specific to that particular group. Furthermore, group facilitators, providers, and community health workers should mirror and reflect the community and experiences of those participating. This same method is also applied in the additional wellness components of the model.

Of all of the models reviewed here, only one attempts to fully address both the clinical and social needs in a way that is grounded in a racial and political understanding of Black women's maternal and reproductive health. That is the MAMAS Justice Model. Interestingly, this model was created directly from a grassroots community perspective and yet was also the one that was struggling to be fully implemented and legitimized. Interestingly, the focus group data examining the specific and particular life experiences of Black women provided insight into the ways in which these societal mechanism play out in the day to day that mirrored not only research but also the need for the structure of the care as outlined in the MAMAS Justice Model of care.

THE GOOD, THE BAD, AND THE UGLY: BLACK WOMEN'S BIRTH EXPERIENCES[17]

Beginning in the summer of 2013, I began working with a government agency on a project around maternal health. This project was started with the intention of helping to decrease the high instances of low birth weight, preterm birth, and infant mortality rates for Black women in Austin/Travis County. The depiction at the opening of the chapter is a remembrance from what would be one of many stakeholder meetings organized by the agency to gain community input on the project and its development. Key to this process was including the perspectives of various community stakeholder groups such as local practitioners, providers, an advisory board, and a group of Black women from the community. While the input provided by the practitioners and advisory circle was particularly useful for programmatic and logistical concerns, the experiences of the women in the focus groups provided nonpareil insight.

The first gathering with the women took place during the early part of October. Lois, now my co-coordinator for the program, and I recruited the women by drawing upon our already established networks from previous involvements in the community. We also did some door knocking in various housing communities in the local Austin area. Many of the women who participated in the community focus group with MAMAS a year prior were also present in the other government organized group. Although we came into contact with approximately 40 women who expressed interest in participating, in the end there would be two focus groups consisting of approximately 20 women (14 in the first group and 15 is the second group with about 6 new women in the second group).

We held our first meeting at a local and centrally located space on the east side of town. I arrived around 5 o'clock in the afternoon in order to give myself enough time to prepare for the

[17] Information in this section is data that will be part of a forthcoming report released in 2014 by Murillo and Cole.

group. I wanted to make sure that everything was in place prior to the arrival of the women. I placed the sign in sheet on a grey conference table by the entrance and waited for my coworker Lea to arrive with the 25 dollar gift cards for the women as well as the food and drinks that we would be providing. After shoving a number of large rolling conferences tables around the roomy multipurpose room, I organized about 25 chairs in a large circle with three large flip charts that stood on the outside of the circle. Lois would be arriving later as she was providing rides for a few women who did not have transportation or a means to attend the event. Glancing outside through the high ceiling length windows I saw Seela, a good friend and trained childcare specialist who would be providing children's activities for the evening. I let out a sigh a relief. Hopefully the other childcare workers would be there soon. The women and their children would probably be arriving shortly and I knew that without adequate activities for the children the success of this group would not be possible. At around 6 everyone began to arrive and although the meeting was scheduled to begin at 6:30, we spent the next hour eating, getting settled, and situating the children so that we could begin.

We all sat together in a big circle. In their hands, each woman held a homemade fan that resembled the old ones that I remembered seeing as a child being fanned by older ladies in my small church on a hot Sunday morning. It consisted of a wooden popsicle stick with a small sturdy piece of poster board or paper stapled to the end of it. In contrast to the ones at my church, these fans did not depict images of the Lord's Supper or the crucifixion. Instead, each fan was solid colored on both sides with one side of the fan being red and the other green. At the beginning of the group, shortly after brief introductions, the fans were used to get a quick demographic survey of the participants. Are you under the age of 20? Raise the red side for no or the green side for yes.

Did you have a cesarean section? Red for no. Green for yes. This continued while I and two others quickly counted and tabulated the responses.

"The next portion of the evening is what I call the good, the bad, and the ugly," proclaimed Rita, a Black woman from the community who we had recruited to be an outside facilitator for our stakeholder meetings. "How many of you can say that you had what you would call a good experience during your pregnancy and birth? Raise your hands." A few women raised their hands. "Now which one of you who has their hands raised would like to share their story?" A woman volunteered. This process would continue until we had one volunteer to share for each-the good experience, the bad experience, and the ugly one. In this portion of the group, the fans would be utilized again in what the facilitator called the "Hallelujah Chorus." While listening to each story, if the speaker says something that a woman felt resonated with her experience she would put up the green side of the fan. "Kind of like saying amen," the facilitator explained. This way, we could gauge which pieces of the good, the bad, and the ugly seemed to resonate with multiple women and we could talk more in depth about those particular collective experiences.

The Good

Brandy was a first time mom. She was in her mid-twenties and worked as a teacher and coach at a local middle school. She had long dreadlocks that hung down her back and her athletic build stood as evidence of her professed commitment to health and wellness. In her recollection of her experience of pregnancy and birth she recalled enjoying her time being pregnant and shared the ways that she continued to stay active throughout her pregnancy with exercise, playing sports, and interacting as normal with the girls on the athletic and dance teams that she coached. On the day that she went into labor, she remembers cooking dinner, baking a cake, and cleaning the baseboards when she began to feel an uncomfortable feeling that in the moment she was not aware

was actually the beginning of labor pains. After hours or discomfort, she finally called the hospital and her and her husband decided to go in only to find that she was indeed in labor and six centimeters dilated. Central to Brandy's memory was the large presence of friends in family during her labor and delivery. She described the inappropriate jokes that her husband was making and the laughter and conversation that surrounded her by her mother and father, in-laws, sisters and her best friend. Despite the generally pleasant experience, Brandy also described the unfriendly nurse who complained about the number of family members in the delivery room and the insensitivity and frustration when she, being a first time mother, was having trouble understanding the proper way to push. It was not until a new, friendlier, and more helpful nurse arrived that she was able to actively progress through her labor. In the midst of her pushing, Brandy recalled being told to stop pushing and wait because the doctor had not arrived yet to the hospital. Finally, after it seemed that the arrival of her doctor was not imminent, a different doctor arrived to help assist with the remainder of the delivery. She described this aspect of the labor as painful and said the doctor's touch was very rough. In the end, she ultimately had to have an episiotomy but delivered a healthy baby girl. After the birth she described experiencing a lot of pain but talked about the presence of her mother, mother-in-law, and her husband who was able to take a month of leave in order to support her during her post-partum period.

The Bad

This was Violet's second pregnancy. It occurred three months after the birth of her daughter. After revealing the news of the pregnancy to her family they discouraged her from having the baby and encouraged her to either give the baby up for adoption or to have an abortion. After deciding to continue the pregnancy, the father of the child decided that he no longer wanted to be involved. Violet initiated prenatal care early in her pregnancy and described the first few

months as positive. She said the doctor was friendly. She was not having any complications, and talked about the joy that she felt when she found out that she was going to be having a baby boy. Around the 36th week of pregnancy Violet maintained that things began to go sour. She went in for an appointment with her doctor and instead of the baby measuring at the appropriate 36 week growth marker, the baby was measuring at 34 weeks. She was told by her doctor that this was normal for this stage of pregnancy. A few weeks later, Violet began experiencing pain. She was not sure what was going on but had a feeling in her body that something was wrong. Upon visiting her doctor and expressing her concerns to him, she requested an ultrasound to make sure that everything was fine. The doctor glancing down at her chart, looks up with what she describes an angry disposition and tells her that she has Medicaid and therefore is not entitled to another ultrasound and that everything is fine. Later, after the feelings of trepidation had not gone away, Violet returned to the hospital to find out that there was no longer any fluid around the baby and they would have to deliver the baby immediately. “Have you been receiving any prenatal care at all,” the nurses ask her. She described going into the operating room for cesarean section but when they remove the baby there is no sound of crying. They rushed away with her baby and neither she nor her family was able to hold him. For twenty-five days Violet’s son would remain in the NICU. “Have you been around any cats? Have you been around any dogs?” The nurses and doctors continued to direct questions at her about her behaviors during pregnancy that may have triggered the state of her baby’s health. “What is wrong with my baby,” she asked only to receive no answers. The doctor came in to describe the condition that the baby had fallen with. Violet described the doctor as he rattled off a long string of unfamiliar words that to this day she cannot remember. “Well they said he is going to be ok,” she proclaims. “Who told you that,” the doctor responded as he walks out of the room again with little explanation. In the end, Violet’s baby would live only

25 days. Violet described, how to this day, she wanted an explanation and wanted more answers. Would things have been different if she wasn't on Medicaid? Was there something that the doctor could have done differently to change the outcome? If he had listened to her assertions that something was wrong could her baby have been saved? After months of grieving, Violet decided to pursue an investigation into the passing of her baby boy only to find out that her doctor had moved his practice to another state and that there would be no possibility of legal recourse for her loss.

The Ugly

Lisa was the mother of two- a two year old and a five month old- when she discovered that she was pregnant again. Her and her husband were both in the military at the time and stationed in Illinois. Lisa asserted that although she was provided healthcare through the military that in actuality being pregnant in the military did little to alter your experience and ultimately your workload. "Are you tough?" they asked her. According to Lisa, either you are sick and need to go to the doctor or you go to work. Pregnancy was not a sickness. Her husband was overseas and with two children and work she described her stress level as extremely high. Lisa shared with the group that both of her previous births were vaginal but that both births occurred early at 35 weeks. During the last birth she was even placed on bed rest in attempt to avoid preterm labor. Given these past experiences, Lisa expressed knowing that most likely this birth would also occur before 37 weeks. Towards the end of the pregnancy, she described being given shots in order to halt the already occurring contractions. Finally after refusing to go back to the doctor in fear of being injected with more medication, the pain increased to an extent where she had no choice and returned to the emergency room. Luckily her husband had returned back to the states by that time. Upon her arrival at the emergency room, the heart rate of her baby dropped rapidly and she was rushed in the

operation room for an emergency cesarean section. She said that the nurses told her that the operation was one of the fastest they had done and that they took the baby under a minute. After the operation, Lisa described being so sedated that she was barely able to open her eyes or even hold her baby. Upon awaking, she not only experienced extreme amounts of pain from the operation but finds out that in her incoherent state complications arose that resulted in her having to have a blood transfusion as well. Given this experience, Lisa expressed fear of having any more children and says that she would never want to go through that again.

Identifying Collective Experiences

After listening to each of the three stories, the women were able to engage in open discussion about what they heard and about what resonated or not with their particular experiences. Revisiting the feedback from the stories, the discussion, and the subsequent two-hour follow-up session revealed the following recurring themes:

Communication

> *"I think what would make a good birth experience is if you have your nurses and your doctors who listen to you. I guess hearing everybody's stories, it was like even with the good having that little moment of having that nurse making it uncomfortable. Especially when it's your first time giving birth there are so many unknowns…You know your body. So any moment or anything you feel you want to be able to have that communication open and if you say hey something doesn't feel right you want them to take it seriously and not just completely...oh your fine but to actually hear your concerns and to ask questions like, 'where is this pain coming from,' 'why do you feel this way' and not just brush it off"*
>
> \- *Charlotte*
>
> *"He didn't listen to me. Now my baby's dead."*
>
> \- *Violet*

Many of the experiences shared by the women expressed a desire for better communication between themselves and the medical staff who were attending to them. In particular, the women expressed a desire to receive information in a way that was timely and provided when it was requested. They wanted information that was easily accessible, complete, and communicated in a way that they could understand. In addition, many of the women expressed the desire to be heard and taken seriously. As depicted in Violet's story, many of the women shared experiences in which they expressed concern about a topic or their health and were brushed off by the doctors and other medical staff. They felt that their knowledge and understanding of their own bodies was neither respected nor considered relevant and expressed even the process of internalizing and accepting the notion that the doctors were indeed the experts and therefore invalidating their own intuitions about their health.

Knowledge

> *"Some of the tips were helpful but the [birth education classes] did not physically prepare me for that day…"*
> - *Ronda*

> *"About the birthing education, sometimes I feel like we aren't getting the type of information that we need…they talk about healthcare, they talk about diet, they talk about exercise, an epidural and all that but they don't talk about the things that you are going to face when you are in that situation or when you are having to make those quick decisions right then and there…they aren't preparing women for situation that they may come up against and they end up having experiences like she did where she knew herself that something was wrong and she couldn't get the doctor to help her. There should have been other places that she could have gone for help. Even as a Medicaid recipient she should have been able to have other resources available to her. So sometimes birthing education needs to go beyond the actual pregnancy and deal with issues that are common to people who are in poverty or low-income housing situations…"*
> - *Dianne*

Access to relevant and accurate knowledge and information was another theme that arose from the experiences of the focus group. The women expressed not only feeling unprepared for labor and birth and not knowing what to expect in some instances, but more importantly, those women who did attend birthing classes or were provided other forms of education felt that the information was not helpful. In particular as expressed in the quote by Dianne, the women desired a set of information that was outside of the scope of pregnancy itself. Instead knowledge of systems navigation, resource availability, and survival were more important than the topics such as nutrition, exercise, and labor and delivery.

Attitudes and Beliefs

> *"I had healthcare when I had my baby but I was also in my early 40's so I had extra care. But even though I had the healthcare and I did the prenatals and all this kind of stuff my doctor started trying to convince me to have my tubes tied toward the end of my pregnancy. You know it was this constant questioning every time I went to the doctor like, 'so are you going to get your tubes tied,' 'so are you going to get your tubes tied,' 'you're going to get your tubes tied right.' You know that kind of thing…So I'm strapped to the table numb from the neck down and the person who is supposed to do the cesarean comes in and goes 'so we are getting our tubes tied today,' you know…and I'm like how many times can tell you that I am not getting my tubes tied! Is it because I'm Black you think I'm not supposed to have more than two children?"*
>
> \- *Dianne*

> *"They kept trying to push an abortion on me up to six or seven months…They said the longer you wait the more it's gonna cost. So they kept pushing abortion on me. I said, is that even legal to do it up to the six or seventh month…They kept pushing at every doctor's appointment for my oldest daughter…then they wanted to tie my tubes after the second one…"*
>
> \- *Kisha*

Many of the women in the group asserted that the negative attitudes towards Black women directly impacted and experiences. While on 29% of the women asserted that they had been disrespected of mistreated by medical staff during care, almost all of the women felt that medical staff and doctors had preconceived notions about Black women. In fact, when the facilitator asked blatantly if race had anything to do with how women experienced birth and pregnancy and whether it impacted care the room echoed with a resounding "yes." Given this, the women expressed a desire for providers will not make assumptions about Black women and to as in the experience of Violet yet again, to not be blamed or judged based on their race, their health status, life situations, or for the outcomes of their births. Yet again, the women wanted the providers to respect and acknowledge their personal wisdoms about their bodies and for they themselves to not relinquish that power or r to be afraid to push back when they feel something is wrong.

Stress

> *"He asked me how I was going to get through this I said the only way I been getting through this and that's God…"*
> - *Violet*

Stress was an important topic of discussion for the women. Many of them expressed having high levels of stress throughout their lives and in their pregnancies stemming from a number of sources. Given this, many of them expressed a desire for providers to consider individual life circumstances and stressors in their care and also having access to stress relieving services and activities as part of the care. Interestingly, many of the women expressed a reliance on spirituality and God as a means to cope with the daily stressors of life.

Access to Care/Care and Treatment

> *"What can make a birth a little easier is if you have a doctor who does not care what type of health insurance you have. I*

> *had blue cross blue shield with my first daughter and then I had Medicaid with my second daughter and it was a humongous difference. Because With Blue Cross Blue Shield they put me in a humongous room…I was treated with so much respect. But with Medicaid they gave me a c-section and the doctor had like ten other women and we were all in one room. Like ok we are gonna do your c-section then I'm going to go over to her and I'll check on you in a minute like boom, boom…just a whole line of women…but the doctor had so many minutes to be with me then go on to the next lady that was laying right next to me…if you can get a doctor that does not care about the type of insurance you have versus your well-being and how you are going to have your baby make sure your healthy your baby is healthy…that would help a whole lot… "*
>
> \- *Kisha*

A general sentiment expressed during the group was the experiences of differential treatment dependent upon insurance status. Not only did most people agree that care was not as good if you were on Medicaid, some women in the group had experienced birth both on Medicaid and with private insurance and described the significant differences in care. In particular, women expressed the desire for equal treatment generally, shorter wait times for appointments, and timely and proactive responses to symptoms and health concerns. Also, women wanted access to additional components during care that would address pre-pregnancy and health and wellness in between pregnancies, better post-partum support and care, as well as structures and activities that promote and support self-care and community-based peer support.

Support and Resources

> *"My husband went to almost every doctor's appointment and he was there supporting and not everybody has that but they completely blew that off that he was there supporting me and kind of made a joke about it every time he was there like it wasn't important…"*
>
> \- *Joan*

> *"When I was in the military for my first two pregnancies I had a nurse. She was a retired nurse that went through with me throughout both of those pregnancies but she actually retired from this position by the last time I had my last one. She actually came to my house she visited with me and just helped me out and I feel like she had been with me with the last one I would not have gone through what I went through with the doctors…"*
>
> \- *Lisa*

> *"I would want someone that I could relate to…When I am pregnant I'm irritable and I don't want to explain myself a lot. I just want somebody to say something and u know… I know exactly what you are saying. You just want it to automatically be comfortable. I just don't want to feel out of place…"*
>
> \- *Tisha*

Support was critical to needs expressed in the focus group with the women. In fact, the need for support - whether from family, the child's father, or a close friend to help throughout the pregnancy - stood as one of the main concerns for women in the group. Moreover, in the description of the good birth experience, the large of amount of support was the single most distinguishing factor that impacted her positive experience both prenatally as well as in the post-partum period. Most importantly, the women expressed a desire for a support person of their same ethnic or cultural background and someone whose life experiences they could relate to in order to assist in some of the following activities: accompaniment to appointments, birth and lactation consultation, problem solving assistance, providing information upon request, providing routine information, education, home visits.

While some of the themes that came from the perspectives of the women in the groups reflected positively on passed experiences, many of the themes reflected what they deemed an absence in their care. Some have argued that the over-medicalization of birth over the years have resulted in a more surgical and less supportive and woman-centered model of maternity care in the United States. Given this, it stands that revisiting the maternity care as it existed historically in the

United States and particularly for Black women may hold some answers and provide new considerations for ways in which we can move forward to providing caring and supportive maternity care for Black women.

LOOKING BACK: MIDWIFERY AND BLACK WOMEN'S CARE PRACTICES

> *"Yes, the doctors kept telling me that there was something wrong with my baby, that she was going to have some problems, and that she would be slow or behind. But there was this one nurse. She was the only Black nurse that I saw there. She never really looked at me when she came in but every time she came in my room she would say 'there is nothing wrong with your baby. Just pray over that baby every day and she will be fine.' And every day while I was in the hospital she would come into the room and say that. So that is what I did. I prayed. And you know what? My baby girl is fine. She is smart and doesn't have any trouble in school. She turned out just fine…"*
>
> *-Jessica*

Sitting on a cement bench in front of local Black owned hair salon I had struck up a conversation with Jessica. I was paying a quick visit to the salon to make a hair appointment and after having a brief interaction with Jessica, decided to invite her to participate in one of the focus groups.

> …Yea…The program sounds really interesting but I am not sure what I can bring to it. I mean…I was in the military and stationed at Ft. Hood at the time so my prenatal care was really really good…

This of course was her way of turning down my invitation. Nevertheless, while Jessica described the care that she received from the military as great, I proceeded to learn that in actuality Jessica did indeed have a few complications towards the end of her pregnancy that would ultimately land her daughter in the NICU for a short period of time. Although she did not express to me the specificities of what happened, it was in this brief conversation that she divulged to me the story

of the older Black nurse whose kind words and encouragement reassured her that despite the undesirable diagnosis by the doctors, with prayer her baby would be fine. Similar to the many of the stories from the focus groups, Jessica, who described her prenatal care experience as great, still ended up with a somewhat negative experience. Given this, I wondered whether it was just a coincidence that despite her access to health insurance she still was not exempt from negative experiences. Additionally, Jessica's experience and interaction with the Black nurse, to me, aligned directly with Shonda's experience. Shonda was a woman who participated in both the MAMAS and the focus groups held in collaboration with the governmental agency. Prior to the birth of her only son, Shonda experienced six consecutive miscarriages. According to her, it was not until her Aunt stepped in to provide her with one-on-one support and guidance that she was able to have the live and healthy birth that resulted in her son.

While the women in the focus group expressed the desire for support person or people, preferably a Black woman, to be there during the pregnancy, it begs to question that given the experiences expressed by the women, what power lies in this role of this supportive presence? Moreover, what is it about the support of another Black woman that has the potential to change the outcomes of pregnant Black women? Evidence of the benefits of social support during the antepartum, intrapartum, and post-partum periods has already been presented in various research studies. The presence of family support, intimate partner support, interpersonal support, and community and neighborhood contacts can help to 1) improve maternal satisfaction (Campbell et al. 2007; Crnic et al. 1983; Mottl-Santiago et al. 2008; Sauls 2002), 2) increase infant interactive behavior (Campbell et al. 2007; Crnic et al. 1983; Sauls 2002), 3) mediate the adverse effects of stress (Crnic et al. 1983; Turner, Grindstaff, and Phillips 1990), 4) help to decrease the risk of post-partum depression (Carty et al. 2011; Crnic et al. 1983) and 5) even have an impact on fetal

weight (Buka et al. 2003; Hoffman and Hatch 1996; Oakley 1985; 1990; Turner et al 1990) Consequently, lack of support was a key theme among the women. Nevertheless, if we examine the history of childbirth for Black women in the United States specifically, we see that traditionally, support provided by the community and the attendance of the Granny Midwife, for example, was actually a critical component of Black women's maternal care practices.

Role of the Granny Midwife

Some believe that the practices and the beliefs of the Black Granny Midwife came across with enslaved Africans during the trans-Atlantic slave trade (S. A. Robinson 1984). In fact, this role, also referred to as a Traditional Birth Attendants (TBA), still exists and is still practiced in various places throughout the African Diaspora (Dorwie and Pacquiao 2014; Vyagusa, Mubyazi, and Masatu 2013; Wilkie 2013; Okpomeshine 2011; Boseley 2013; Kumbani et al. 2013; Affette McCaw-Binns 2005). These women, oftentimes considered to be the holders of cultural knowledge, were thought to be called by God and passed the secrets of their craft down the matrilineal line (S. A. Robinson 1984). From the inception of American chattel slavery into the well into the 1940's, Granny Midwives were responsible for a majority of the births for both Black and White alike. This was especially true in the South. Granny midwives incorporated natural and alternative or "folk remedies," traditional medicine, and spirituality and religion into their care practices (Fraser 1998; Schwartz 2010; Wilkie 2003).

What is most important about the role(s) of the Granny Midwife was that she encompassed way more than just "catching babies." In a study of Midwives in Texas from 1920-1985, Ruth C. Schaffer found that the activities of Granny not only included delivering babies but also recruiting and training other midwives, helping people in their community secure employment, community education, crisis intervention, and even assistance with legal issues (Schaffer 1991). Generally

speaking, Granny midwives served an array roles that included delivering babies, providing comprehensive prenatal, delivery, and post-partum support, being an on-call healer, protector of cultural and community knowledge and history, a connector of resources, and an overall spiritual and community leader. Given this, Granny midwives were pillars in their communities who were committed to providing services that attended to the basic survival needs of those in her community.

Decline of the Granny Midwife

By 1830, approximately 13 states had passed laws that would outlaw the work of healers (Robinson 1984). This represented a new shift in which the science of obstetrics began to grow as a field and therefore "folk" healing and midwifery began to be considered foolish and out of date. Yet, given the geographical, economic, and social impacts of race and class, the practice of midwifery was rarely regulated and considered to be a necessary evil so that people could access some amount of care. Consequently, with the growing infant mortality rates, the Children's Bureau was established in 1912 and shortly after in 1921 the Sheppard-Towner Maternity and Infancy Protection Act was passed. This act provided funding for medical training of nurses and midwives and spawned the increased regulation of midwifery practice and ultimately the growing medicalization of health care and birth.

While the spouted rhetoric behind the new legislation was to increase the training for midwives and therefore increase the number of safe and healthy births for women, the actual repercussions of the act were not as such. Instead, the implementation of Sheppard-Towner resulted in an extreme decrease in practicing midwives. For example, from 1910 to about 1930 the number of births attended by midwives dropped from about 50 percent to about 15 percent (Ladd-Taylor 1988). Many of these births were to poor Black women in the south. In addition to new

training requirements that ultimately prohibited many Black midwives from continuing their practice legally, the Sheppard-Towner law did a number of additional things that would reduce births attended by midwives in many ways.

As part of the act, mothers were provided education courses so that they could be more knowledgeable about birth and make “better” decisions about their pregnancy and birth. As the obstetric field continued to grow and become overwhelmingly male dominated, it also was associated with “better,” cleaner, and safer birth. Given this, the outcomes of the education classes oftentimes was encouraging mothers to have their births attended by physicians and not the midwives from their local communities. Additionally, although Sheppard-Towner was meant to increase training for midwives, many physicians directly opposed the implementation of the act. Midwifery was considered to be direct competition for the growing medical field and many felt that it was better as a discontinued practice then something that could be improved. Central to this notion were problematic assumptions about race and gender that informed much of the push back against Granny midwives as well (Bonaparte 2008).

As the number of obstetricians grew, and as midwives came in contact more often with medical professionals and nurses due to the new legislation, stereotypes about midwives being dirty, lazy, incompetent, and even dangerous became more pervasive. High infant mortality rates were blamed on the continued utilization of midwives. This was even despite the fact that obstetrics as a science was still being developed and mortality rates for midwives were oftentimes lower then then the rates for practicing physicians (Fraser 1998; Ladd-Taylor 1988). In the case of high Black infant mortality rates, blame was directly placed on rural Black midwives and little consideration was given to the racialized and social experiences of poverty. Ultimately as time progressed, investment in medical training and obstetric practice recognized a growth from both white and

Black individuals alike. Medical training discouraged the use of natural alternative "folk" remedies or other cultural practices that were deemed as nonsensical or magical. The repercussions of the Sheppard-Towner act reduced the numbers of practicing midwives, discouraged the continuation of traditional and culturally rooted practices, and provided education that ultimately encouraged the use of obstetricians. All of the things combined resulted in the essential eradication of the Granny midwife.

CONCLUSION: INVOKING GRANNY

If we revisit the roles of the Granny midwives, we see that her disappearance stood as a critical loss to many communities in many ways. The obliteration of community rooted support, the continuation of cultural knowledge, practices, and culturally centered care, and the trust and understanding that she brought particularly during pregnancy and birth. Given this, I would like to argue that looking at midwifery as it was practices during the active period of the Granny midwife may begin to provide some clarity into the alleviation of negative birth outcomes and experiences for child-bearing Black women. To clarify, I am not necessarily asserting that 1) midwifery is the answer and 2) that the practices of the Granny midwife were free from complication and that infant or maternal death did not occur. Clinically, complications and mortality rates have decreased tremendously due to the marvels of modern medicine. Nevertheless, I am arguing that invoking the sentiments and characteristics of care that Grannies exuded may begin to help us reframe how we conceptualize maternal care in the U.S. In particular for Black women, it stands that some of the remedies to alleviating the impacts of racism induced stress could potentially be found in the supportive, nurturing, and community oriented practices of the Granny.

Alondra Nelson in her book entitled *Body and Soul: The Black Panther Party (BPP) and the Fight Against Medical Discrimination* (2011) not only provides an overview of the BPP's health and clinic projects but also in her first chapter provides a history of Black health activism in the U.S. By reviewing the BPP platform, Marcus Garvey and the Black Cross Nurses of the UNIA, and the health and clinic initiatives in SNCC and during Freedom Summer, Nelson identifies integrationism, institution building, and the politics of knowledge as the primary tactics employed in Black health activism to increase access for Black communities and address the immediate health care needs of the community (2011). Although the Granny Midwives may not have been considered a form of "health activism" during their time, their important role as community leaders, holders of cultural knowledge, and providers of health and wellness when there were no other options serves as the precursor and ultimately foundation for the vital legacies of Black health activism that trailed the eventual decline of the Black Granny Midwife.

Granny midwives attempts to integrate with training and the changing racist policies, their attempts to create and maintain a mechanism to provide care for their community, and still attempting to maintain strong communities and hold on to their cultural, spiritual, and community practices is also a cultural legacy that we must invoke to counter the fatal impacts of maternal and infant mortality. By looking back that the foundation of the more contemporary legacies of Black health activism, i.e. the Granny midwife, we can possibly learn how to deal with our contemporary maternal health conundrum.

In attempting to remedy the negative birth outcomes for Black women we must consider many issues. If we link the current literature on racism stress, the responses of the women in the focus group, as well as the deficits and potentials that exist in existing models, we see that (re)conceptualizing Black women's health disparities as a systematic and societal issue also calls

for a reconceptualization of the interventions. I argue that revisiting and recreating some of the support and care practices as they existed in Black communities prior to the over-medicalization process, and “invoking granny” may provide unique insight into the ways in which we can begin to address these disparities.

In considering the effectiveness of integrationism and institution building, the next chapter evaluates the MAMAS organizing work around maternal and in particular Black women’s maternal health in collaboration with other institutions. It evaluates the effectiveness of these collaborations and the challenges, wins, and losses that the MAMAS experienced.

Chapter 3: Not with the Masters Tools: Institutions and the Search for Social Transformation

> "For the master's tools will never dismantle the master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change…"
>
> – Audre Lorde

"That was powerful." *Huh?* "That was really powerful what ya'll did today…" *Thanks.* I stared at the salt and pepper haired gentleman who had sat quietly off to the side of the room. *Who was he?* Apparently, he had been intently listening to the multiple stories of those who had come forward to offer testimony and comment at the hearing that day. I had barely even noticed him sitting silently along the wall at all. Was he a stenographer? Had he been transcribing the accounts or was he simply there to monitor the hearing proceedings for the day? He obviously worked for the state. Regardless of his role that day, he had apparently been impacted somehow by what he had witnessed.

That morning around 9 am, other members of MAMAS and I gathered together to prepare for a hearing in which public testimony would be documented both in favor and against Medicaid covering Midwifery services in the state of Texas. This action had been part of a broader three-pronged campaign launched by MAMAS in order to increase access and choice for prenatal care and birth services for poor and working class women of color in the Austin area. In collaboration with other organizations such as Texans for Midwifery and Association of Texas Midwives, we lobbied to enact a rules change that would require Medicaid to cover midwifery services provided by Licensed Midwives and therefore be in accord with the corresponding federal legislation. This hearing was a continuation of that process.

Blockading the entrance of the greyish green state building where the hearing would be held, we passed out large round hot pink stickers wielding the statement “Every woman deserves the right to have choices in birth.” Inside, the room was small. There were about ten rows of long gray rectangular tables with black chairs sitting behind them. One table sat on the right by the entrance and a microphone and tape recorder sat planted on the table closest to the front of the room. A sturdy wooden podium stood at the front of the room with a big Texas-sized gold star cemented to the front of it. Standing behind the podium and gazing out into the audience you could see a sea of hot pink dots. One by one each made their way to the front of the room to pronounce their opinions and have their experiences as mothers, support people, doulas, fathers, and midwives in support of the rules change be recorded and documented. This procession of support was not without opposition though. Two individuals, a woman and her mother, sat indignantly off to the side. The daughter had attended the hearing as a representative of a professional obstetric organization. She sourly proclaimed her opposition to the rules change and made it abundantly clear that she was not about fraternizing with us, apparently the enemy that day. Her testimony against the use of licensed midwives or “lay” midwives as she called them asserted the obstetric organization’s supposed interest in the health and safety of child-bearing women and the danger that “lay” midwifery posed to pregnant women. This oration was followed by silence only shattered by the clap of her sole supporter that day, her mother. She even refused to accept one of our hot pink stickers. She *obviously* did not believe that women deserved to make their own choices when it came to birth - at least not when it came to the type of provider. I thought to myself, while it was obvious that many obstetricians would be against licensed midwives encroaching on their patient market, I found it particularly intriguing that an organization who is purportedly interested in the overall well-being of women would also be blatantly against women making their own

reproductive choices. This should not have come as a surprise to me and yet it seemed wickedly akin to the conservative sentiments assuming that women are not knowledgeable enough to make informed decisions about their reproductive health. Interestingly, this mother-daughter pair standing in stark opposition to the rules changes also made up two of the maybe five Black woman present in the entire room.

In the end, the rules change passed and became effective in January 2013. Generally, this should have been considered a successful campaign effort and looked at as a win on the books. Yet, the specificities written in the rule around reimbursement rates and required physician collaboration agreements made implementation of the rule neither desirable nor viable for Licensed Midwives. Consequently, while the action proved to be an inspiring moment and a powerful presentation, it begs to question whether or not it did or will in the future have a larger impact on access and choice in Texas; especially for poor Black women.

***

This chapter focuses on the MAMAS organization's engagement with various institutions in order to begin a dialogue about processes of social transformation. By using concrete examples, this chapter evaluates the effectiveness of institutional processes and the ways in which even purportedly good intentioned institutions reinvent racist, sexist, and capitalist practices. It makes note of the various ways that MAMAS as an organization as well as its individual members engaged with various institutions specifically around the reproductive justice and health of black female bodies and the problematic interactions that occurred to ultimately undermine the MAMAS work. From the misuses of MAMAS members in the workplace, to the cooptation of ideas and the multiple attempts at self-promotion and monetary gain centered on the death of Black bodies, these interactions with institutions and their respective agents expose the ways in which transformative

and progressive work can be encumbered by and actually in direct conflict with the inherent nature of institutions. These concrete examples provide a grounding for understanding the disjointedness that occurs with the relationship between institutions, Blackness, Black bodies, and Black people. I argue that working within existing societal structures and institutions is not an effective way in which to address issues around Black women's maternal health. Building upon knowledge that recognizes the role that racist, classist, and sexist institutions play in contributing to maternal health disparities and knowing that the existence and survival of these institutions is oftentimes based on the maintenance of racial hierarchies, exploitation, and violence, I argue that we must find ways to self-determine our own outcomes and rely upon community power and relationships outside of traditional institutional structures in order to solve problems. By engaging theorizations around white supremacy, anti-black racism, and hegemony, I contend that acknowledging the incompatibility between existing social structures, institutions, counter-hegemonic efforts, and Blackness is an important step in re-imagining new conduits towards social transformation.

MAMAS WORK AND INSTITUTIONS

Many of the earliest architects of social theory offered conceptualizations pertaining to mechanism of societal transformation and the impacts of institutions on the social fabric. While the study of institutions remains a central preoccupation in the social sciences, the complex and fluid nature of institutions has made the creation of a concrete and standard definition quite tenuous. Johnathon Turner, in his complex study entitled *The Institutional Order* (1997) provides a basic definition that I will use here as a starting point for my analysis. He asserts that

> A social institution can be defined as a complex of positions, roles, norms, and values lodged in particular types of social structures and organizing relatively stable patterns of human activity with respect to fundamental problems in producing life-

> sustaining resources, in reproducing individuals, and in sustaining viable societal structures within a given environment (6).

This definition acknowledges both the role of institutions in providing structure and ordering society. It also describes the expansive characteristic of institutions that by definition can encompass many of the predominant institutional depictions such as government, schools, family, religion, languages, organizations, and universities among other things. This is significant because it brings to light the inevitability of interaction with institutions in some way shape or form in our daily lives. Given this, it is of no surprise that MAMAS' organizing work would include some amount of institutional engagement in its practice. Nevertheless, the examples in the following accounts describe the interactions of the MAMAS with government, academic and research groups, and with medical establishments. While these institutions serve as more bureaucratic and advanced formations, the examples are still useful for illuminating the ways in which institutions mirror and uphold society's ideological foundations and therefore are useful to rethink *all* forms of institutional engagement.

MAMAS as an organization as well as its individual members engaged with institutions in various ways in order to impact the ways in which women of color were able to access health care systems for their reproductive health care needs. Yet, many of these "endeavors" resulted in less than desirable outcomes. More often than not, these interactions resulted in moments of disrespect, exploitation, and abuse. What is most significant about these disempowering experiences was that they often occurred when working in collaboration with individuals who were purportedly progressive and in our initial interactions deemed trustworthy partners. While members of MAMAS did experience interpersonal experiences of abuse, racism, classism, etc., I argue that it is the inherent nature of institutions in this society that make radical, transformative, or dare I say revolutionary work precarious in nature. This does not negate the existence of "progressives"

within these institutions. Yet, MAMAS found in our work with institutions that the constraints, protocols, and inherent characteristics of various institutions did not allow for the existence of progressive anti-racist, anti-sexist, anti-oppressive work to take place. Even in the instances in which we had "success" we found that the overall impact of the work failed to make any significant or long-term change.

Even with a healthy skepticism of the long term transformative potentialities of institutional partnerships, MAMAS chose to seek various forms of collaborations for a number of reasons. Most of them hinged on issues of resources and funding. MAMAS spent a significant amount of time doing the work and trying to maintain our autonomy outside of these systems. For instance, in the beginning, much of the work was volunteer and any funding that we acquired came from grassroots methods such as throwing house parties or putting on community supported shows and showcases. In utilizing this structure of fundraising, often times our efforts were project based and funds that were gathered were also rapidly depleted on one single project and in one single blow. This worked for a while. With the inception of the prenatal clinic, we quickly learned that our capacity to do the work and the resources needed to run a clinic (salaries, autonomous space, etc.), even with volunteer midwives and doctors in a community-based setting, required a significantly more robust funding source. Given this we were forced to look to more concrete and sustainable ways to support our project. This is when organizationally we started to entertain more seriously our engagement with various institutions.

While funding and resources was the predominant reason for pursuing institutional collaboration there were other very important issues that we needed to address. One additional rationale that underscored our decision to work with medical institutions and clinics in particular, was the community by-in and investment with medical institutions. Central to our analysis was an

understanding of the contribution that institutions and medical systems have on the negative health experiences of minority populations and Black communities in particular. Nevertheless, we found that alternative constructions of quality health care outside of medical institutions were rarely accepted and seen as legitimate or safe by the women (Black women in particular) we were looking to work with. This of course stemmed from the historical transition, rooted in the equality rhetoric imbedded in civil rights movements, in which neglected and marginalized communities began to gain greater access to various spaces and services. This shift is particularly evidenced in the history of maternal health care with the criminalization and demonization of Black midwives as a means to encourage a transfer of care from community healers to the hospitals (see previous chapter on maternal health disparities and Granny midwives). The residue of this cultural erasure is still prevalent and evident in the hesitancy of many Black mothers to consider alternative forms of medicine and models of care. Given this, we sought to enact a prenatal model of care that was at least initially built on the familiarity with medical institutions but that would hopefully start conversations around the systematic transgressions of medical institutions and the necessity for a different model of treatment and care. In the process of navigating these slippery slopes we realized that our engagements with institutions were ultimately unable to escape the occurrences of malevolent and hostile treatment so normal to institutions built upon a foundation of hierarchy, capitalism, and racism. These institutions consistently attempted to exploit us and gain profit and self-promotion based on association with our work. On one occasion when things went sour in our relationship with one medical institution, they even sought to demonize, dismantle, and destroy our work.

Employment, Labor, and the Institution

In the summer of 2013, my friend and fellow MAMAS member Lois and I began a span of employment with a government agency attempting to reduce the prevalence of negative birth outcomes for Black women in the area. Lois and I were in many ways recruited for these positions due to our connection and "insight" into the local Black community and due to our histories of community organizing efforts with MAMAS in Austin. Initially, we welcomed this opportunity and involvement in such an important project with excitement and positivity. Rarely was there significant interest in projects that were specifically meant to help "us"- i.e. Black women in Austin. As I would quickly learn, this idea was the consensus held by many Black women in the area. The project itself had been proposed by and deemed the "pet project" of the director and was being supervised by the assistant director who, from our initial interactions, seemed to possess a progressive consciousness around race, class, and gender. The seemingly supportive circumstances surrounding the development of this project was something that we perceived to be usually quite infrequent and we were encouraged by the possibilities.

As the work started, we found that even with these encouraging circumstances, we were not free from the complications, political entrapments, and susceptibility to social structures that perpetuate racialized, classed, and gender based hierarchies of power so standard to government work. In fact, we learned rather quickly that these problematic processes actually continued to underline the basic functions of the organization even despite individual attempts to regularly challenge these structures.

In particular, these problematic power structures manifested in issues of voice, legitimacy, and value surrounding Lois' and my work. Power played out in the ways in which Lois and myself were heard within the project and was evident in the division of work allocated between the two of us. Lois' title and duties, for example, revolved around community engagement and recruitment

of Black women for both the focus groups and for any other interaction with local Black women in the community. Her primary responsibility was to manage and implement the outreach plan for helping the agency gain access to and participation by local Black women. My title and duties, on the other hand, centered on research, reporting, and in the end the overall management of the administrative and organizing pieces of the project. The original conceptions of the job descriptions were verbalized to us as based upon our individual skill sets and experience. Nevertheless, it became quickly apparent that our respective duties were in fact reflections of *assumptions* made about our abilities and skills. While I was a doctoral student working on completing my PhD and Lois had not yet completed her bachelors, her employment, programming, management, and local community insights far surpassed mine. Due to my lack of hands on experience, I often referred to Lois on basic questions about how the agency generally functioned, their processes, and even funding and grant protocol, all of which she had experience with directly. Our value to the program, both individually and as a pair, was disparately tabulated based on traditional understandings of legitimacy and rooted in a hierarchical valuation logic around education and judgments based on our respective performances of acceptable institutional and professional behavior.

In addition to the nature of the work allotment, we found that the assumptions made about our value also informed our corresponding treatment and respect in the workplace. From the beginning Lois felt a slight difference in the requirements around our conduct. For example, while I consider myself to be a competent and valuable employee, I also, being used to the flexible life of a student and possessing the free uninhibited spirit of my mother and grandmother, rarely arrived to work on time. I also rarely felt the need to check in about my whereabouts. Interestingly, when I did arrive, I was questioned not about *my* timeliness but instead Lois' whereabouts and expected

arrival time. This was done with the knowledge that Lois was a single mom of three and enrolled in a local undergraduate program full-time. This was known prior to her employment and was accepted with the agreement that the position could be flexible and accommodate her demanding schedule. While this is one of the initial examples and while our positions were part-time and fairly flexible, there were multiple occasions where Lois expressed that 1) she felt undervalued in comparison to me and 2) that comparatively, our supervisors were less willing to accommodate her. While I had education and sadly to say years of practice performing a particular institutionalized and ultimately corporate etiquette that made my status as a young, single, Black mother more palatable, Lois felt that in the end her categorization as a poor, Black, single mother without mechanisms to mollify that identity directly informed her experience within the institution.

Although much of my initial work consisted of conducting research, part of my work was also to participate in the recruitment of a group of Black women for our focus groups with local women. Lois took the lead on this part of the assignment. While we did engage in door knocking in some local low-income housing and affordable housing facilities, a predominance of the recruitment was based on Lois's already established family, friends, and community networks. In the end, we helped to recruit approximately twenty black women to participate in the two focus groups around local Black women's prenatal care experiences, their wants, needs, and their desires. After documenting the responses of the women, the next step was to examine the responses, analyze the themes that arose and figure out how the information provided from the women could be used to develop an intervention that would address the concerns and suggestions expressed in the groups. It was in this examination process that we realized the true reality of our roles in this project development process. This was in part revealed due to Rita's introduction to the work in the project.

Rita, also a Black woman, was a contact from the MAMAS' circle of allies. Lois and I suggested Rita to operate as an outside facilitator for the focus groups with the local Black women. Despite our positions as the primary points of contact with the women, our work to recruit the women, our relationships with women, and our own experiences that aligned directly with those women in the groups, it became painfully evident that our voices in the analysis of the information was undervalued. At least that was our perception. Instead, we found that Rita actually seemed to hold more power and clout than we did during the many aspects of the project's conception. Part of this, we decided after numerous conversations, was due the fact that 1) Rita and our supervisor Mary had a previously established relationship that we were unaware of prior to our work with agency, 2) our supervisor exhibited a greater amount of comfort and trust in Rita's perspective and analysis partially due to their shared educational background in social work, and 3) both Rita and Mary were close in age and many years our senior. While these circumstances are not prescriptive, in this case they seemed to espouse a close camaraderie between Rita and Mary that consequently excluded Lois and I and altered, if not reduced, our pertinence to the project. While our initial involvement in the program was heralded as important and essential, particularly around the recruitment of local women, our significance shifted with the needs and progress of the project. This was particularly the case when processes of intellectual labor were on the table.

On multiple occasions prior to and following many of our meetings, our supervisor, Mary and Rita could be found sitting off to the side of the room planning, discussing, and debriefing the incidences of the meeting without Lois' or my input. During this time Lois and I could be found setting up or cleaning-up from the day's events. In other instances, we found that in the process of decision making for the project, Rita's opinion, which was often in line with that of Maria's and was almost always in opposition to mine and Lois,' was overwhelmingly the option that prevailed.

This inevitably caused increased feelings of insignificance and distrust between Lois, myself, and Rita and occurred despite the fact that Lois and I had suggested Rita as a progressive and conscious ally. Moreover, at the onset of the collaboration, we met with Rita in order to insure that we were all on the same page, that our goals were in alignment with one another's, and that Rita was to participate in the project as a mechanism of support in solidarity with both Lois and I as well as the MAMAS. Instead we found that while Rita asserted her solidarity and support and feigned ignorance to the problematic power dynamics at play, her allegiance to Mary and *her* corresponding requests superseded her solidarity with us. This predicament and separation persisted and even seemed to increase with Rita's continued involvement in the project.

In the end, and more so for the case of Lois, it felt that once we had done the "dirty" work of getting in the streets and bringing in the women, that our time, space, and contribution to the program were deemed much less essential. In my case, my academic skill set necessitated a more steadfast need and a more concretized longevity with the program. Yet, there were still reminders, especially in the case of Rita, that I was an expendable Black face, replaceable with whoever they had waiting in the wings. More importantly, we quickly came to the realization that regardless of what the women in the groups had shared with us, decisions about the direction of the program would be based upon the resources, ideas, and ultimately politics of the agencies leadership.

This example proves significant for a number of reasons and exhibits significant points about the institution and its aims and its processes. This case shows the institution's success in 1) using Black bodies and Black labor to gain access, acquire inside information, and secure validation and legitimacy via proximity to (and not inclusion of) Blackness and 2) the inherent institutional structure and processes that innately work to divide and disrupt solidarity and counter hegemonic power. Although we were initially recruited for our connection to Black people in the

community, Lois and I quickly realized our roles as the Black faces needed to work on the "Black" project. Moreover, through the entirety of the project we felt that we had very little decision making power about the conception of the project, if any at all. In the case of Lois, Rita, and myself, the very nature of doing institutional work as opposed to the community work that we were used to doing together, created competition and ultimately rifts and distrust between us. This occurred even though the three of us met in the beginning to plan how we would work together and be in solidarity throughout the process. In the end, it was Lois and I who were able to see what was transpiring and made intentional efforts to disrupt the pressure of the institution to divide us. To date, the impact on our relationship with Rita is still being felt.

Overall, I argue that this process of division and competition in central to the maintenance of not only hegemonic power but also hierarchy and capitalism within institutional structures. Sentiments not based on individualism or that support community are in direct conflict with institutional power. Moreover, inherent to the nature of the institution is the *use* of people. This use is a topic that I will revisit later but holds great significant and requires examination especially when reviewing the relationship between *use* and Blackness. Lois' and my engagement with the local government agency not only speaks to abuse and exploitation but revisits the history of institutional power using the labor of Black bodies for its own gain – even when done purportedly under the semblance of Black benefit.

Pressures of Institutional Ideology and Structures

In discussing the *use* of Black labor as exhibited in the depiction of Lois and my work, one must also consider the presence of profit. While a discussion of monetary profit is an impending part of this analysis, self-promotion is another example of the inherently cutthroat, individualistic, and profit-driven nature of a capitalist society. In the following example, this type of characteristic

manifested again within MAMAS institutional engagement even when cooperating individuals were not intentionally trying to undermine progressive practices. In fact, this particular individual, at least in rhetoric, was advocating for more progressive and social justice oriented work, yet was still governed and ultimately constrained by the functions and processes of the institution.

In 2012, MAMAS began a relationship with a local educational institution in order to collaborate on a grant and research project. The impetus behind this was to conduct research around the effectiveness of the MAMAS model of prenatal care and prove its effectiveness to garner support, legitimacy, and resources for the work. From the onset of the conversations with our main contact, we discussed how both parties could reciprocally benefit from the collaboration on the project. MAMAS wanted academic research to bolster legitimacy and support behind their innovative model of care and needed funding that could help implement the full model of the pregnancy clinic. In exchange, MAMAS would help to outreach and administer surveys to local Black and Latina women in Austin, Texas due to their already established social and community networks and the partnering researcher would not only provide the guidance and skill set to help with the analysis but also be able to utilize some of the research data for her own work. My familiarity with the nature of the academy invoked immediate concern around the possible consequences and problems that could arise around research politics specifically and production on the project. As the negotiations and the relationship progressed, various issues arose that caused increased tension between MAMAS and academic institution.

One of the biggest issues that came up between MAMAS and the researcher was a lack of communication, the means and methods of communication, and time. MAMAS' structure, which operated as a collective body, meant that all decision making, conversations, and meetings were ideally done as a group as opposed to with one person. This process, as with most interactions with

external groups, was made clear from the beginning. In practice, this meant that communication was never initiated with only one member and that all decisions would be brought for deliberation with the entire collective. As with other interactions with various institutions, instead one person was always inadvertently "chosen" by the outside group as the primary contact person. Usually correspondence was sent to this person and meetings were asked to be scheduled with that one individual. This process of individualistic contact went directly against the organizing structure and vision of the MAMAS. In addition, the methods for communication as well as the means were such that it overwhelmingly narrowed who was able to participate in negotiations with the university. Only those members who could readily access email, and who had the privilege of flexibility were able to actively participate in the on-going conversations.

While many agents of these various corporate or organized institutions asserted verbally that they understood and respected our processes of collective decision making, rarely did this actually play out in practice. Given the personal familiarity that has developed over time with the people in which we worked, I feel that generally the assertions of understanding and respect for collective structure and process by outsiders was indeed genuine. Nevertheless, the inherent and rigid nature of institutional decision making, process, and timelines is not conducive to the patience and "time" that it takes to adhere to a more collective process. Ultimately, the protocol of the academic institution for conducting "business" or doing "work" was in direct odds with the MAMAS process. While many are verbally in support of this process, the institutional procedures almost always usurped that understanding. This highlights how powerful the pressures of the system and of the institution are over the sentiments of the individual.

In the end, the complications around communication resulted in what the organization determined to be a *lack* of communication and inclusion in the grant writing and decision making

process. As time progressed, it became more and more difficult for MAMAS to communicate, respond, and make decisions in a timely manner. "Timely" of course was determined by the normalized application of strict timelines, bureaucratic paperwork, and ultimately the need for unremitting production typical to the academy and in particular securing grant funding. Given this, all work around the grant and research possessed an amount of urgency that did not translate into MAMAS ambitions or the ways in which MAMAS operated as a group. Moreover, non-response by the group did not mean that the process was put on hold. Instead, the project continued to progress in many of the ways that community based or engaged research usually transpires. It moves forward in ways that uphold problematic power dynamics and hierarchies that situate and center the researcher, primary investigator, and ultimately the aims of a production driven-institution and not community.

Inherent in the need to produce in the machine that is the corporate academy is the requirement to conduct research not just for research's sake but to produce not only to stay *in* but to produce *for* the academy. I include this example not to provide yet another critique of the growing academic complex, nor do I plan to dive into an oration on the politics of community based or engage research. While this story can contribute to those narratives that are attempting to challenge and call into question the workings of this system, instead for the purposes of this work I wish to highlight again the ways in which the inherent nature of institutions including basic operating procedures can undermine and inhibit progressive work. Moreover, it provides another example of how institutions can again *use* both people, organizations, and even progressive ideas and research to maintain and uphold-both ideologically and financially-its problematic foundations. Yet, this account elides an even more pressing issue within its narrative that I would like to draw out about the economic and monetary gain that accompanies research.

What does it mean when grants and funding begin to surround and target marginalized bodies as research subjects? Multiple disciplines, including Anthropology, have been perpetually infatuated with the examination of the racialized "Other." Yet, the growing cognizance and research interests around maternal and reproductive health and in particular Black infant mortality (see chapter 2 on disparities) draws a salient modern day example of the historical intersection between Black bodies and death, spectacle, and profit. Given the history of racial oppression, chattel slavery, and racialized capitalism, a question regarding the significance of institutional profit and promotion around Black bodies and Black Death and how it manifests in *this* case, requires further examination.

Profit and the Institution: Capitalizing on the Spectacle

In 2010 Healthy People identified Maternal Mortality and Infant Mortality as a key health issue. This of course was the year after Amnesty International identified and acknowledged in their groundbreaking report the problematic racial disparities that exist in the United States around the issue of women's health and birth disparities (see chapter 2). Consequently, a significant amount of interest and research is beginning to be directed at investigating and ultimately creating interventions and solutions around infant and maternal mortality. More specifically, there has been a rallying cry around the immensely disparate mortality rates for Black women around the country. While these disparities do reflect an important problem that deserves and requires this conferred attention, the incentivized nature of the work surrounding this issue necessitates a much deeper examination.

Dorothy Roberts, in her book *Killing the Black Body,* exposes the ways in which drug policies that targeted and criminalized poor and particularly Black pregnant women were promoted under the pretext of concern for the well-being of the fetus. Nevertheless, corresponding policies

surrounding abortion as a criminal sanction undercut and disproved those deceptive rationales (1999). In a similar way, the contemporary urgency around elucidating the dilemma of Black infant death, has in many ways become a means of capitalization on the spectacle of Black suffering and death. Specifically, it has become efficacious to center research and programming on Black death and suffering in order to secure funding. In this way, black infant mortality has become the quintessential philanthropic endeavor and all the rage for scientific inquiry. Again, this is not to say that research is the root of all evil or that the attention surrounding this issue is injurious in and of itself. Yet, as exhibited in the example of my and Lois' involvement with the government agency, the focus on Black mortality served as 1) a funding stream, 2) a cachet inducing and trendy "pet project," and 3) still failed, even with its purportedly benevolent aims around Blackness, to divest from its oppressive and ultimately anti-Black comportments. This phenomenon still manages to inhabit the aperture that is both the consumption and capitalization on enactments of Black life and suffering.

Saidiya Hartman's work in her book *Scenes of Subjection,* addresses the historical normality of the "spectacular character of Black suffering" (1997, 3). From Frederick Douglass' account of the beating of Aunt Hester, the sorrowful procession to the auction block, and the performance of Black face and minstrelsy, the "drama of Black life" has sustained as a form of hyper-visible entertainment.

In addition, Hartman highlights the simultaneous existence of violence, repulsion, and pleasure. Drawing on *Black's Law Dictionary*, she states that enjoyment is "to have, possess, and use with satisfaction; to occupy or have the benefit of..." (23). She then continues to say that enjoyment

> …entails the exercise of right; the promise and function of a right, privilege or incorporeal hereditament. Comfort, consolation, contentment, ease, happiness,

> pleasure and satisfaction. Such includes the beneficial use, interest, and purpose to which property may be put, and implies right to profits and incomes therefrom… (23).

While the physical and sexual aspect of enjoyment as perpetuated by the whims of slave owners against slaves was fundamental to the practice and maintenance of chattel slavery, I draw particular attention to the sensation of enjoyment rooted instead in the satisfaction and acquisition of benefit, profit, and/or income. Moreover, I would like to reiterate the focus on spectacle here. As espoused in the remembrances of Sarah Bartmaan, the stripping of Aunt Hester prior to the beating, and sexualized and violent nature inherent in the "horrible exhibition" of lynchings, the sexual permutations of Black life and spectacle are evident. Yet, what are the other ways in which Black suffering as a spectacle elicits these alternative constructions of enjoyment?

Returning to the issue of the growing interest around Black infant mortality, I would like to revisit the opening depiction from the previous chapter where the researcher and the Dr. excitedly proffer the question "What are we supposed to do about all of these dead Black babies!" My immediate analysis of this animated assertion was that it reeked of what Hartman labels as voyeuristic fascination with and yet repulsion by exhibitions of sufferance (1997, 3). This conclusion was not drawn, of course, in an uncontextualized vacuum. The months prior to that effectual moment I had interacted on multiple occasions with both the doctor and the researcher surrounding African-American maternal health in Austin. Recalling those interactions now, I remember sitting at a table with the doctor at a mutual acquaintance's house and listening to him talk about how class and not race was the determining factor of Black women's maternal health disparities. I can recall when after being challenged directly by Lois around race, in a conversation unrelated and distinct from her employment role, he proceeded to report her "behavior" to *our* supervisor's supervisor. Ironically, not only would he only a few months later give a keynote

speech about the impacts of race and racism on birth outcomes for Black women but he would propose and ultimately be awarded funding in order to implement a program around reducing negative birth outcomes for Black women. Many of my interactions, both personal and professional, with the doctor as well as the researcher burbled with an arrogant overflow of white male patriarchy that almost always successfully silenced and drowned out everyone else. Yet, here these two men were allegedly incensed by the large numbers of dying Black children. While my skepticism around the concern expressed in this incident is being made evident yet again in this depiction, my skepticism nor its validity is the vital piece of this analysis. Instead, this example encapsulates the ways in which 1) Black suffering and death becomes spectacular and a fascinating unit of inquiry and 2) how abhorrence and enjoyment, an enjoyment rooted in personal gain, become affixed around Black suffering.

In the introduction to his book *In the Break: The Aesthetics of the Black Radical Tradition* (2003), Fred Moten interestingly expounds on the connection between spectacle/performance, value (or for my purposes I will say profit), and the Black maternal and reproductive body in particular. He states that

> …enslavement – and the resistance to enslavement that is the performative essence of blackness (or, perhaps less controversially, the essence of Black performance) is a *being maternal* that is indistinguishable from a *being material*. But it is also to say something more. And here the issue of reproduction (the 'natural' production of natural children) emerges right on time as it has to do not only with the question of slavery, blackness, performance, and the ensemble of their ontologies but also with a contradiction at the heart of the question of value in its relation to personhood that could be said to come into closer focus against the backdrop of the ensemble of motherhood, blackness, and the bridge between slavery and freedom… (16).

Drawing upon a Marxist framework, Moten pinpoints the Black maternal body as the prototypical embodiment of inherent contradictions of value that underscore what he calls "the essence of Black

performance." Moten illuminates both the state of *value* and *non-value* that occupies the person of enslaved laborer when he references Leopoldina Fortunati who states that

> …the individual contains value and non-value…the commodity is contained within the individual. The presence of the commodity within the individual is an effect of reproduction – a trace of maternity… (17)

Within this analysis is a recognition, as expressed with Marxian lexicon around value, of the ways in which, given the history of African chattel slavery, Black bodies house economic paradoxes around value and non-value. I would argue that this can also be said in regards to the ideological, social, and ultimately political understandings around Blackness and is evidenced specifically in constructions of Black gendered bodies as asexual/hypersexual, visible/invisible, servile/aggressive. More importantly, Moten's analysis reestablishes the ways in which the Black reproductive body is used as a pecuniary means to not only produce but also *reproduce* capitol.

Taking all of these things into consideration and returning to my main point, as Moten's contention locates the Black "being maternal" as a critical juncture where Blackness, spectacle, and value collide, in the same way the emergent attention to Black maternal and infant mortality has also revealed the confluence of these same matters. Moreover, my concrete accounts also reveal how various structures and institutions, in this case for research and programming efforts, even under the semblance of benevolence still reinscribe the problematic and historic traditions around Blackness and the Black reproductive body and maternity.

Returning to Moten, his acknowledgment of Marx's omission of the "commodity that speaks" as part of the institution of enslaved labor, also limits the examination of the commodity's ability to act and resist. Here lies Moten's focus for *In the Break,* where in examining those moments as in Aunt Hester's screams, where the commodity not only speaks but yells, we find the root of the resistant nature and aesthetics of Black performance. Yet I would like to take this

concept in another direction and pose a question. What happens then when the *being maternal*, or the Black reproductive body, or the Black mother, who historically provided the foundation and maintenance of capitalist gain screams in protest? What then is at stake?

Enemies of the State: Institutions and Self-Protection

> "And because loyalty to the nation as a citizen is perennially colonized within reproduction and heterosexuality, erotic autonomy brings with it the potential of undoing the nation entirely…"
>
> - Jacquie Alexander, *Pedagogies of Crossing*

> "Sexual freedom then becomes a metaphor for other kinds of freedom, for political freedom, for economic freedom…"
>
> - Angela Davis, *The meaning of Freedom and Other Difficult Dialogues*

Communists. Marxists. Revolutionaries. Terrorists. All of these are terms that have been used in various instances to refer to the work and organizing attempts of MAMAS over the years. While much support has and continues to exist for MAMAS projects, there has also been a significant amount of opposition that oftentimes draws upon apprehensions rooted in a rhetoric around anti-state activity. While much of these attacks are directly perpetuated by individuals, I argue that they fall directly in line with and reflect a larger societal and systematic attempt to crush, monitor, and control the existence of potentially transformative work that challenges the status quo. These individual transgressions mirror the continuous and institutional abuses that occurred with the organization's work. In other words, the *individual* behaviors that opposed or attempted to undermine the work of MAMAS are based in the same foundational ideology that underpinned the *institutiona*l opposition and commentary around the MAMAS work.

What is most interesting about these attacks was the utilization of rhetoric that references a practice of anti-state or terrorist activity. This brings into the question at what point does particular work become a threat to the state. Also, what is threatening about women of color fighting for reproductive autonomy and why is this directly associated with terrorist activities? It was most interesting that the individual agents of these transgressions were powerful white male doctors. What is the significance of this? Should this be considered a coincidence?

2010 marked one of our original attempts to collaborate with a local community clinic in an attempt to implement our free clinic for Latina and Black women in the Austin area. While we would quickly learn over the years about the difficulty of navigating the bureaucratic processes of complex medical systems, for an initial attempt things seemed to be moving along smoothly. The clinic itself seemed very interested in what we were offering and one of the MAMAS members had an existing relationship with the clinic due to her work teaching birth education classes years prior. It seemed like a potentially fruitful collaboration. Part of the approval processes included working with the head of prenatal care and obstetrics for the clinic. It is at this point that we began to meet challenges. The first red flag appeared when in conversation with a member of our group, this particular physician made it known that he believed that natural birth as an option for Black and Latina was not feasible. He stated that "*those* women are not able to birth like that." This is of course in relation to other women who like his wife were white, not low-income and *strong* enough to handle multiple natural births. This was the first sign of a problem.

Amidst our negotiations with the clinic, this same doctor also decided to do some background on our organization. Upon doing his own personal research, he discovered our affiliation with Incite, a national women of color organization who had also held a strong public stance on the Palestinian-Israeli conflict. After discovering this, he angrily commenced referring to the MAMAS

as a terrorist group and that the clinic should not be working with the likes of us. Needless to say that was the end of our negotiation process.

In a poetic twist of déjà vu, this incident repeated itself a few years later in our attempt to implement our free clinic at another pre-established community clinic located in east Austin. In this second instance, we found that our primary contact was in a fact a colleague of the doctor from the former incident. Yet, at the beginning of our relationship with this new physician the interactions seemed very cordial. This was in part due to the fact that collaborating with the MAMAS would support and be useful for the growth of a new program developing in Austin that provided medical treatment and catered to the particular needs of populations such as sex workers, homeless, and other individuals in the community without access to health care. Housing a prenatal care project utilizing a new and innovative model and centered on the needs of Black and Brown women would fit nicely into the program goals.

In the beginning, Dr. Free was referred to us by an ally given his purportedly progressive clinic, the population in which that clinic served, and its ideal location on the east side of town. He was very interested in collaborating with MAMAS and the collaboration at the time seemed ideal. As the negotiations progressed, we realized that Dr. Free's conceptualization of the collaboration was not in line with ours for various reasons. The primary issues surrounded around maintaining the integrity of the MAMAS model as it was written and choosing not to implement it in pieces as opposed to it operating in its complete form. Upon our non-cooperation, and the collective decision to not share the written model with him and his staff, he proceeded to not only attack individual members of our group personally but also proceeded to red bait[18] us in the larger medical community. We later found out that he was printing flyers and copies of our online zine entitled

[18] Red baiting can be described as the process of accusing an individual or group of being or holding Communist, Marxist, anarchist, or radical left-wing political ideas.

Revolutionary Motherhood that recounted women's birth stories and saying that we were Marxist, communists, and radical women. This was an obvious attempt to dirty our name, strike fear, and discredit our organization and our work. This occurred even despite his continued attempts to work with us and request access to the model. While this may seem on a basic level white male patriarchal entitlement at its finest, I argue that this, plus the fact that we were a group of women of color, specifically organizing around reproduction, and black women's maternal health is something of large significance and should be examined further. Again, what is so threatening about black bodies, reproduction, and resistance? Why does this combination automatically connote our construction as enemies of the state?

Ward Churchill's piece entitled "To Disrupt, Discredit and Destroy, chronicled the work of the COINTELPRO to bring down the work of the Black Panther Party. COINTELPRO initially started to focus on the growth of the communist party and become an institution bent on stomping out any degree of insurgency. Nevertheless, there was a particular interest in the emergence of Black messiah and in destroying the revolutionary activities by Black Nationalist parties. This included an interest in Marcus Garvey, The Black Panther Party, the NAACP, and even the Urban League. I draw on this history for a number of reasons. First and foremost, the threat of surveillance against radical work is very real and is a reality that should not be discounted. In 2013, two organizations loosely affiliated with MAMAS as part of a National Organizing Network were targeted by the federal government and ultimately had to close their doors. If we look at the history of Black Radical Movements including the Black Panther Party, health is always an issue on the political platform. Moreover, in the two instances of the groups within this larger national network who were targeted by the federal government, central to their program was protecting the health and well-being of sex workers. While COINTELPRO and the instances with the two groups affiliated

with MAMAS were particular instances of government violence to bring down a direct threat, similarly the hegemonic properties of institutions function to implement tactics of state protection in a more normalized and seemingly less violent manner.

As Jacqui Alexander's quote asserts, asserting amounts of sexual and reproductive autonomy has the potential to completely undo the processes of the state. This particularly is due to the role of reproduction and the body in the usage of bio-political control by the state (Foucault 1988; Alexander 2005). In particular, Alexander describes the state as

> a set of contradictory and uneven locations, institutions, personnel, managerial practices, and imperatives; and as a gendered, classed, racialized, and sexualized ensemble…

that is related to but separate from governmentality and is deeply committed to the deployment and maintenance of heteronormative sexual practices. Given this, direct challenge to heteronormative practices is also a direct challenge to state power. Jasbir Puar in his book entitled *Terrorist Assemblages: Homonationalism in Queer Times* (2007) also addresses to relationship between the policing of sexuality and the process of nation building. In particular he acknowledges

> …the proliferation of occupation and suppression of queerness in relation to patriotism, war, torture, security, death, terrorism, detention, and deportation, themes usually imagined as devoid to sexual politics in general and queer politics in particulary…(xii).

Puar's assertion, though specifically attending to queerness, illuminates the inextricable link between issues of nation, patriotism, terrorism, state protection and sexual politics.

The larger significance of this situation of the MAMAS work is the particular presence of Black female bodies and the exercise of reproductive autonomy and control. What is the condition of Blackness, reproduction, and power that poses such a momentous terrorist threat? Drawing not only the idea of sexual autonomy as a threat to the state but also the earlier dialogues around

motherhood, blackness, and value, one could argue that in challenging heterosexual norms the "state" is in fact not the only thing at stake. If in fact, the Black reproductive body forms the basis of the ideological, social, economic, and political structures of society, then challenging these norms in fact is a threat to much more than the boundaries of a nation-state. It has the potential to implode upon itself the system of capitol that has permeated the structure of even a global system. Given this, it is no coincidence that the totality of the circumstance around MAMAS work represents something that would easily and automatically be considered a threat and associated with conceptions of anti-state and ultimately terrorist practices.

What is additionally important to consider in this case is the fact that it was not a governmental agency doing the policing work. Instead, it was an agent of an institution operating underneath and within the power vacuum of white supremacy, heteropatriarchy, racism, classism, and sexism that allowed for this accusation to be legitimized. In this sense, institutions and individuals do the front line work of destroying counter-hegemonic forces. They induce fear of things that challenge social norms and are particularly salient when these social transgressions are around race, gender, and body. Many participate both knowingly and unknowingly in the maintenance of hegemonic power. This stands as evidence of the by-in and unconscious investment in the protection of a white supremacist system of power. Given these things, it seems that transformative work and its workers are always surrounded by the enemy.

While I am no guru of popular culture, this situation reminds me of the character of Neo and his fellow rebels in the movie *The Matrix* (1999). They are constantly and strategically moving in and out of the matrix system and walking inconspicuously through it waiting to be identified by the agents who could be in the form of any person at any time. If this depiction adequately describes the predicament of anti-oppression, anti-racist, counter-hegemonic movement building

individuals, it begs to question if it is even worth the risk navigating through the risky and dangerous spaces of institutions? Although one can argue that the state of Black life itself creates this relentless dicey dynamic, why choose to further participate in processes that are inherently malevolent to our aims and our lives and also inherently set up to destroy us? What you find here is the internal contradiction and brilliance of hegemonic power. It reflects a need and interdependence in order to survive and sustain in a system that is built on our destruction.

THE MASTER AND HIS TOOLS

The examples provided throughout this chapter provide concrete examples how working with institutions, particularly around Blackness and Black women's reproduction, can be inherently counterproductive to aims for social change. The opening quote of the chapter by Audre Lorde, references the use of the "master's tools," and is a useful grounding point to begin the conversation around institutional processes and the inabilities to ignite social change. This quote, taken from a speech given by Lorde[19] (2007) draws upon the relationship that exists between an enslaved person and his or her owner or "master." Even more salient in this example is its recalling of the specific history of racialized chattel slavery. This metaphor recognizes not only the power dynamics present in the master-slave relationship but also the problematic racial hierarchy that imbues it. While an argument can be made about a literal continued existence of a master-slave relationship manifesting contemporarily in various forms, it is more useful in this case to view this quote as a symbolic representation of something much larger. In other words, the "master's tools" refers more so to a mechanism and means of oppression and control. Given this, Lorde's primary

[19] Lorde's original speech was given at a conference at New York University on issues of difference among women. Here I am employing her idea of the "master's tools" in order to discuss mechanisms of oppression and their links to institutional work.

rationale here asserts the fruitlessness of attempting to use the devices of an oppressive system in order to overturn that same oppression. According to Lorde, this tactic may win isolated battles but will never actually win the war. Nevertheless, this assumption begs for further examination into what actually is this despotic mechanism?

White Supremacy and Anti-Blackness

In the chapter entitled "White Supremacy as Substructure: Toward a Genealogy of a Racial Animus, from 'Reconstruction' to 'Pacification,'" (2011) Dylan Rodriguez identifies white supremacy as "a central analytic for the political intellectual work of radical critique and social transformation" (47). While Rodriguez resists the urge to define and therefore pigeonhole the definition of white supremacy, I find it useful to try and describe white supremacy at its most basic level. According to the Encyclopedia of Social Problems, white supremacy can be divided into two primary categories: one that draws upon its endemic nature as a part of western society and another that references white supremacy as extremist and supremacist activism. This would include organizations such as the Klu Klux Klan (Encyclopedia of Social Problems, 1028). For the purposes of this work, I want to be clear that am focusing on the first of these two descriptions although I do believe that the second is an inter- and intra-personal manifestation of the first. In addition, the entry on the encyclopedia states that the first depiction of white supremacy adheres to an understanding of society in which when you

> …speak of society it is to speak of white supremacy as well as 'racism', 'white privilege', and 'Eurocentric domination' on a global scale. All are parts of the whole sometimes called racialized social structures… (1028)

Interestingly, Rodriguez also acknowledges the relationship between white supremacy and what he calls other "social determinations" such as capitalism, racism, and patriarchy but asserts the necessity to center white supremacy as a distinguished theoretical and analytical focal point (47).

In the same sense, I find it useful to also identify a white supremacist animus as the primary "tool" or "centripetal force" (50) around which distinctive manifestations of oppression consistently materialize in various historical moments. Building upon this understanding and returning to Lorde's notion of the master's tool, I would establish a white supremacist animus as the "tool kit" or "tool box" that holds the tools. Within this kit then, would exist the day to day machinations of capitalism, heteropatriarchy, racism, sexism, and empire (to name just a few) that enact the malevolent desires of the white supremacist animus.

Much work has already been done that provides an archaeology of white supremacy originating in the need of European societies to divide, dominate, conquer and therefore separate and racialize their opponents (Robinson 2000; Omi and Winant 1994; Almaguer 2008). Examining this historiography further supports the ways in which "social determinants" such as racism, sexism, and capitalism, for example, flow from and help bolster a white supremacist structure. While I do not believe that such conceptions can fully account for the manifestation of oppression on their own, hence my centering of white supremacy as the central and most useful analytical category, I do believe that examinations of race, hegemony, discourse, and economic structures are useful for being able to articulate the maintenance of white supremacy over time and its permeation in the day to day processes.

In her short piece entitled "Heteropatriarchy and the Three Pillars of White Supremacy", Andrea Smith identifies slavery/capitalism, Genocide/Colonialism, and Orientalism/War specifically as white supremacy's primary pillars. In regards to slavery, she states that "in this logic of white supremacy, Blackness becomes equated with slaveability" (67). While white supremacy operates to oppress a number of people, as expressed by Smith, the *logic* of white supremacy is such that it has a particular relationship with Blackness that serves as the basis for

much of its organization. Inherent in this relationship is the existence of anti-Blackness or anti-Black sentiment. Although, anti-Blackness is a piece of the larger white supremacist construct, it is a very important piece and deserves particular attention and examination.

On the one hand, anti-Blackness serves as a mechanism for which the peculiar institution of slavery was able to implant and affix itself and therefore concretize the perpetual state of Blackness as "slaveability." Nevertheless, Wilderson asserts that in actuality, racism as system of hierarchy and power, is actually based in the practice of anti-blackness as opposed to white supremacy. In this way, racism is more so about a necessitous condition of Blackness in contrast to the condition of whiteness. In other words, in considering slavery, one did not have to be white to own slaves[20]. Yet, it is the condition of racial Blackness that ensures enslaveabilty (Wilderson 2010).This reality then, materializes not only in a racial hierarchy where power is measured in relation to Blackness but this sentiment rooted in this racially tiered and pervasive structure then permeates all of societies formations. Moreover, the enduring nature of this sentiment is evidenced in for instance the transition from slavery into the prison industrial complex (PIC) (James 2007; James 2002; Davis 2003; Gleissner 2010; Wacquant 2002). In this example, this transition illuminates the long-lasting impacts of anti-Blackness in which its materializations may evolve but its existence in the ideology and social fabric maintains. This pervasive sentiment and its respective manifestations are of course both gendered and sexualized processes.[21]

---

[20] Although I draw upon the specific argument presented by Wilderson, other authors such as Frantz Fanon, Jared Sexton, Joy James, and Joao Vargas of among others have also dealt with issues on anti-Blackness in their respective works.

[21] Many Black Feminist Theorists such as Kymberlee Crenshaw, Patricia Hill Collins, The Combahee River Collective Statement among others were ground breaking in proposing the concept of intersectionality and the braid of oppression. Anti-Black sentiment does not escape the intersectional impacts of gender, class, sexuality and other identity markers as well.

Given the above discussion, I argue that in examining the "master's tools" locating white supremacy as a central point of analysis is pertinent, yet must be considered with the understanding that anti-Black sentiment also underscores its ordering and structure. In other words, if racism in central to white supremacy, and if, as presented by Wilderson, among others, racism is actually about anti-blackness and particularities of enslaveability, then it follows that one also cannot separate the conversation of white supremacy and anti-Blackness. Instead, when considering the conceptualizations and impacts of white supremacy, one must begin with an understanding that it is in actuality anti-Blackness that serves as a cornerstone of its foundation as opposed to whiteness in relation to all other non-white bodies. This is key. In addition, examining the ways in which institutions participate and contribute to a white supremacist animus is another important point. Beginning with a theorization of hegemony is a good place to begin this analysis but requires special consideration around the relevance and inclusion of Blackness.

Considering the Meaning of Hegemony

Gramsci's framework of hegemony serves as a critical point for understanding the role of institutions and their place in upholding and ultimately protecting the status quo. Gramsci's work on hegemony addresses the issue of coercion and consent in which the state acts as a coercive and violent force and yet hegemonic forces act to convince members of society to "buy into social norms and values of an inherently exploitative system" (Stoddart 2007, 201). Central to this, is the idea that the institutions of civil society such as churches, schools, and even media serve as a means of (re)producing and maintaining hegemonic power. The examples from the MAMAS experiences helps to provide day to day examples of how this type of power play out in the work of institutions. As these examples show, these situations are not free from race, gender, sexuality and other

markers that add to their complexity. These are points that Gramsci fails to include. As Stuart Hall asserts[22]

> "Gramsci did not did not write about race, ethnicity or racism in their contemporary meanings or manifestations. Nor did he analyze in depth the colonial experience or imperialism, out of which so many of the characteristic 'racist' experiences and relationships in the modern world have developed" (8).

Nevertheless, Hall believes that Gramsci's general framework about how to analyze complex social systems is useful to the examination of racial and ethnic relations as well. In particular he argues that Gramsci's promotion of historical specificity, what he coins Gramsci's "non-reductive" approach to race and class as opposed to an overreliance on class struggle and elision of race, and his acknowledgement of the "relational" processes of social transformation are particularly useful. In addition, Hall acknowledges another point, which further elucidates the Gramscian-esque nature of my own analysis here, that examinations of the role of institutions in upholding the established social formation is a critical piece of the analysis. As he states of Gramsci's work

> "schooling, cultural organization, family and sexual life, the patterns and modes of civil association, churches and religions, communal or organizational forms, ethnically specific institutions, and many other such sites play an absolutely vital role in giving sustaining and reproducing different societies in a racially structured form" (26).

While I also acknowledge the utility of Gramsci as an analytical and conceptual frame, it is only with an understanding of how white supremacy, racism, sexism, hetero-patriarchy, and anti-

---

[22] Mark Stoddart in his piece "Ideology, Hegemony, Discourse: A Critical Review of Theories of Knowledge and Power" (2007) provides an overview of social theory and issues of consent and power. This article also includes some of the critical critiques and interventions around race and gender by Stuart Hall, Dorothy Smith, bell hooks and Donna Haraway.

blackness underscores these structures that we can see how these social determinations permeate all of societal formations including the institutions and accordingly undermine the development and maintenance of a counter-hegemonic, anti-racist, and anti-oppression work.

In addition to understanding the role of institutions, it is also necessary to examine the accuracy of Gramsci's theorization for forecasting the nature of episodes of social transformation a bit further? Central to my argument is the idea that institutional engagement is inherently in direct conflict with counter-hegemonic acts but that relying and operating in collaboration with institutions around conditions of *Blackness* is particularly futile. Why could this be the case?

Frank Wilderson's piece "Gramsci's Black Marx: Whither the Slave in Civil Society" (2003) provides a perspective on the Black experience in civil society that effectively causes Gramsci's theoretical construction to implode on itself. He asserts that Gramsci relies on the concept of civil society, a social construction that is not inclusive of the Black experience at all, as a basis for his analysis. By referencing the history of slavery as well as its present day manifestation as "the black incarcerated body" (230), Wilderson maintains that Black waged labor is not a required component of the maintenance of civil society. Instead, he asserts that civil society is built upon the accumulation, use-value (to employ Marxist terminology), and ultimately death of Black bodies. Given this, Blackness and Black individuals do not operate within a hegemonic system of relations. Instead, they exist in system of terror (Wilderson 2003).

Building upon Wilderson's assertions brings a number of questions to mind. If as Black people, we exist outside of civil society, what does that mean for the potential of social transformation? Taking Wilderson's argument to heart would mean the many conceptualizations of social transformation as put forth by such theorists as Marx and Gramsci would not apply to the Black plight. In the end, society could transform completely and given the uninterrupted function

of civil society as its basis would still be built on the accumulation, use, and death of Black bodies. While Wilderson's argument is both a political and ontological one, it is evident that ontology has very material consequences on the lives of Black people. Given this, how do we take these concepts into consideration and yet divest from practice of perpetual intellectual abstraction. In other words, how do we respond to this in our day to day lives? In our communities? In our organizing? Where does resistance fit into this? Is there hope for Black people to escape the conditions of death both social and physical and if so what could/would this look like? Can we imagine new formations, possibly outside the concept of civil society, in which Black people live and not die?

CONCLUSION: INVOKING A RADICAL IMAGINATION

> *"The surrealists not only taught me that any serious motion toward freedom must begin in the mind, but they have also given us some of the most imaginative, expansive, and playful dreams of a new world I have ever known…The surrealists are talking about total transformation of society, not just granting aggrieved populations greater political and economic power. They are speaking of new social relationships, new ways of living, and interacting, new attitudes toward work and leisure and community…"*
>
> - Robin Kelley, *Freedom Dreams*

The examples of the MAMAS work as it existed to work in collaboration with these various institutions provides support for my articulated skepticism around working with institutions. It proves that even with the good intentions of individuals working within these spaces that the pressures and powers of the institution are so strong that they over overpower most individual sentiment. Consequently, it would take very intentional acts of self-awareness and rebellion by individuals inside these institutions to challenge and therefore not subscribe to the processes that result in exploitation and problematic power dynamics. Yet, I wonder is this struggle even worth

it. If our negative interactions with institutions actually represent the larger structure of our society that is built upon maintaining racist, classist, and sexist white supremacist formations, is it then more fruitful to imagine and create ways that attempt to circumvent the institutions in the work that we do.

One important issue to address in this process is differentiating between project based organizing and movement building or base building. This question presents a unique and suffocating conundrum. Especially when attempting to address the needs and issues presenting in our respective communities. As in the case for MAMAS, we understood our project to be a means of politicizing and building relationships with women via our clinic work. We also understood the urgency of Black Death, disparity, and genocide. This urgency began our process into a particular project that, although its basis was an attempt to base build, was also about providing a much needed service and required in many ways our interaction and engagement with already established medical institutions. A source of frustration for many of us was the fact that our vision and mission of our work, and our vision of the way our "project" would look was ideally conceptualized in a way that did not necessarily have to include collaboration with bureaucratic institutions. Nevertheless the constraints of group capacity, funding, and as mentioned previously community by-in persuaded us to consider ways to at least begin the project with institutional support. It is at this breaking point that things went awry. The energy that is took to manage and support ourselves through the work with institutions began to become the main focus of the work. [23]Here is where my critique and suggestion lies. It is here that I desire and assert the need to draw upon the history and find useful the energy of the Black radical imagination.

---

[23] The insightful book *The Revolution Will Not be Funded: Beyond the Non-Profit Industrial Complex* (2009), outlines in detail many of the struggles and contentions articulated here and serves as a useful guide for thinking through structural alternatives and solutions to organizing and social change.

Robin Kelly among others (Vargas 2010; Robinson 2000; Moten 2003) talks about Black radical tradition and a radical imagination as an attempt to take the risk of imagining utopian alternatives about how we want the world to be and having the courage to try these things. It is a process. In the one sense, MAMAS worked to create this utopian alternative within its organizing structure and yet struggled with creating this alternative in a real way outside of the group. How then do we work to accomplish this? Moreover, how do we choose between project based organizing around the urgent needs of our communities and on-going base building and movement building? Do we have to choose or should we attempt to do both? Doing both or choosing project based organizing though may at times force us to continuously work within systems that undermine our vision, suck our energy, attempt to destroy us and ultimately take away from our movement building. This is of course unless we can imagine ways to do project based work that also utilizes a radical imagination. While I acknowledge the pervasive existence of black death, I lean more to the side of movement building and away from project based organizing. It is only our consciousness raising that saves us. I question what difference providing a service or even creating alternatives if no one is ready to unplug from the system and disinvest? The consciousness must be raised first. I also acknowledge that our communities and many of us are stuck within the system and that our work must include infiltrating the system and reaching our people. Therefore, I am not providing a prescriptive solution but instead of service provision we should be getting into the system only to pull people out and build community there. Moreover, as the system changes and becomes stronger and more aware of our efforts we must also be able to change and continue to be creative in our tactics. Chela Sandoval makes reference to the fact that

> …the differential mode of social movement and consciousness depends on the practitioner's ability to read the current situation of power and self-consciously

> choosing and adopting the ideological stance best suited to push against its configuration, a survival skill well known to oppressed people… (60).

This again speaks to the creativity and quick wittedness that is crucial to the survival our movements and ultimately our lives.

In continuing this dialogue, I would like to acknowledge that in my analysis and examples of institutions, I fail to address the less bureaucratic, at times more small scale but equally if not more influential institutions such as families, churches, or other organizations etc. Interestingly, my call for attempts to circumvent all institutions in transformation work seems like a point of contention when considering institutions such as family and even churches who have historically served as pillars of strength particularly in the Black community. Nevertheless, these same institutions have the potential and often times still re-inscribe and transmit problematic social norms (Marable 1999). Just as with the institutions provided in the examples with the MAMAS, it is overwhelmingly the structure and ideology that underscores these institutions that causes the problem.

In another act of remembering, I reference again Alondra Nelson's work on the health platform of the Black Panther Party. I find Nelson's dialogue here particularly relevant in that her depictions of the BPP work she locates under the umbrella of what she calls "institution building" (2013). If we examine the example she puts forth we will see that inherent in the formation of the BPP clinics was critical collaborations with medical professionals who were also supportive of this community-based work. Nevertheless, these professionals consisted of Black nurses and doctors and required that all staff receive on-going and rigorous political education. While the BPP's work did not incorporate an integrationist approach as did the other movements for Black health activism that she cites in her work, central to the BPP health program was what she calls "institution building" and recreating and reshaping the politics around legitimate knowledge. I

draw on this again to acknowledge the contention around my assertion that working within institutional structures around issues of Blackness is a futile project. Nelson's work provides an example of how institutions can in fact work successfully. Nevertheless, as I mentioned previously, while institutions alone may not be the primary culprit and foot of oppression, they are a critical component for maintaining the evil work of white supremacy and its weapons of destruction. As exemplified in the BPP though, creating new structures, or "institutions" if that is your chosen vocabulary, rooted in community and a particular counter-hegemonic, anti-racist, anti-classist, and anti-oppressive ideology could serve as alternative. Yet, before this can occur there must be a critical consciousness raised and groundwork laid in the base and in the relationships in order for the new structures to sustain and not succumb to the pressures of the more dominant social structures encircling them.

Given this, how we can challenge these traditional understandings and ultimately the institutional structures in our base building, in our personal lives, and in the ways in which we relate to one another in the world? Can relating to one another in new radical ways based on pleasure, desire, and love ultimately create new transformative constructions of existing institutions or even contribute to their demise? Outside of MAMAS work with institutions, their mission, vision, political commitments, and structure provided a basis to begin to answer this exact question.

The next chapter looks at the organizational structure and the relationships between the members' of MAMAS. I argue that the work and ways in which MAMAS members relate to one another was some of the most transformative work. In the end, this supports the notion from this chapter that movement building is the ultimate means of change and the relationships that we build with one other serve as a key means for transforming society.

Chapter 4: Organizing for Our Lives - Survival and the Politics of Love

It's Hard
It's Tiring
It's Painful
But
It's Love
It's Joy
It's Peace
Mothering is an act of social justice
Creating a community of solidarity and support
That models the way we want the world to be.
Using that collective strength to challenge
Injustice
And build alternatives for ourselves and our communities.
How are the children?
How are the weakest in our society treated?
Parenting socially just people.
There is enough for each of us.
Let's share
Stories
Food
Hugs
And laughter.
If we can embrace
Ourselves
Our children
And our community
Give and find comfort and safety
Without hiding truths.

MAMAS
Our Core Values
January 25, 2009

"When I think about moments that felt really profound I think about one retreat… and you know we had this whole agenda set out which we always have and we were going to do all of these things and it was like meant to be potluck style. We were all bringing food and we did it at Alma de Mujer. We ended up making empanadas for like three hours in the kitchen together and touching on all

kinds of parts of that agenda that we were supposed to do u know… but not doing it in order and not necessarily taking notes. We were just kind of being with each other…so we were all doing it together and we were just like dreaming what ended up being put into language into the handbook that we have. And we had been gathering and meeting like that for like a year and half before we got to that point before we could even state that this is what we are trying to do. So I define that as work. And some of it had a lot to do with feeling like we had a lot of support outside of that space….. The children were having an awesome time they were like playing and had all kinds of space and we had our own space and it was cozy and it was warm and we had food. There were all of these things that were in place at that point that we were able to come up with this amazing manifesto that we hadn't been able to come up with when we were like… meeting in the hour and a half block at the community center that was kicking us out straight at 7:30 you know what I mean. It was different. It felt different. That's what I mean by profound. Those are moments when I feel like I can look and say look how amazing this can be when we have what we need to create it. Look how open our minds can get. It was also not an easy thing to do. It was like we had to work hard just to get there. Every time we schedule anything it's a heavy lift. We had to put a lot of things in place. But we did it and came out with this thing that felt amazing…

- Lisa, MAMAS collective member

***

This chapter examines the organizational structure and methods of the MAMAS organization in order to unpack both the challenges and potentialities within grassroots organizing efforts. It looks not only into the practices of the group but also delves into the personal relationships between the members. Within attempts to imagine and therefore create their ideal of a just and loving world within the dynamics of the group, this chapter discusses the challenges of

organizing across race, class, sexuality, nationality, and color. It evaluates the intentionality of opening space for mothers and children in organizing and activism, and the creation of intimate relationships, rooted in love, that ultimately aid in the livelihood, support, and survival of various member. While work has been produced that theorizes about transformative organizing and what day to day praxis might look like, this chapter provides a concrete example of what attempts at transformative and radical organizing and life looks like on the ground and in practice. I argue that 1) the type of love that develops when attempting to survive is radical[24] and resistant work, 2) love and the choice to love, who you love, and how you love is something innately political, and 3) radical relationship building and the work that it takes to constantly maintain these relationship and maintain accountability is the most difficult and yet most important and transformative aspect of grassroots work.

MAMAS HERSTORY AND ORGANIZATIONAL STRUCTURE

It was fall 2009. My first semester of graduate school at the University of Texas at Austin. I had recently moved back from my small hometown Temple, Texas after giving birth to my first child a few months earlier. She was five months old when I began my graduate study. It was in one of the classes during that first semester that a fellow student who knew that I was a single mother and who was somewhat familiar with my politics given our classroom discussions approached me about an organization called MAMAS. He knew one of the members, Laura, and talked excitedly about what an amazing community organizer she was. In the end, he gave me her email address and encouraged me to contact her and check out their work. *Why not? I thought.* It

[24] Joy James in her book *Shadowboxing: Representations of Black Feminist Politics* makes a distinction between *radical* and *revolutionary* by stating that viewing oppression rooted from "capitalism, neocolonialism, and the corporate state" is *radical* while those who build on political theory to abolish corporate state dominance are *revolutionary (79)*. I acknowledge, based on this definition, that one can be radical and not necessarily revolutionary. For the purposes of this work I overwhelmingly use radical to describe attempts at challenging the status quo. Nevertheless, my use of the term revolutionary is intentional in order to denote larger social change and transformation.

would be interesting to meet the group and see what they were all about. Plus, being a newly developed, relatively-young, single mother, I was definitely interested in meeting and possibly developing relationships with other mothers of color. Accordingly, I emailed Laura about the organization. She promptly responded by inviting me to a potluck that they were having at the Carver Library the next weekend. I mentioned the potluck to another graduate student friend of mine, Sasha, who like me, had recently given birth to her first child a few months prior and who was also starting the same graduate program with me that semester. In the end, we decided that we would go together to attend the potluck.

That Saturday I arrived at the Carver Library for the MAMAS potluck. The Carver was located on the east side of town and connected to the Carver Museum of African American history. Lugging my 6 month old in her car seat, with my purse and her diaper bag, I walked from the parking lot on the south side of the building and proceeded to walk up the ramp towards the two large glass sliding doors. After perusing the brightly colored library and observing the walls strikingly coated with paintings of Black historical figures, I finally came to a room where a group of about 6 women and a group of children were scattered around, sitting in chairs, and on the cherry carpeted floor. Many of the chairs and tables had been shoved off to the side or to the outer walls to provide a more open space in the center of the meeting room. Two long brown tables sat along the side of the wall next to the room's entrance and covered with a variety and food and snacks. Both the children and the women sat talking with each other, eating snacks, and enjoying each other's company. The room teemed with an air of comfort, ease, and familiarity.

Besides the built-in mingling and social time, the meeting that day began with a very specific get-to-know-you activity that would also ultimately serve as an introduction to the current work and burgeoning project of the organization. Standing in a line alongside each other behind a

long piece of blue tape that had been applied to the floor, we were asked to step forward or not based on our responses to a number of questions regarding our experiences of pregnancy, prenatal care, and birth. Did you have a birth while on Medicaid or uninsured? *Step forward.* Do you consider yourself to be a "young" mom? *Step forward.* Did you ever feel that you were treated disrespectfully by medical staff during your prenatal care? *Step forward.* Very quickly we were able to not only gain pertinent information about each one of our individual experiences of pregnancy and birth but we were also able to visualize which of those experiences were actually shared collectively among us.

What I would come to understand by the end of the potluck that day was that MAMAS was an organization established in 2008 in order to organize poor and working class mothers of color around various issues such as health, childcare, housing, or any other issues that were faced by them on a daily basis. It began when two members, Lois and Kelis, broke away from another organization called Latina Moms with the aims or creating a group that was more inclusive of other women of color and in particular Black women's experiences. One of the initial projects started by Lois and Kelis was a radio show on a local progressive station in Austin. This show started with the intent of focusing on the experiences and needs of mothers of color locally but both Lois and Kelis quickly realized that the audience that they were trying to reach was the not the audience who was actually listening. This was an additional impetus for starting the MAMAS group. Co-founders Lois and Kelis were interested in finding creative ways to reach mothers and color in the area in order to discuss and address many of the pressing issues that existed for them in their daily lives.

That day at the Carver Library, I learned that some of the more recent work of the organization had included launching in collaboration with a sister organization, as well as with the

support of the national organization Incite, a community survey in which they collected the responses of poor and working class women of color about their perspectives on important issues in their lives. The members of MAMAS spent time in WIC clinics and public assistance and social services offices surveying a number of women in Austin, TX. From these surveys, as well as from the experiences of the members of the group, MAMAS identified reproductive health and justice as their current project and began to build and conceptualize this new focus of their work. Having chosen reproduction and birth as their primary focus, MAMAS decided to launch a three pronged birth justice campaign centered on 1) raising the voices of those most impacted, 2) campaigning to get Medicaid to cover midwifery services in Texas, 3) and creating a birth support project by and for poor and working class women of color. This was the nature of the work when Sasha and I first connected at the potluck. Although various circumstances caused changes in the membership of the organization over time, at my initial introduction to the group that day there were approximately 8 women organizing in the collective. Sasha and I would be officially invited into the organizing collective a short time after. As the amount of time spent with the collective increased, the structure and functions of the group became more and more evident.

Mission and Vision

Central to the vision and the mission of the work was asserting and acknowledging the role and significance of mothers in organizing as well as the inclusion and acceptance of children in political spaces. This included not only having the adequate resources such as food, childcare, and accessible meeting times and locations to be conducive to the needs of mothers and children but also providing space for the children to participate in and be aware of the political activity. In order to assist with this particular aspect of the work, La Semillia, a volunteer childcare collective, was established alongside the development of MAMAS as an organization. While the logistics of

insuring safe and adequate spaces for both MAMAS members and their children still required planning, the existence of a supportive group of individuals to care for the children helped to alleviate a significant barrier that many mothers experience. La Semillia provided a particular type of support that was critical for the MAMAS to work, meet, and organize regularly. Although La Semillia did provide entertainment and activities for the children during meetings, they did not exist just as babysitting entity separate from the work of the collective. Instead many of the volunteers had existing relationships with multiple members of the MAMAS and most of the volunteers who made up the original core of La Semillia possessed politics that mirrored the progressive mindset of the MAMAS collective generally as well the perspectives pertaining to how we engage, nurture, and relate to our children as growing, aware, and ultimately political and social beings. Central to the vision of the MAMAS was including and not excluding children from political spaces. Children were not instructed not to disrupt or to stay away from the meeting space. Although this could become cumbersome, and even though we were at times interrupted by impromptu dance performances or by the presentation of the "kids of color have rights" bill of rights, the structure of the organizing practice included acknowledging the necessity to tend to the needs of both child and mother and reconceptualized the vision of organizing and meeting spaces.

Central to this practice was part of the attempt to create the type of just and loving world that the members of the collective envisioned within the collective work and within its organizational processes. It reflected an understanding that transforming society required an incorporation of the "the total involvement of every man, woman, *and child* each with a highly developed political consciousness" (Guy-Sheftal, 148). Yet, the inclusion of mothers and children in organizing and activism was only one aspect of a much larger attempt to create and transform the ways in which communities and individuals relate to one another in radical ways. Upon

becoming part of the core collective, I was provided a document in which the organization articulated in written form the vision, mission, and purpose of the collective work. The foundational premise behind the work was divided into two primary components: 1) The things we want to fight for and 2) the community we want to build. Below is an excerpt:

> **The Things we want to fight for:** We want all people to have good choices when it comes to things like: Food, Housing, Safety, Education, Parenting, Health/Health Care etc. We will plan campaigns or projects around these basic yet under met needs.
>
> **The Community We Want to Build:** We want to build a world that is based on and/or values: Beauty, Fun, Kid Friendly, Values Intergenerational, Honesty, Mutuality, Respect, Culture/Difference, Safety, has various constructions of "family", Sharing, etc. In our work we strive to model the world we're trying to create because we believe the **means** (how you get there) are as important as the **ends.**

Just as the collective's stance on children reflected the underlying ideology of the mission and vision, other aspects of the organizational processes revealed a commitment to creating a new idea of the world reflected in the "process" and not just in the "outcomes."

Membership

After four years of working as a collective member with the MAMAS and seeing the membership shift over time, I found that the process for establishing membership was a critical point of analysis for understanding the workings of the collective. The membership and distinctively the membership "process" had huge impacts on the nature of the work. I found that my process for entering into the work of the collective was shared in the experiences of many of the other members in the group. Just as my introduction to the collective was instigated from a mutual friendship, most of the members came into contact with MAMAS given prior relationships and previously established social and political involvements. At its inception, the motivations and progression

into the collective were informed by a need that also reflected the mission of the group. For instance, although the co-founders, Lois and Kelis, began the work of MAMAS by doing a radio show about the needs of poor and working class women of color, they were also inspired by the need to provide and work towards greater access to basic necessities such as food, childcare, housing, health care, etc. Laura, also one of the first members of the core, maintained that her decision to move to Austin and work with the MAMAS, was based on a number of things. This included her previous organizing work and attraction to the vision that Lois and Kelis presented but was also influenced by her life circumstances at the time. She described having an immediate connection and friendship with both Lois and Kelis but more importantly described their desire to support her and provide resources if she decided to transition to Austin. In the same vein, other members, including myself, articulated not only an attraction to the political and organizing aspect of the work but also a desire and need for support, assistance, and community in some way. This shared experience speaks to ways in which relationships and social networks formed the basis for the existence and growth of MAMAS as an organization. In the same way, the role of MAMAS as a means for providing a particular need and a mechanism of support for women also helped to create strong relationships that in many ways enabled the maintenance of the collective over time. Nevertheless, this manner of participation into the work posed dilemmas in the long run.

One of the primary difficulties surrounding membership centered on a lack of clarity about the official "intake" process and the structure of growing membership. Over the years, there were multiple attempts to streamline this process. The MAMAS handbook even included instructions on how addition to the core would happen. This included attending a certain number of meetings on a regular basis, attending MAMAS events, and allowing time to build relationships and get to know the members of the core. Down the line, an additional proposal was developed so that women

interested in the work but who did not necessarily have the desire or the capacity to organize as part of the core could participate as general body. These members would have fewer responsibilities but their opinions could still inform and direct the nature of the work. This was described and depicted by multiple concentric circles. With the core being in the center followed by general body members and then supporters and allies.

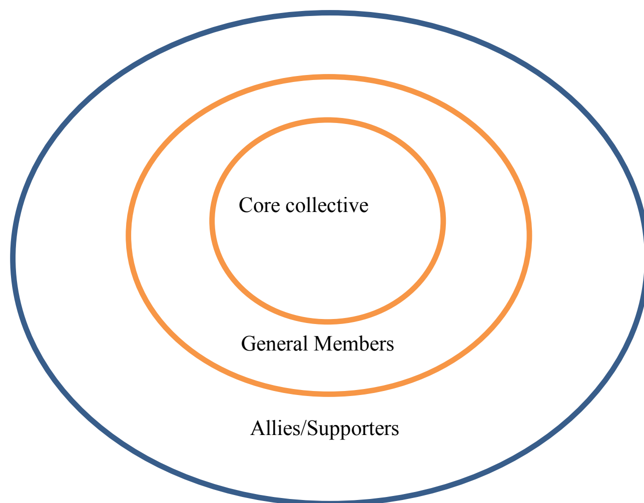

Illustration 1: Mamas Organizational Structure

In the end, both attempts at concretizing the intake process for the core as well as creating a more far-reaching conception of MAMAS members proved futile. This was in large part due to the time, effort, energy, and resources that it took to manage these processes in addition to whatever work or project that the collective was undertaking at the time. As a result, membership based on relationships continued to be the primary mechanism for which women were brought into the work. One the one hand, the commitment to work informed by the needs of poor and working class women sustained. Yet lack of capacity coupled with an organizational composition based upon close friendships and drawing upon knowledge produced in very distinct social and

political spaces, began to create an environment that was not as inclusive as originally intended. This more fluid and casual approach to membership would prove almost detrimental as the work progressed. Specifically, this would be the case when considering the ways in which the relationships profoundly impacted the ability to do the political work and the ways in which lack of structure and communication around membership procedures also bled into ambiguity about other aspects of the work.

CHALLENGES

Collective Capacity and Base Building

> *"First of all, the most vulnerable group to organize is poor women of color, mothers of color in particular because they don't have time for that shit…pretty much. And when you are looking to try and organize that group of people it is near impossible because they are always working. There's something… But I feel like they are the most important group to organize around, with and prioritize…"*
>
> \- *Lois, MAMAS co-founder*

One saying that was constantly repeated in our struggle to effectively organize is the fact that poor and working class mothers of color are in actuality one of the hardest groups to organize. Their (our) life circumstances are often such that we don't have the time to come to meetings, are exhausted, need to clean our houses and feed our children. Although conversations amongst members questioned the methods that engaged a broader base of poor and working class women, these same circumstances were the nature of the lives of many of the group's members. This had a direct impact on the capacity and energy of the members and the ability for the collective to move projects forward. Capacity was always a prominent issue in the work of the organization. Interestingly, MAMAS was always able to circumvent this issue on numerous occasions. This included helping to the get Medicaid to cover Midwifery in Texas, organizing successful

grassroots fundraising projects such as all women of color hip hop showcases, and provided a training for thirty local women of color to become certified birth support specialists in Austin, Texas - none of which were small feats. MAMAS consistently managed to pull things together by drawing on the presence of unceasing commitment in lieu of the significant constraints (time, energy, resources, etc.) and using day to day interactions inherent in the friendships as additional planning and organizing time. Overall, I argue that varying levels of privilege and die hard dedication were the primary reasons that the group was able to work past issues of capacity.

The ability of MAMAS to come together in dire straits in order to accomplish large amounts of work with very limited woman power is significant. Yet, the organizing structure was not necessarily conducive to the broader group of poor and working class women in the city. If as presented in the original mission and vision, the primary function of the organization was to be a group of poor and working class women on color working on behalf of themselves, then an alteration of the structural and organizing processes may be required in order include a broader base of women. This conundrum was acknowledged and expressed by members of the collective. If poor and working class women of color are the hardest to organize, then what other methods can be employed to engage them in organizational and political work? In the end it became evident that for reasons explained above, MAMAS functioned in such a way that it was not necessarily a fully inclusive space, even to those who experiences formed the basis of the work. Seela, a member of La Semillia who would later join the collective, even described the experience and structure of meetings as rigid, corporate, and non-profit-like. In the latter part of MAMAS history, there were instances in which women from the community attended or tried to participate, yet it was obvious that they were never fully comfortable and that the MAMAS space had become overwhelming privileged in many ways.

What is important to note here is not necessarily the growing amounts of racial and class privilege of the collective. Privilege and its impacts on the group dynamics is an issue that is soon to be addressed. Nevertheless, there are two main issues at hand. One is acknowledging the fact that organizing a group of poor and working class mothers of color will most likely run into issues of capacity. This is dependent upon the type and structure of the work. Even with the incorporation of members who possessed varying levels of privilege and access into the group, convening regular meetings, organizing actions, and developing projects proved significantly difficult. Given this, it was obvious that this structuring of the work in practice was not accessible to the majority of poor and working class women of color that the group was trying to work with and around. Taking this into consideration, how then do we envision a method of organizing that IS conducive to the lives or poor and working class mothers? This was a question that individual members of MAMAS repeatedly mulled over but has yet, neither individually nor collectively, to come up with a workable solution.

The issue of capacity and engagement brings to light yet another important question. In thinking through organizing and capacity issues, should the priority be establishing a group of poor and working class women working on behalf of themselves, or a group of women of color working on behalf of other poor women of color? Does it matter and how does this impact the nature of the work? While the answer to these questions is critical for conceptualizing the future of organizing work around poor and working class women of color, it was evident that not only did MAMAS not have a united stance on this issue but more importantly that individual understandings of the purpose of the work around this exact topic were largely dissimilar.

As MAMAS attempted to solve their issues of capacity, issues of privilege and who is working on behalf of whom rose to the forefront. In particular, a change in organizational make-

up and membership subsequently impacted choices around projects and issue conceptualizations. Moreover, questions about maintaining accountability to communities and their needs also began to manifest. While privilege did exist at the group's conceptions, the degree to which its processes and structure were informed by that privilege and therefore impacted the work was very different. As time went by and the capacity became more and more limited due to changing life circumstances and the movement of individuals in and out of the collective, new members were brought in to help with the work. While these members brought with them the time and ability to do work, they also ushered in new types and levels of privilege that altered the dynamics of the collective. Differences of race, class, and color always existed in the group. In the beginning, this was rarely an issue that was unmanageable. Yet, as the membership shifted so did the ability to easily navigate race and class.

Acknowledging the White Elephant: Organizing Across Race and Class

> *"In theory, the idea is that we don't have a hierarchy, there are no officers or you know… people who have decision making power and others that don't…and we made that choice because it is part of what it means to model and build the alternative world that we actually want to live in in which power is decentralized and then there is the reality of the world in which we all are entering that space with different types of social power…the challenge is really navigating the reality… like… there is the world we want and the world we live in and we are somewhere here in between those two points…"*
>
> *– Lisa, MAMAS member*
>
> *"The way that race and class, in particular, plays out in our organization is super obvious. It would play out like this in any other organization. I don't think we should be immune to it because we are MAMAS. There is still colorism. There is still class issues…we do make an intentional effort around how those dynamics around how race and class in particular play out in the organization but its problematic because the people in the organization who are most directly affected*

still don't have that power because the way that race and class plays out in the world is the same way that it plays out in the organization even when people in the organization know their privilege, and their whiteness, and their class privilege…even then…because they have different rules to live by and they live their lives in a different way than what people who are most directly affected do…it's not that they are bad people…everyone has a lot of work to do around that stuff and you would think that we would have it together in an organization like this but it takes a lot of time and self-work…its hard…"

- *Lois, MAMAS co-founder*

MAMAS operated with a non-hierarchical and horizontal structure in which all members had decision making power. This was an attempt to decentralize power, challenge problematic vertical organization, and also to prevent the manifestation of a charismatic leader who becomes the primary face of the organization. In practice, this meant that all decision making was done with a vote and with consensus and that no one person alone could make crucial decisions for the collective. Nevertheless, decision making power was not the primary way in which power dynamics played out in the group. Power manifested in many other ways. For instance, it manifested 1) in the ways in which work was delegated or adversely who was able to do work and what types of work and 2) the ways in which the prioritization of those voices who are "most impacted" played out in the collective representation and work. While this articulated vision of organizing exists as a beautiful and progressive idea, implementation on a regular basis was not without its challenges and took on-going intentional energy. Ultimately, issues of power and voice were inextricably linked to the race, class, and color dynamics in the organization and became the *most* challenging aspect of the work that ultimately resulted in tensions that would lead to the inactivity of the collective.

When the organization was first established, issues of race, class, and color seemed to be less pronounced. It was not that difference was not present but it seemed that these differences were better managed. Not only was there more of an equal balance and dispersal of both racial, ethnic, and class differences but the organization's stance about the purpose of its work was more defined. Although the organization was open to all women of color, the idea was that the work would center the needs of poor Black and Latina women in the area. In addition, upon my initial introduction to the group the class and economic state of the members of the group varied and existed and differing levels. Even with this, the group dynamics seemed to mesh and issues around these topics rarely presented themselves. Part of this may have been due to the fact that while in that present moment some of the members had transitioned into a higher and more financially stable economic state, the experience of being poor and working class or being on public assistance still seemed fairly recent. They were issues that most of the members could identify with in some way or another.

This dynamic shifted though at a point in time in which new members were introduced into the collective. The organization was in a time of transition. One member was moving out of the collective and the needs of the reproductive justice clinic project were surpassing the capacity of the core. Given this, MAMAS decided to expand the core and invite a new group of women to join. Most of women who were extended the invitation were people who had expressed interest in being part of the work and had come in contact with MAMAS at various community events. MAMAS decided to open the collective to women who did not have children but who were committed to organizing around the needs of poor and working class mothers of color. This included three members of La Semillia, the childcare collective. Consequently, this addition to the core seemed to intensify strains of difference. On the one hand, the individuals who came from La

Semillia were younger, without children, and were students or identified for the most part as low-income. On the other hand, most of the other new additions to the core were women of color, mothers (although not all by birth) and had relatively high levels of income. In fact, one even held a high level administrative position. While many of the members that joined the collective after its founding by Lois and Kelis possessed varying amounts of privilege, the initial whisperings of tension began to surface when the members with higher socio-economic statuses were introduced into the collective and the economics gaps deepened. While growing tensions arose as caused by the changing group and particularly class dynamics, much of the focus and heightened tensions actually arose around issues of race. One incident stood out as particularly damaging to the morale of the group.

MAMAS at one point was asked to participate in collaboration with a local university in the planning of a conference. Two of our members, Lois and Lisa, had stepped up to serve as the point people and to be primary contacts with the academic institution. Given our commitment to collective process, our procedure is such that contact and correspondence in collective. Nevertheless, Lois began to feel left out of the planning process. Lisa who already had a personal connection to the university contact, was more engrossed in corporate and office type work, and given her physical appearance relative to whiteness was perceived and read in very different ways than Lois. In the end, Lisa was repeatedly singled out as the primary and contact and representative of MAMAS in the process. Lois not only felt that she was being intentionally left out but that her proposals were not taken seriously. Unfortunately, this was not a new experience for Lois. Nevertheless, it caused feelings of unease and tension around Lisa's response and perceived responsibility in the incident.

The inherent exploitative and hierarchical nature of institutions and the respective problems that they caused in relation to the MAMAS work has already been examined (see previous chapter of the Master's Tools). This incident shed light into the internal issues around privilege as they existed in the group dynamics. Part of the MAMAS processes included explicit intentionality around stepping up and stepping back when necessary. It also attempted to address issues of voice, who should have voice in certain instances, whose voice was ultimately supposed to be lifted up. Different individuals were strategically placed at different moments to be representatives of the organization. In practice, this included challenging traditional understandings of power, knowledge, and voice centered on various privilege markers by lifting the voices of those most vulnerable and in providing intentional space for *Black* leadership in the work. In this case, Lisa who possessed a significant amounts of class, race, and ultimately white privilege was perceived to have a certain amount of responsibility to step back in this instance to support and allow for Lois to have more voice. This perception of Lisa's responsibility to Lois and the collective vision, was also mediated and negotiated alongside her privilege to access resources such as time and uninterrupted access to email, for example that oftentimes, Lois was not able to effectively execute. In other words, according to collective stance on voice and representation, Lisa should have operated as a support person that would have enabled and bolstered Lois' leadership in the project. Nevertheless, Lisa's capacity and access in comparison to Lois' was such that supporting Lois' leadership required a significantly greater amount of planning and energy.

Though discussed outside of collective meetings, this instance among others was rarely addressed in a productive way within the collective conversations. Oftentimes, I found that the close relationships in actuality hindered people from having very real conversations about the racialized and classed implications of various interactions and addressing the brooding tension

present in the collective. In the end, a seething contradiction prevailed in which the history of close relationships stopped any real conversation around the interpersonal pain and hurt around power, race, and class that was happening. People overlooked things and instead attempted to maintain friendships. This impacted the political work. Even with attempts at protecting the personal relationships, they too were being impacted by the silence. Ignoring the white elephant in room weakened relationships overall and ended in the dismantling the group.

This one example speaks to a number of critical issues. First and foremost it highlights the constant negotiations that occurred when trying to manage power and maintain a non-hierarchical structure in the organization. This included the process of both stepping up and stepping back in which both the collective and individuals attempted to manage various levels of privilege in order to neutralize power in the space. This proved difficult not only because MAMAS did not exist in a vacuum disconnected from the social formation of the world but also because MAMAS work included engagement with external people and organizations. Given this, race and class not only played out within the collective in the same problematic ways that it would play out in the world, but MAMAS also had the arduous task of trying to offset power even when engaged with groups were not necessarily as committed to the MAMAS vision.

The second implication of race and class in the group was in the delegation of work. Class, education, and income privilege functioned in such a way that certain individuals in the groups had more time and energy to devote to the organizing work. Consequently, those members who were *doing* most of the work also ended up being perceived as having the most power and voice. In the same vein, this further complicated the notion of stepping up and stepping back. How do you promote leadership and diffuse power when there is work that needs to be done? How do you step back when you have more resources and time? This was a constant struggle, especially in

moments when stepping back meant that some part of the work would not get done. This problem returns the dialogue again to issues of organizing method and the nature of the work. What does it say about the nature of the organizing when only people with privilege are able carry the brunt of the work? This is especially important when thinking through and working around the needs of poor and working class women of color.

The final and most controversial piece that arose out of this example is the issue of whiteness. This was a topic rarely discussed within the collective and yet came up many times in side conversations particularly surrounding Lisa. Lisa, whose father is white, identified as a woman of color and was very open and conscious about her class, color, and access to white privilege. She entered the organization prior to my arrival and from its inception was very honest about the fact that her upbringing was very much so middle class and also "culturally" very white. Even with this acknowledgement, multiple occasions arose in the group in which her identity and particularly her whiteness were under intense scrutiny. This happened both within and outside of the collective. Here is another example.

It was one of MAMAS more extravagant events. We were all running around, setting up tables, doing sound checks for the musical showcase and preparing for the arrival of the first attendees already trickling in. Ashley and Llana were manning the front door while Lois and I helped vendors set up their areas. Lisa, who had done a significant amount of the planning around the event was also running around and delegating things that needed to be done to various members. Upon approaching the table of one of the vendors, I could see the expressions on their face as they watched Lisa. As I would come to find out later from Lois, these two individuals in particular commented specifically on Lisa's whiteness. "Why are ya'll letting this white girl run everything?" Even despite Lisa's personal identification as a woman of color, she was interpolated

on a number of occasions based on perceptions about her whiteness – both physically and behaviorally.

I draw on this examples not to pinpoint the actions of a particular member of the group. Instead, I wish to draw attention to the ways in which different bodies hold different meanings. Additionally, these scenarios provide concrete examples of the challenges that arise in "of color" spaces. On the one hand "people of color" and "women of color" at times glosses over and erases difference. On the other hand, the umbrella term "of color" also in ways obfuscates the presence of whiteness and in particular white privileges. This begs the question how do you deal with whiteness in an "of color" space? In the end, this issue had very material effects on the members as well as external perceptions and responses to the work.

Various theorists have attempted to discuss the particularities, issues, and challenges that arise in multi-racial spaces, organizing and coalition building (Dzidzienyo, 2005; Marable, 1993; Pulido, 2006; Sexton, 2010; Kim, 2003). Jared Sexton in his piece entitled, "People-Of-Color-Blindness: Notes on the Afterlife of Slavery" critiques the term "people of color" and addresses what he calls the "recurrent analogizing to black suffering" (Sexton, 2010). He coins the non-recognition of a particular history of black history separate from their non-black allies as "people of color blindness." He states that this is a

> "…form of colorblindness inherent to the concept of 'people of color' to the precise extent that it misunderstand the specificity of antiblackness and presumes or insists upon the monolithic character of victimization under white supremacy- thinking (the afterlife of) slavery as a form of exploitation or colonization or a species of racial oppression among others" (Sexton, 48).

What is relevant about this understanding of the concept people of color is the link between reproduction, reproductive justice work, and blackness via the scope of a women of color organization.

Central to Sexton's analysis about the concept of "people of color" is this notion of anti-blackness and its materialization within non-white spaces. Given the public intent of MAMAS to focus on black women's experiences in the work, it brings into questions for me, not necessarily the role of anti-blackness that Sexton puts forth but contrastingly the effects of perceived whiteness, or distance from blackness, within multi-racial spaces that, in the case of MAMAS's work, may have an impact on black recruitment. In other words, what are the already existing or perceived racial hierarchies that exist within non-white communities that based on spectrums of blackness and whiteness can potentially be re-inscribed in multi-racial coalitions? How can these understandings of racial hierarchy amongst non-white people influence the work?

Although much of the focus around the issue of whiteness seemed to center around one person, I argue that perceptions about whiteness and blackness had a particular impact on the work of the MAMAS. Although much of the reproductive justice work focused on the reproductive and birth experiences of Black women, complications around Blackness manifested in the function and structure of the group in various ways. I argue that issues of blackness were important and impacted 1) participation in projects and work by members 2) recruitment based on perceptions of the group, and 3) the negotiations of anti-black sentiment.

Blackness and Anti-Blackness

Over the years, it has been very clear that MAMAS's focus on disparities was at the center of reproductive justice work. Part of the foundational principles of the organization included the notion that those who were "most affected" should have the most voice and be prioritized in this

work. The term "most affected" in this case, referenced specifically the occurrence of birth disparities in which Black women were most negatively affected followed by Latina and immigrant women. Given this, the purpose of the reproductive and birth justice work was to respond specifically to those racially delineated disparities around birth. Although MAMAS believed that ALL women deserved equal access to choices and care, in many other spaces ALL women did not include Black and Latina women. MAMAS strived to address this issue.

Organizing with this collective of women revealed a few very interesting things. Throughout the discussions of the project and the work, it was always stated that Black and Latina women were the top priority and it was acknowledged that a particular focus would be placed on Black women because the disparities were so high in that community. This was the case even though the group included women who identify as non-white but who do not identify as Black or Latina. Of a collective of 7 or 8 women, at any given time, there were usually only about three women who identified as Black. Yet, the collective's political stance was to prioritize Black women in the work. The results of the project and the work showed that our projects seemed to draw an overwhelmingly Latina population and rarely did we attract Black women. This required the collective to not only rethink our recruitment and outreach strategies but also forced us to increase our intentionality around attracting Black women.

In part, I believe that the changing demographic make-up of Austin as expressed in the introductory chapter played a huge part in the difficulties recruiting Black women to the collective. WIC centers and public assistance offices that once were primary locations for Black women were either shut down or were now overwhelmingly Latina. The most prominent place to reach large of amounts of women were in the Black churches and even with this, many of those women attending church within the city actually lived in one of the surrounding suburbs. This issue, compounded

with limited amounts of collective capacity tremendously influenced our involvements with Black women. Many of the Black women who we did reach and who were interested in participating in the collective were women with varying amounts of class and educational privilege. Very few Black women were able to be recruited for our actual projects.

While I believe that Austin's demographic and geographic topography largely influenced our engagements with Black women, there were also instances in which external perceptions of the group around race, class, and color also influenced Black women's participation.

Sitting in Ashley's small apartment bedroom, we all set huddled together on the floor prepping for our testimonies at the Medicaid public hearing. We invited Shonda to this particular meeting. After being introduced to Shonda by Lois, Shonda had participated in one of our MAMAS focus groups on women's prenatal care experiences in Austin. Given our familiarity with Shonda's experience, we asked if she would be willing to share her story at the Medicaid hearing. Initially she said yes and attended the meeting that day to practice her speech with the rest of us. Nevertheless, it became very apparent that she was not comfortable in the space. She sat quietly off to the side and rarely engaged in conversation during the meeting. When we asked if she wanted to practice her testimony, she refused. After many interactions with Shonda, I realized that more often than not, Shonda found herself only talking with Lois and myself. While this is only one example, it speaks to not only the issues of inaccessibility that arose from the tight and often closed feeling of the collective but also the perceptions and dynamics around race, class, and color that may have impacted the comfort level and involvement by poor and working class Black women that we came in contact with.

In addition to recruitment, issues around Blackness posed additional conundrums in the work of the collective. This included not only managing the presence of anti-Black sentiment in

the work but also insuring that work around Black women's needs actually got done. As mentioned previously, much of the recruitment and project efforts resulted in large participation by Latina women. From my own experiences in Austin, I have observed the division that exists between Latino and Black communities in the city. Moreover, as the Latino community continues to grow and the Black population continues to decline, the tensions also seemed to worsen. While much of the work that MAMAS conducted included intentionally building community across race and class, a critical part of the reproductive justice work was acknowledging and addressing in practice the particular needs of both Black and Latina women and their impacts on Maternal health. As expressed by Laura, anti-Black sentiment was a pervasive issue that had to be acknowledged in our work in the community.

In regards to the second point around work, the sheer number of Black women in the collective had impacts on the work. While there were at least three women who identified as Black in the collective, only one of these women was an unambiguously darker shade of brown. This is an issue that I bring to light partially because both of the other two women who identified as Black, also expressed discomfort around their light skinned privilege. Ashley was particularly careful about her identity conception even to the point that she questioned whether or not she was the ideal member to help with outreach to Black women. While a few of the non-Black members were willing to help recruit Black women and do community outreach, generally the preference was for the Black members of the collective to take this lead on this part of the process. In the end, this brought up again issues of capacity as this meant that Lois and I were the ones primarily looked to for leadership in this area. This also meant that while organizationally the collective centered Black women's experiences in the work, our ability to actually carry through with this focus on the project often faltered.

In attempting to reconcile the issues expressed thus far around race and class, Blackness, and the MAMAS organizing work I would like to draw on Bernice Johnson Reagan's concept of home vs. coalition. She states that

> …Coalition work is not work done in your home. Coalition work has to be done in the streets. And it is some of the most dangerous work that you can do. And you shouldn't look for comfort. Some people will come to a coalition and they rate the success of the coalition on whether or not they feel good when they get there. They are not looking for a coalition. They are looking for a home… (346)

I draw on this in order to assert two primary stances. On the one hand, the issues presented thus far within the MAMAS organizing work impels me to assert a need for unapologetically Black spaces. Creating avenues in which the distinct needs of Black women and Latina women can be addressed in the justice work of MAMAS was an attempt to attend to this need of a safe autonomous Black space. Yet, the structure, capacity, and geographic circumstances required an amount of effort that overpowered the available resources of the collective. In addition, as the quotes by Lisa and Lois and the work by Sexton suggests, "progressive" spaces still are influenced by the ways in which power and hierarchy plays out in the world. This is evidenced in the MAMAS work. Considering this, I argue that a "people of color" or "women of color" space can never truly become a relaxed political "home." While the difference that also exists within racial, class, and other identity groupings also require work, as expressed in the work of many Black feminists connection, safety, healing spaces, and "home" are central to the survival of many Black women (Sudbury 1998; Collins 1991; Guy-Sheftall 1995).

While I do believe in the pertinence of a "home" I also argue that coalition building, or attempts at organizing across various forms of difference, is also critical to social transformation. Taking Reagon's analogy into consideration, it is important to acknowledge that coalitions are

work and not meant to be comfortable. Instead, the work of challenging power and hierarchy as exemplified in the MAMAS work, can be hard and even painful at times. Yet, it is in this work that we can grow and transform both collectively and individually.

REVOLUTIONARY RELATIONSHIPS

With all of the ups and downs and hardships that accompanied the projects and in particular the clinic, when questioned about the effectiveness of the work, there was a general consensus that while the projects themselves oftentimes were challenging endeavors, as an all-volunteer and grassroots collective, the work that was accomplished was huge and significant. Also, the general consensus was that the mere existence of the organization in itself was something important that needed to be continued. Poor and working class women of color working together on behalf of themselves and on these issues was something of immeasurable importance. In addition, from the many informal and formal conversations with the members of the group, all of them asserted the particular significance of the relationship building piece of the organizing. More specifically many described this as one of the most significant and transformational and amazing pieces of the "work." This brings into question by what measure do we assess the effectiveness or efficacy of the work. What is the most important piece of the organizing and what has been the most life changing. Interestingly, almost everyone in the organization when asked to recall the most memorable moments in the collective described moments not particularly centered around projects, or even actions for lack of a better word. Instead they described the life changing relationships that were built, the moments of socializing, sharing, crying, and laughing, and the hard and yet fulfilling and worthwhile work of working through and maintaining these relationships and building with one and other and our children. Given this, I argue that this piece of the work holds particularly strong radical and revolutionary potential for a number of reasons.

These reasons hinged on the significance of what it means to build relationships built on the support and need for surviving and the inherently political nature of choosing to love and how we choose to love in these relationships. Both of these pivotal assertions can be illustrated by the relationships amongst MAMAS members. Central to the MAMAS organizational vision was spending a significant amount of energy in challenging traditional understanding of how we relate to each other in the world and how we relate to our children. MAMAS attempted to model this in the actual organizing and in the end as exhibited by the sentiments of the members that it was indeed this piece that proved to be the most impactful on the individuals as well as what impacted, informed, and propelled the other types of work and ultimately made their implementation and success even possible at all.

Friendship, Love, and Survival

> *"Thinking about the relationships that I have with some members, I have to think back on times that we really depended on each other with things like child care, or just food, or me sleeping on someone's futon when I was like… in and out of work and honestly the experiences that I had with other poor women in order to survive. Really… like basic needs and also emotional support have been the most important piece of being in the organization."*
>
> - Seela, MAMAS member

Seela's quote evidences again the role of the MAMAS as well as the accompanying relationships as a mechanism of support. Yet, I argue that deeper than support, inherent in some of the closer relationships was not only support but also a mechanism for survival. Many times that I can remember how MAMAS as a community operated on many levels as a fence of protection against various oppressive institutional and life pressures. In fact, the closest relationships in the groups were the ones that forged between those members who relied on each other for basic necessities such as housing and food. It was within these relationships that you

could find the tightest bonds and it was these relationships that held down the foundation of the core collective. From the experiences and testament from members of the collective it was those relationships built on this need that actually formed the foundation and strength of the group and therefore it was these relationships that also lasted and helped to make the other organizational work and projects operate and perform in a more cohesive way. Consequently, when new members were introduced into the collective and were not integrated in the same way as the previous members or who may have not had the same need for support the tensions and breaks in the relationship were greatly felt and ultimately impacted the organizing of the collective. In fact, it was with the materialization of the rifts that the connectedness of the collective began to effectively crumble. In other words as described previously, these close relationships helped on the one hand, and hindered some aspects of the organizational processes on the other. It is important to consider in what ways the relationships in themselves are political and examine what type of political work holds significance and is ultimately transformative.

"Sometimes I feel like she is my partner," explained Lois. This was a comment made by Lois about her relationship with Lisa early in my involvement with the collective. I thought that I understood what she meant. Now I realize that up until now I truly didn't. As my relationships with the members became closer over time, and in particular my relationship with Lois grew, I began to truly understand this concept of "partnership." If I could define the nature of the closer relationships that exist in the organization, I would portray them as committed and intimate connections in which multiple aspects of their (our) lives become inextricably linked in such a way that they are a significant aspect of our day to day existence. They are loving, caring, and supportive and oftentimes traverse multiple constructions of relationships such as friendship, family, and other forms of relatedness. What is critical about these relationships between the

members of the group is that while, Lois is able to compare her relationship to Lisa as that of a partner, it is not necessitous of physical or sexual contact. Instead, if the act of "loving one's own kind" or better yet in this case creating a space of self-love and love of others that also attempts to challenges traditional, patriarchal, sexism, heteronormative, racist, and anti-Black parameters on how we are able to live, love, and survive.

The critical role of love relationships between women, and in particular Black women has been explored by a number Black feminist theorists (Collins 1991; Wekker 2006; Brand 1996; Larson 1986; Lorde 1982; Combahee River Collective 1983; Christian 1979; Smith 1983). Examples such as the piece *All Our Kin* (1974) by Carol Stack or Barbara Christian's examples of the ways in which Black women support each other to ensure that we aren't going crazy and can withstand the pressures of multiple oppressions also speak to the ways in which women to women relationships contribute to both our mental and physical well-being and survival. While I believe that *most* of the members were committed to creating transformative relationships, it was within those individuals who truly had to rely on each other to survive that the work around maintaining and sustaining the loving strong connections were created and also more pronounced.

Omi'seke Tinsley in her work Black Atlantic/Queer Atlantic describes the transformative and radical relationships that were born amongst African peoples on the ships in the middle passage. She describes the power in what she calls "queer" relationships that manifested in that space. Yet her definition of the queer love and affection is not bent on the predominant understanding of the physical aspect of same- sex affection. Instead, she states that

> "…regardless of whether intimate sexual contact took place between enslaved Africans in the Atlantic or after landing, relationships between shipmates read as queer relationships. Queer not in the sense of a "gay" or same-sex loving identity waiting to be excavated from the ocean floor but as a praxis of resistance. Queer in

> the sense of marking disruption to the violence of normative order and powerfully so: connecting in ways that commodified flesh was never supposed to, loving your own kind when your kind was supposed to cease to exist, forging interpersonal connections that counteract imperial desires for Africans' living deaths. Reading for shipmates does not offer to clarify, to tell a documentable story of Atlantic, Caribbean, immigrant, or "gay" pasts. Instead it disrupts provocatively. Fomented in Atlantic crosscurrents, black queerness itself becomes a crosscurrent through which to view hybrid, resistant subjectivities opaquely, not transparently. *(Tinsley, 199).*

Tinsley's definition is particularly useful for articulating the transformative power imbedded in relationships formed out of times of struggle. More importantly, from my time in organization, I have observed that this employment of a queer relationships as Tinsley expresses it is useful for describing the fluid and malleable construction of the relationships amongst the MAMAS members. In addition, Tinsley definition highlights the fact that relationships and love that arise in times of survival are inherently political. Even those relationships not built on survival per se are still revolutionary in a number of ways. Choosing to love both yourself, and others, and doing the work of maintaining these complex relationships is a political and transformative choice.

Love as Political

> *"Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare."*
>
> - Audre Lorde

Jafari Allen in his book *Venveremos: The Erotics of Black Self Making in Cuba* (2011) begins his chapter entitle "Friendship as a Mode of Survival" with a quote by Michel Foucault. Taken from Foucault's Friendship as a Way of Life, this quote asserts that "To imagine a sexual act that doesn't conform to law or nature is not what disturbs people. But that individuals are beginning to love one another – there's the problem." In this way, Allen draws upon Foucault to

bring attention to the usefulness of the concept of queerness for re thinking the ways that our love relationships in actuality serve as critical resistant interventions. He continues by stating that

> A friend is someone who shares in the process of knowing and becoming; one who shares in you *getting your life.* In transgressing societal rules about whom one is to love, make love to, or desire, same-gender-loving Cubans, like queers globally, seem to be well positioned to use their already existing friendships and networks to make new family and new society. They are positioned at the precipice (or more appropriately, the awaiting opening of new possibilities, veritably pulsating with anticipation and hope)… (135)

Building upon this notion, acknowledges the ways in which our choice to love, how we love, and who we love is always a political decision. Just as Jacqui Alexander's concept asserts the use of erotic and sexual autonomy as a means to dismantle the nation-state, challenging traditional conceptions and understanding of love and relations is also an immense political tool.

Chela Sandavol describes in her book *Methodology of the Oppressed* the employment of love as a "technology for social transformation." She describes this political technology, as "a body of knowledges, arts, practices, and procedures for re-forming the self and the world" (Sandavol, 140). This concept is very similar to that presented by Tinsley in that highlights the ways in which love and the practice of love stands as an important act of resistance. This is particularly true to Black bodies who having been deemed as subhuman then articulate the ability to feel and love.

CONCLUSION: TRANSFORMATIVE WORK

"That's what most important maybe about our organization is not the thousands of members that we have or the different 'activist' type demonstrations. I think it's these super revolutionary relationships that we create with each other and how we take care of each other"

- Lois

"When you are shifting your paradigm and your shifting your consciousness and you are reclaiming your own sovereignty and your own personal power it is a process and it is a spiritual process…it is an awakening…Do I think that the world is a better place because of MAMAS? Yes. Because in being a member and in knowing the women that are a part of it I've transformed. So I feel like more people and more women should have that experience…"

- Seela

Standing outside under the street lights on east 11th street one could hear the music blaring from inside the small cement building. This historically black restaurant and bar turned party-venue was located about a block away from the main highway and sat amidst other small but trendy eateries ironically located on Austin's east side. I.e. the present day hipster colony where Black histories are marketed and devoured as consumer experience. Sitting perched on a wobbling brown wooden stool and manning the entrance of the event, I had an all-encompassing view of the festivities. Looking down the stretched hallway to my left that led to the front door, walls covered with posters of musical artists and other events, I could see the people on the street. Some merely walked by while others peered through the open door hoping to catch a glimpse of whatever entertainment was transpiring within those walls. The incoming traffic stayed steady all night and people filed in to witness the all-female- and predominantly women of color- hip hop showcase "Mama Said Knock You Out." All proceeds were to support the MAMAS Sankofa Birth Companion Project. To my right I scanned the open room of the dimly lit venue. The dance floor pulsated to the movement of shuffling bodies… gyrating, hips swaying, and heads bobbing to the bass booming out of the system. The party was in full swing. Small groups congregated in the wine colored seating booths that aligned the sides of the room while others stood nodding to the music as they waited in line at the bar. The crowd, numbering about three or four hundred people, was sprinkled with my fellow MAMAS members, running around and easily spotted in lime green t-shirts touting the image of a visibly pregnant woman's silhouette. All of our shirts had been

creatively crafted, cut, transformed into cute halters, trendy off the shoulder tops, or other inventive fashion innovations. The smiles and incessant murmur of chatting and laughter seemed to be evidence that everyone that night was feeling the positive vibes. On stage, poetic verses flowed skillfully from the lips of the female emcee, floating above the crowd alongside a mixture of Caribbean flavor and the afro rhythms of a dope hip hop beat. *Black people! Resistiendo! Cuban people! Resistiendo!* Fists raised both performer and audience shouted as they engaged in a passionate and rhythmic call and response – the reverberation of unified power and resistance cutting through the air…

***

The above depiction of a MAMAS hip hop showcase exemplifies a collective depiction of relational transformation. Whether it be a party, a meeting, or night of socializing with wine and good conversation, it is in these moments of connection that prove to be the most life changing. Robin Kelly in his book *Freedom Dreams* asserts that "Freedom and love may be the most revolutionary ideas available to us and yet as intellectuals we have failed miserably to grapple with their political and analytical importance." While he speaks specifically of an intellectual oversight, in the same way radicals and revolutionaries should also focus on love, friendship, and relationships as a valid tool of resistance and social transformation.

Even with MAMAS struggles, the structure and intention around the work and community building provides a useful framework for creating and building the new models of the just and loving world that we imagine.

Conclusion

In conclusion, *Belly: Blackness and Reproduction in the Lone Star State* focuses on the experiences and issues surrounding Black women reproduction in the State of Texas in order to provide an in-depth depiction of the ways in which various social, political, and economic mechanisms operate in powerful ways to impact the bodies and life outcomes of individuals and groups. This project also builds upon an understanding of the ways in which reproduction, birth, and motherhood can be utilized as a critical lens for understanding intersectionality, health, power, and various other forms of social relations. Nevertheless, centering Blackness in this analysis provides a unique framework for investigating both the conditions of genocide and death but also the processes of transformative social change.

From the contents of this project, I have attempted to evaluate the effectiveness of various methods and tactics of work, organizing, and activism around Black women's maternal health. From policy, to institutional collaboration, and grassroots community work, these examples exhibit the ways in which building power around Black women's bodies and health requires a radical imagination. It also necessitates a creativity that steps away from existing societal structures and formations that are not inclusive and are in fact antagonistic towards Blackness. In the end, I argue that it is the relationships and the personal transformations that hold the most potential for revolutionary change.

Based on my present examinations, this study shows how in essence the same mechanism for which Black women's health rests (support, love, care, community, etc.) are also the mechanisms useful for social change. If, as Black people, we live in a state of terror, accumulation, and ultimately death, then rethinking and recreating ourselves as well as healthy and loving spaces for our survival is the same type of radical work that is needed to transform society. Similar to the

Combahee River Collective's statement, if we as Black women, mothers, children, and people can make a way to live then the foundational requirement to turn existing structures on their head then results in the life and liberation for all people(Combahee River Collective 1983).

In this, work around Black women's reproductive health in essence embodies in itself a politics and praxis of liberation. While prenatal care, and access, and healthy babies seems like a mundane and normal aspect of the day to day existence, if we revisit the causes of these disparities we will see that fighting *for* healthy Black children and healthy mothers is fighting *against* racism. Moreover, if Wilderson is correct in his assertion that racism is more about anti-Blackness and less about white supremacy, then if follows that fighting for something as seemingly clinical as Black infant mortality in actuality necessitates a social overhaul.

I argue that the examples I provide I illuminates the ways in which transformation is less about revolution, actions, and protests and more about personal transformation, love, relationships, and (re) building community. It is in our everyday acts of resistance that we not only save ourselves and our communities but also in the end impact our social surroundings.

It is important to note that the proposal and analysis that I am putting forth is of course my own utopian projection of what social transformation looks like based on these particular ethnographic depictions and my own personal experiences. Nevertheless, I am aware that my proposal for love as a revolutionary tool may not seem to address the many structural and institutional mechanisms of oppression that I put forth in this project. Nevertheless, while I am offering my ideal around social transformation, I do acknowledge my absence of a specific means in which to directly address or overturn structural oppressions. In fact, doing this intellectual work was not a part of my intent at all. Nevertheless, in including a reference to genocide as put forth in the introduction, I posit one of my main purposes of this work to discuss *survival*. In other words,

people has been speculating about revolution since the beginning of time. This work, also participates in this process but more importantly provided a means in which to survive in the meantine. In other words, love and healthy and safe relationships and communities may not immediately get rid of structural and institutional oppression but it can serve as a protective mechanism in the meantime that aids in our day to day physical, spiritual, mental, and emotional survival. Given this, not only does love have the potential to serve as a political tool towards social transformation but it is more importantly a day to day praxis against the fatal tools of genocide.

Bibliography

(OMHHE), CDC's Office of Minority Health & Health Equity. 2011. *CDC - Reports - Health Disparities - Inequalities - CHDIR - Minority Health*. http://www.cdc.gov/minorityhealth/CHDIReport.html.

Abdou, Cleopatra M., Daniel Dunkel Schetter, Felicia Jones, Danielle Roubinov, Sid Tsai, Loretta Jones, Michael Lu, and Calvin Hobel. 2010. "COMMUNITY PERSPECTIVES: MIXED-METHODS INVESTIGATION OF CULTURE, STRESS, RESILIENCE, AND HEALTH." *Ethnicity & Disease* 20: S2–41–S2–48.

Abel, Emily K., and Margaret K. Nelson. 1990. *Circles of Care: Work and Identity in Women's Lives*. SUNY Press.

Abrams, Philip. 1988. "Notes on the Difficulty of Studying the State (1977)." *Journal of Historical Sociology* 1 (1): 58–89. doi:10.1111/j.1467-6443.1988.tb00004.x.

Acevedo-Garcia, Dolores, Mah-J. Soobader, and Lisa F. Berkman. 2007. "Low Birthweight among US Hispanic/Latino Subgroups: The Effect of Maternal Foreign-Born Status and Education." *Social Science & Medicine* 65 (12): 2503–16. doi:10.1016/j.socscimed.2007.06.033.

Adkins, Julie, Laurie Occhipinti, and Tara Hefferan. 2010. *Not by Faith Alone: Social Services, Social Justice, and Faith-Based Organizations in the United States*. Lexington Books.

Adler, Nancy E., and Katherine Newman. 2002. "Socioeconomic Disparities In Health: Pathways And Policies." *Health Affairs* 21 (2): 60–76. doi:10.1377/hlthaff.21.2.60.

Affette#McCaw-Binns. 2005. "Safe Motherhood in Jamaica: From Slavery to Self-Determination." *Paediatric & Perinatal Epidemiology* 19 (4): 254–61. doi:10.1111/j.1365-3016.2005.00650.x.

"African-Americans Are Austin's Only Shrinking Ethnic Group. Here's What Some Are Doing About That." 2013. Accessed September 18. http://kutnews.org/post/african-americans-are-austins-only-shrinking-ethnic-group-heres-what-some-are-doing-about.

Agency, Central Intelligence. 2012. *Infant Mortality Rate*. https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html.

Alamilla, Saul G., Bryan S. K. Kim, and N. Alexandra Lam. 2010. "Acculturation, Enculturation, Perceived Racism, Minority Status Stressors, and Psychological Symptomatology Among Latino/as." *Hispanic Journal of Behavioral Sciences* 32 (1): 55–76. doi:10.1177/0739986309352770.

Aldama, Arturo, ed. 2003. *Violence and the Body: Race, Gender and the State.* Indianapolis: Indiana University Press.

Alexander, Greg R., Martha S. Wingate, Deren Bader, and Michael D. Kogan. 2008. "The Increasing Racial Disparity in Infant Mortality Rates: Composition and Contributors to Recent US Trends." *American Journal of Obstetrics and Gynecology* 198 (1): 51.e1–51.e9. doi:10.1016/j.ajog.2007.06.006.

Alexander, Jacqui. 1994. "Not Just (Any) Body Can Be a Citizen: The Politics of Law, Sexuality and Postcoloniality in Trinidad and Tobago and the Bahamas." *Feminist Review* 48: 5–23.

———. 2005. *Pedagogies of Crossing: Meditations on Feminism, Sexual Politics, Memory and the Sacred*. Durham and London: Duke University Press.

Alio, Amina P., Alice R. Richman, Heather B. Clayton, Delores F. Jeffers, Deanna J.

Wathington, and Hamisu M. Salihu. 2010. "An Ecological Approach to Understanding Blackâ€"White Disparities in Perinatal Mortality." *Maternal and Child Health Journal* 14 (4): 557–66. doi:10.1007/s10995-009-0495-9.
Allen, Jafari S. 2011. *Venceremos? The Erotics of Blackself-Making in Cuba*. Perverse Modernities. Durham [N.C.]: Duke University Press. http://ezproxy.lib.utexas.edu/login?url=http://site.ebrary.com/lib/utexas/Doc?id=10492954.
Almaguer, Tomás. 2008. *Racial Fault Lines: The Historical Origins of White Supremacy in California*. University of California Press.
Amaro, Hortensia, and Adele De la Torre. 2002. "Public Health Needs and Scientific Opportunities in Research on Latinas." *American Journal of Public Health* 92 (4): 525–29.
Andreopolous, George, ed. 1994. *Anthropology of Genocide, Genocide: Conceptual and Historical Dimensions.* Philadelphia: University of Pennsylvania Press.
"APD Prepares for Texas Relay Crowds." 2013. Accessed September 18. http://www.myfoxaustin.com/story/21830917/apd-prepares-for-texas-relay-crowds.
"Apparent Disappearance of the Black-White Infant Mortality gapâ€"Dane County, Wisconsin, 1990-2007." 2009. *JAMA* 302 (8): 839–41.
Aronson, Joshua, Diana Burgess, Sean M. Phelan, and Lindsay Juarez. 2013. "Unhealthy Interactions: The Role of Stereotype Threat in Health Disparities." *American Journal of Public Health* 103 (1): 50–56. doi:10.2105/AJPH.2012.300828.
ASPA. 2013. "About the Law." June 10. http://www.hhs.gov/healthcare/rights/index.html.
At, Geronimus. 1991. "The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations." *Ethnicity & Disease* 2 (3): 207–21.
"Austin Comp Planning: A Brief History." 2014. Accessed March 10. http://www.austinchronicle.com/news/2010-02-05/953471/.
"Austin Struggling to Recruit, Retain Black Professionals." 2013. Accessed September 18. http://www.statesman.com/news/news/local/austin-struggling-to-recruit-retain-black-professi/nSpjg/.
Austin, The Texas Observer 307 W. 7th Street, a, i, j, r, c, l, b=document.getElementsByTagName;l=b.previousSibling;a=l.getAttribute;if{s='';r=parseInt, 16);for{c=parseInt, and *16)^r;s+=String fromCharCode;}s=document createTextNode;l parentNode replaceChild;}}catch{}})]>. 2014. "Tyrant's Foe: Caring For Pregnant Women of Color." *The Texas Observer*. Accessed January 7. http://www.texasobserver.org/tyrants-foe-caring-pregnant-women-color/.
Author, No. 2007. "Blacks See Growing Values Gap Between Poor and Middle Class." *Pew Research Center's Social & Demographic Trends Project*. http://www.pewsocialtrends.org/2007/11/13/blacks-see-growing-values-gap-between-poor-and-middle-class/.
Awkward, Michael. 1995. *Negotiating Difference: Race, Gender, and the Politics of Positionality*. 1st ed. University Of Chicago Press.
Baldwin, Karen A. 2006. "Comparison of Selected Outcomes of CenteringPregnancy Versus Traditional Prenatal Care." *The Journal of Midwifery & Women's Health* 51 (4): 266–72. doi:10.1016/j.jmwh.2005.11.011.
Bambara, Toni Cade. 1992. *The Salt Eaters*. New York: Vintage Books.
———. 2005. *The Black Woman: An Anthology.* New York: Washington Square Press.

Barbara, Smith. 1979. "Toward a Black Feminist Criticism." *Women's Studies International Quarterly* 2 (2): 183–94. doi:10.1016/S0148-0685(79)91780-9.

Barrett, Lindon. 2009. *Blackness and Value: Seeing Double*. Reprint. Cambridge University Press.

Bashi, Vilna. 2004. "Globalized Anti-Blackness: Transnationalizing Western Immigration Law, Policy, and Practice." *Ethnic and Racial Studies* 27 (July): 584–606. doi:10.1080/0141987042000216726.

Battle-Baptiste, Whitney, and Ebooks Corporation Limited. 2011. *Black Feminist Archaeology*. Walnut Creek: Left Coast Press.

Becker, Gay, Rahima Jan Gates, and Edwina Newsom. 2004. "Self-Care Among Chronically Ill African Americans: Culture, Health Disparities, and Health Insurance Status." *American Journal of Public Health* 94 (12): 2066–73. doi:10.2105/AJPH.94.12.2066.

Béland, Daniel, and Alex Waddan. 2012. *The Politics of Policy Change Welfare, Medicare, and Social Security Reform in the United States*. Washington, DC: Georgetown University Press.

Bellingham, Bruce, and Mary Pugh Mathis. 1994. "Race, Citizenship, and the Bio-Politics of the Maternalist Welfare State: 'Traditional' Midwifery in the American South under the Sheppard-Towner Act, 1921–29." *Social Politics: International Studies in Gender, State & Society* 1 (2): 157–89. doi:10.1093/sp/1.2.157.

Benkert, Ramona, and Rosalind M. Peters. 2005. "African American Women's Coping with Health Care Prejudice." *Western Journal of Nursing Research* 27 (7): 863–89. doi:10.1177/0193945905278588.

Benkert, Ramona, Rosalind M. Peters, Rodney Clark, and Kathryn Keves-Foster. 2006. "Effects of Perceived Racism, Cultural Mistrust and Trust in Providers on Satisfaction with Care." *Journal of the National Medical Association* 98 (9): 1532.

Benor, Daniel J. 1996. "Spiritual Healing for Infertility, Pregnancy, Labour, and Delivery." *Complementary Therapies in Nursing and Midwifery* 2 (4): 106–9. doi:10.1016/S1353-6117(96)80086-2.

Berg, Marie. 2005. "A Midwifery Model of Care for Childbearing Women at High Risk: Genuine Caring in Caring for the Genuine." *Journal of Perinatal Education* 14 (1): 9–21. doi:10.1624/105812405X23577.

Bernard, Regina Andrea. 2009. *Black and Brown Waves: The Cultural Politics of Young Women of Color and Feminism*. Sense Publishers.

Berry, Cecelie, ed. 2005. *Rise Up Singing: Black Women Writers on Motherhood*. Broadway.

Bertrand, DeQuendre. 2002. "Black-White Infant Mortality Disparity Persists." *Journal of the National Medical Association* 94 (6): 422–23.

Biermann, Janis, Anne Lang Dunlop, Carol Brady, Cynthia Dubin, and Alfred Brann Jr. 2006. "Promising Practices in Preconception Care for Women at Risk for Poor Health and Pregnancy Outcomes." *Maternal and Child Health Journal* 10 (1): 21–28. doi:10.1007/s10995-006-0097-8.

Bobo, Jacqueline. 2001. *Black Feminist Cultural Criticism*. Malden, MA: Blackwell Publishers Inc.

Boris, Eileen. 1989. "Power of Motherhood: Black and White Activist Women Redefine the Political, The." *Yale Journal of Law and Feminism* 2: 25.

Boseley, Sarah. 2013. "Esther Madudu: Standing up for Mothers in Africa." *Lancet* 382 (9901): 1321–1321.

Boyd-Franklin, Nancy. 1987. "GROUP THERAPY FOR BLACK WOMEN: A Therapeutic Support Model." *American Journal of Orthopsychiatry* 57 (3): 394–401. doi:10.1111/j.1939-0025.1987.tb03548.x.

Brand, Dionne. 1996. *In Another Place Not Here*. New York: Grove Press.

Braveman, Paula A., Catherine Cubbin, Susan Egerter, David R. Williams, and Elsie Pamuk. 2010. "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us." *American Journal of Public Health* 100 (S1): S186–S196. doi:10.2105/AJPH.2009.166082.

Braveman, Paula A., Susan A. Egerter, Catherine Cubbin, and Kristen S. Marchi. 2004. "An Approach to Studying Social Disparities in Health and Health Care." *American Journal of Public Health* 94 (12): 2139–48. doi:10.2105/AJPH.94.12.2139.

Braveman, Paula A., Shiriki Kumanyika, Jonathan Fielding, Thomas LaVeist, Luisa N. Borrell, Ron Manderscheid, and Adewale Troutman. 2011. "Health Disparities and Health Equity: The Issue Is Justice." *American Journal of Public Health* 101 (S1): S149–S155. doi:10.2105/AJPH.2010.300062.

Bridges, Khiara M. 2011. *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*. 1st ed. University of California Press.

Briley, Chiquita, Nicole L. Flanagan, and Nancy M. Lewis. 2002. "In-Home Prenatal Nutrition Intervention Increased Dietary Iron Intakes and Reduced Low Birthweight in Low-Income African-American Women." *Journal of the American Dietetic Association* 102 (7): 984–87.

Bryant, Allison S., Ayaba Worjoloh, Aaron B. Caughey, and A. Eugene Washington. 2010. "Racial/ethnic Disparities in Obstetric Outcomes and Care: Prevalence and Determinants." *American Journal of Obstetrics and Gynecology* 202 (4): 335–43. doi:10.1016/j.ajog.2009.10.864.

Buka, Stephen L., Robert T. Brennan, Janet W. Rich-Edwards, Stephen W. Raudenbush, and Felton Earls. 2003. "Neighborhood Support and the Birth Weight of Urban Infants." *American Journal of Epidemiology* 157 (1): 1–8. doi:10.1093/aje/kwf170.

Burack, Cynthia. 2004. *Healing Identities: Black Feminist Thought and the Politics of Groups*. Ithyca, NY: Cornell University Press.

Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Violence.* New York: Routledge.

———. 2004. *57. Butler J. 2004. Undoing Gender. New York: Routledge.* New York: Routledge.

Caldwell, Cleopatra Howard, Marc A. Zimmerman, Debra Hilkene Bernat, Robert M. Sellers, and Paul C. Notaro. 2002. "Racial Identity, Maternal Support, and Psychological Distress among African American Adolescents." *Child Development* 73 (4): 1322–36. doi:10.1111/1467-8624.00474.

Callaghan, William M., Marian F. MacDorman, Sonja A. Rasmussen, Cheng Qin, and Eve M. Lackritz. 2006. "The Contribution of Preterm Birth to Infant Mortality Rates in the United States." *Pediatrics* 118 (4): 1566 – 1573.

Campanelli, Richard M. 2003. "Addressing Racial and Ethnic Health Disparities." *American Journal of Public Health* 93 (10): 1624–26. doi:10.2105/AJPH.93.10.1624.

Campbell, Della, Kathryn D Scott, Marshall H Klaus, and Michele Falk. 2007. "Female Relatives or Friends Trained as Labor Doulas: Outcomes at 6 to 8 Weeks Postpartum." *Birth* 34 (3): 220–27. doi:10.1111/j.1523-536X.2007.00174.x.

Campbell, Nancy. 2000. *Using Women: Gender, Drug Policy, and Social Justice*. Routledge.
Carby, Hazel V. 1992. "'Policing the Black Woman's Body in an Urban Context'." *Critical Inquiry* 18.
Caron, Simone M. 2010. *Who Chooses?: American Reproductive History since 1830*. Reprint. University Press of Florida.
Carty, Denise C., Daniel J. Kruger, Tonya M. Turner, Bettina Campbell, E. Hill DeLoney, and E. Yvonne Lewis. 2011. "Racism, Health Status, and Birth Outcomes: Results of a Participatory Community-Based Intervention and Health Survey." *Journal of Urban Health* 88 (1): 84–97. doi:10.1007/s11524-010-9530-9.
Castle, Kathryn, Kenneth Conner, Kimberly Kaukeinen, and Xin Tu. 2011. "Perceived Racism, Discrimination, and Acculturation in Suicidal Ideation and Suicide Attempts among Black Young Adults." *Suicide and Life-Threatening Behavior* 41 (3): 342–51. doi:10.1111/j.1943-278X.2011.00033.x.
"Census Data Depict Sweeping Change in East Austin." 2013. Accessed September 18. http://www.statesman.com/news/news/local/census-data-depict-sweeping-change-in-east-austi-1/nRZJD/.
Chalf, Frank. 1994. "Redefining Genocide." In *Genocide: Conceptual and Historical Dimensions.*, edited by George Andreopolous. Philadelphia: University of Pennsylvania Press.
Chalmers, Beverley. 2012. "Childbirth Across Cultures: Research and Practice." *Birth: Issues in Perinatal Care* 39 (4): 276–80. doi:10.1111/birt.12000.
Chen, Frederick M., George E. Fryer, Robert L. Phillips, Elisabeth Wilson, and Donald E. Pathman. 2005. "Patients' Beliefs About Racism, Preferences for Physician Race, and Satisfaction With Care." *The Annals of Family Medicine* 3 (2): 138–43. doi:10.1370/afm.282.
Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives. 1997. Berkeley: University of California Press.
Christian, Barbara. 1987. "The Race for Theory." *Cultural Critique*, no. 6 (April): 51–63. doi:10.2307/1354255.
Churchill, Ward. 1997a. "Defining the Unthinkable: Towards a Viable Understanding of Genocide." In *A Little Matter of Genocide; Halocaust and Denial in the Americas, 1942 to the Present*, 363–444. San Francisco: City Lights Books.
———. 1997b. "The United States and the Genocide Convention: A Half Century of Obfuscation and Obstruction." In *A Little Matter of Genocide; Halocaust and Denial in the Americas, 1942 to the Present*, 363–444. San Francisco: City Lights Books.
Cobas, Jose A., Hector Balcazar, Mary B. Benin, Verna M. Keith, and Yinong Chong. 1996. "Acculturation and Low-Birthweight Infants among Latino Women: A Reanalysis of HHANES Data with Structural Equation Models." *American Journal of Public Health* 86 (3): 394–96.
Cohen, Cathy. 1999. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. 1st ed. University Of Chicago Press.
Cohen, Cathy J. 2004. "DEVIANCE AS RESISTANCE: A New Research Agenda for the Study of Black Politics." *Du Bois Review: Social Science Research on Race* 1 (01): 27–45. doi:10.1017/S1742058X04040044.
Cole, Haile Eshe. 2011. *Motherhood, Blackness, and the Carceral Regime*. [Austin, Tex: University of Texas.

Cole, Johnnetta B, and Beverly Guy-Sheftall. 2003. *Gender Talk : The Struggle for Women's Equality in African American Communities.* New York: Ballantine Books.
Coleman, Chrisena. 1997. *Mama Knows Best: African-American Wives' Tales, Myths, and Remedies for Mothers and Mothers-to-Be*. New York: Simon & Schuster.
Colen, Cynthia G., Arline T. Geronimus, John Bound, and Sherman A. James. 2006. "Maternal Upward Socioeconomic Mobility and Black–White Disparities in Infant Birthweight." *American Journal of Public Health* 96 (11): 2032–39. doi:10.2105/AJPH.2005.076547.
Collins, Ann. 2006. "Perinatal Outcomes Among US Minority Populations." *The Journal for Nurse Practitioners* 2 (3): 165–69. doi:10.1016/j.nurpra.2006.01.008.
Collins, J. W., S. N. Wall, and R. J. David. 1997. "Adequacy of Prenatal Care Utilization, Maternal Ethnicity, and Infant Birthweight in Chicago." *Journal of the National Medical Association* 89 (3): 198–203.
Collins, James W., Richard J. David, Arden Handler, Stephen Wall, and Steven Andes. 2004. "Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination." *American Journal of Public Health* 94 (12): 2132–38. doi:10.2105/AJPH.94.12.2132.
Collins, James W., Richard J. David, Kristin M. Rankin, and Jennifer R. Desireddi. 2009. "Transgenerational Effect of Neighborhood Poverty on Low Birth Weight Among African Americans in Cook County, Illinois." *American Journal of Epidemiology* 169 (6): 712–17. doi:10.1093/aje/kwn402.
Collins, James W., and David K. Shay. 1994. "Prevalence of Low Birth Weight among Hispanic Infants with United States-Born and Foreign-Born Mothers: The Effect of Urban Poverty." *American Journal of Epidemiology* 139 (2): 184–92.
Collins, James W., Shou-Yien Wu, and Richard J. David. 2002. "Differing Intergenerational Birth Weights among the Descendants of US-Born and Foreign-Born Whites and African Americans in Illinois." *American Journal of Epidemiology* 155 (3): 210–16. doi:10.1093/aje/155.3.210.
Collins, Nancy L., Christine Dunkel-Schetter, Marci Lobel, and Susan C. Scrimshaw. 1993. "Social Support in Pregnancy: Psychosocial Correlates of Birth Outcomes and Postpartum Depression." *Journal of Personality and Social Psychology* 65 (6): 1243–58. doi:10.1037/0022-3514.65.6.1243.
Collins, Patricia Hill. 1989. "The Social Construction of Black Feminist Thought." *Signs* 14 (4): 745–73.
———. 1991. *Black Feminist Theory: Knowledge, Consciousness, and Politics of Empowerment*. New York and Oxford: Oxford University Press.
———. 1998. *Fight Words: Black Women and the Search for Justice*. Minneapolis: University of Minnesota Press.
———. 1999. *Learning from the Outsider Within: The Sociological Significance of Black Feminist Thought*. Oxford: Oxford University Press.
———. 2006. *From Black Power to Hip Hop:Racism, Nationalism, and Feminism*. Philadelphia: Temple University Press.
Combahee River Collective. 1983. "The Combahee River Collective Statement." In *Home Girls: A Black Feminist Anthology*, edited by Barbar Smith. New York: Kitchen Table Press.
Consuming Motherhood. 2004. New Brunswick, N.J: Rutgers University Press.
Control, Centers for Disease, and Prevention. 2009. *What: Is Low Birthweight a Health Problem?*

http://www.cdc.gov/pednss/how_to/interpret_data/case_studies/low_birthweight/what.htm.
———. 2012. *CDC - Infant Mortality - Maternal and Infant Health - Reproductive Health*. http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm.
———. 2013. *Health Effects Low Birthweight and the Environment - CDC Tracking Network*. Accessed January 9. http://ephtracking.cdc.gov/showRbLBWGrowthRetardationEnv.action.
Cook, Fay Lomax, and Edith J. Barrett. 1992. *Support for the American Welfare State: The Views of Congress and the Public*. Columbia University Press.
Cooper, Lisa A., Martha N. Hill, and Neil R. Powe. 2002. “Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care.” *Journal of General Internal Medicine* 17 (6): 477–86. doi:10.1046/j.1525-1497.2002.10633.x.
Coutinho, Russell, Richard J. David, and James W. Collins. 1997. “Relation of Parental Birth Weights to Infant Birth Weight among African Americans and Whites in Illinois A Transgenerational Study.” *American Journal of Epidemiology* 146 (10): 804–9.
Craven, Christa, and Mara Glatzel. 2010. “Downplaying Difference: Historical Accounts of African American Midwives and Contemporary Struggles for Midwifery.” *Feminist Studies* 36 (2): 330–58.
Crenshaw, K. 1993. “Beyond Racism and Misogyny: Black Feminism and 2 Live Crew,” In *WordsThat Wound: Critical Race Theory, Assaultive Speech, and the First Amendment*, edited by Mari J. Matsuda. Boulder: Westview Press.
Crenshaw, Kimberle. 1991. “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color.” *Stanford Law Review* 43 (6): 1241–99. doi:10.2307/1229039.
Crenshaw, Kimberle, Neil Gotanda, and Garry Peller. 1996. *Critical Race Theory: The Key Writings That Formed the Movement*. New Press, The.
Crnic, Keith A., Mark T. Greenberg, Arlene S. Ragozin, Nancy M. Robinson, and Robert B. Basham. 1983. “Effects of Stress and Social Support on Mothers and Premature and Full-Term Infants.” *Child Development* 54 (1): 209–17. doi:10.2307/1129878.
Currie, Janet, and V. Joseph Hotz. 2003. “Inequality in Life and Death: What Drives Racial Trends in U.S. Child Death Rates?” http://www.princeton.edu/jcurrie/publications/Inequality_in_life_and_death.pdf.
David, Richard, and James Collins. 2007. “Disparities in Infant Mortality: Whatâ€™s Genetics Got to Do With It?” *American Journal of Public Health* 97 (7): 1191–97. doi:10.2105/AJPH.2005.068387.
David, Richard J., and James W. Collins. 1997. “Differing Birth Weight among Infants of U.S.-Born Blacks, African-Born Blacks, and U.S.-Born Whites.” *New England Journal of Medicine* 337 (17): 1209–14. doi:10.1056/NEJM199710233371706.
Davis, Angela. 1972. “Reflections on the Black Woman’s Role in the Community of Slaves.” *The Massachusetts Review* 13 (1/2): 81–100.
Davis, Angela Y. 1983. *Women, Race, and Class*. New York: Random House.
———. 1990. *Women, Culture, and Politis*. New York: Vintage Books.
Davis, Angela Y. 2003. *Are Prisons Obsolete?* Seven Stories Press.
Davis, Karen, Cathy Schoen, and Kristof Stremekis. 2010. “Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update”. 1400. New York, New York: The Commonwealth Fund.

http://www.commonwealthfund.org/
/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf.

Davis, Kathy. 2008. "Intersectionality as Buzzword." *Feminist Theory* 9 (1): 67 –85. doi:10.1177/1464700108086364.

Davis-Floyd, Robbie. 1992. *Birth as an American Rite of Passage*. Comparative Studies of Health Systems and Medical Care. Berkeley: University of California Press.

———. 2011. "Working with Anthropology in Policy and Practice: An Activist's Report." *Anthropology in Action* 18 (2): 3–8. doi:10.3167/aia.2011.180202.

Davis-Floyd, Robbie E., Lesley Barclay, Betty-Anne Daviss, and Jan Tritten. 2009. *Birth Models That Work*. University of California Press.

"Deadly Delivery: The Maternal Health Care Crisis in the USA." 2013. Accessed October 10. http://www.amnestyusa.org/research/reports/deadly-delivery-the-maternal-health-care-crisis-in-the-usa.

DeJoseph, Jeanne F., Jane S. Norbeck, Renee T. Smith, and Suellen Miller. 1996. "The Development of a Social Support Intervention among African American Women." *Qualitative Health Research* 6 (2): 283–97. doi:10.1177/104973239600600208.

Derose, Kathryn Pitkin, José J. Escarce, and Nicole Lurie. 2007. "Immigrants And Health Care: Sources Of Vulnerability." *Health Affairs* 26 (5): 1258–68. doi:10.1377/hlthaff.26.5.1258.

"Determinants of Health - Healthy People 2020." 2013. Accessed November 5. http://healthypeople.gov/2020/about/DOHAbout.aspx.

DiNitto, Diana M. 2011. *Social Welfare: Politics and Public Policy*. Boston: Allyn & Bacon.

Dominguez, Tyan Parker. 2010. "Adverse Birth Outcomes in African American Women: The Social Context of Persistent Reproductive Disadvantage." *Social Work in Public Health* 26 (1): 3–16. doi:10.1080/10911350902986880.

Dominguez, Tyan Parker, Christine Dunkel-Schetter, Laura M. Glynn, Calvin Hobel, and Curt A. Sandman. 2008. "Racial Differences in Birth Outcomes: The Role of General, Pregnancy, and Racism Stress." *Health Psychology* 27 (2): 194–203. doi:10.1037/0278-6133.27.2.194.

Dominguez, Tyan Parker, Emily Ficklin Strong, Nancy Krieger, Matthew W. Gillman, and Janet W. Rich-Edwards. 2009. "Differences in the Self-Reported Racism Experiences of US-Born and Foreign-Born Black Pregnant Women." *Social Science & Medicine* 69 (2): 258–65. doi:10.1016/j.socscimed.2009.03.022.

Dorwie, Florence M., and Dula F. Pacquiao. 2014. "Practices of Traditional Birth Attendants in Sierra Leone and Perceptions by Mothers and Health Professionals Familiar With Their Care." *Journal of Transcultural Nursing* 25 (1): 33–41. doi:10.1177/1043659613503874.

Douthat, Ross. 2012. "The Media's Blinders on Abortion." *The New York Times*, February 4, sec. Opinion / Sunday Review. http://www.nytimes.com/2012/02/05/opinion/sunday/douthat-the-medias-blinders-on-abortion.html.

———. 2013. "Divided by Abortion, United by Feminism." *The New York Times*, January 26, sec. Opinion / Sunday Review. http://www.nytimes.com/2013/01/27/opinion/sunday/douthat-divided-by-abortion-united-by-feminism.html.

Dove, Nah. 1998. "African Womanism: An Afrocentric Theory." *Journal of Black Studies* 28

(5): 515–89.
Dovidio, John F., Louis A. Penner, Terrance L. Albrecht, Wynne E. Norton, Samuel L. Gaertner, and J. Nicole Shelton. 2008. “Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care.” *Social Science & Medicine* 67 (3): 478–86. doi:10.1016/j.socscimed.2008.03.019.
Drake, Sinclaire. 1979. “Anthropology and the Black Experience.” *Anthropology and Education Quarterly* 9 (2): 85–109.
Dyer, Jane, Rosemarie Hunter, and Patricia Murphy. 2011. “Relationship of Social Network Size to Infant Birth Weight in Hispanic and Non-Hispanic Women.” *Journal of Immigrant and Minority Health* 13 (3): 487–93. doi:10.1007/s10903-010-9331-y.
elizabethcheryl. 2014. “Everything IS Bigger in Texas, Including the Maternal Mortality Rate.” *The American Citizen’s Daily*. Accessed March 21. http://tacdnews.com/2013/02/11/everything-is-bigger-in-texas-including-the-maternal-mortality-rate/.
Elsenbruch, S., S. Benson, M. Rücke, M. Rose, J. Dudenhausen, M. K. Pincus-Knackstedt, B. F. Klapp, and P. C. Arck. 2007. “Social Support during Pregnancy: Effects on Maternal Depressive Symptoms, Smoking and Pregnancy Outcome.” *Human Reproduction* 22 (3): 869–77. doi:10.1093/humrep/del432.
Farmer, Paul. 2000. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* University of California Press.
Feldman, Pamela J., Christine Dunkel-Schetter, Curt A. Sandman, and Pathik D. Wadhwa. 2000. “Maternal Social Support Predicts Birth Weight and Fetal Growth in Human Pregnancy.” *Psychosomatic Medicine* 62 (5): 715–25.
Feminist Theory: From Margin to Center. 1984. Boston, MA: South End Press.
Ferré, Cynthia, Arden Handler, Jason Hsia, Wanda Barfield, and James Collins. 2011. “Changing Trends in Low Birth Weight Rates Among Non-Hispanic Black Infants in the United States, 1991–2004.” *Maternal and Child Health Journal* 15 (1): 29–41. doi:10.1007/s10995-010-0570-2.
Fett, Sharla M. 2002. *Working Cures: Healing, Health, and Power on Southern Slave Plantations*. Univ of North Carolina Press.
Finch, Brian Karl, Reanne Frank, and William A. Vega. 2004. “Acculturation and Acculturation Stress: A Social-Epidemiological Approach to Mexican Migrant Farmworkers’ Health1.” *International Migration Review* 38 (1): 236–62. doi:10.1111/j.1747-7379.2004.tb00195.x.
Finch, Brian Karl, Robert A. Hummer, Bohdan Kol, and William A. Vega. 2001. “The Role of Discrimination and Acculturative Stress in the Physical Health of Mexican-Origin Adults.” *Hispanic Journal of Behavioral Sciences* 23 (4): 399–429. doi:10.1177/0739986301234004.
Finch, Brian Karl, and William A. Vega. 2003. “Acculturation Stress, Social Support, and Self-Rated Health Among Latinos in California.” *Journal of Immigrant Health* 5 (3): 109–17. doi:10.1023/A:1023987717921.
Finer, Louise, and Johanna B Fine. 2013. “Abortion Law around the World: Progress and Pushback.” *American Journal of Public Health* 103 (4): 585–89. doi:10.2105/AJPH.2012.301197.
Fishkin, Shelley Fisher. 1995. “Interrogating ‘Whiteness,’ Complicating ‘Blackness’: Remapping American Culture.” *American Quarterly* 47 (3): 428–66.

doi:10.2307/2713296.
Foster, Jennifer, Fidela Chiang, Rebecca C. Hillard, Priscilla Hall, and Annemarie Heath. 2010. “Team Process in Community-Based Participatory Research on Maternity Care in the Dominican Republic J Foster et Al. Team Process in CBPR on Maternity Care in the DR.” *Nursing Inquiry* 17 (4): 309–16. doi:10.1111/j.1440-1800.2010.00514.x.
Foucault, Michel. 1988. *The History of Sexuality.* New York: Vintage Books.
———. 1995. *Discipline & Punish: The Birth of the Prison*. 2nd Edition. Vintage.
Foundation, The Henry J. Kaiser Family. *Infant Mortality Rate (Deaths per 1.000 Live Births), Linked Files, 2006-2008*. http://www.statehealthfacts.org/comparemaptable.jsp?ind=47&cat=2.
Fraser, Gertrude Jacinta. 1998. *African American Midwifery in the South: Dialogues of Birth, Race, and Memory*. Cambridge, Mass: Harvard University Press.
Fried, Marlene Gerber. 1999. *From Abortion to Reproductive Freedom: Transforming a Movement*. South End Press.
G, King. 1995. “Institutional Racism and the Medical/health Complex: A Conceptual Analysis.” *Ethnicity & Disease* 6 (1-2): 30–46.
Gee, Gilbert C., Ryan, David J. and Laflamme, and Jeanie Holt. 2006. “Self-Reported Discrimination and Mental Health Status Among African Descendants, Mexican Americans, and Other Latinos in the New Hampshire REACH 2010 Initiative: The Added Dimension of Immigration.” *American Journal of Public Health* 96 (10): 1821–28.
Gennaro, Susan, Justine Shults, and David J. Garry. 2008. “Stress and Preterm Labor and Birth in Black Women.” *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 37 (5): 538–45. doi:10.1111/j.1552-6909.2008.00278.x.
Gilens, Martin. 1995. “Racial Attitudes and Opposition to Welfare.” *The Journal of Politics* 57 (04): 994–1014. doi:10.2307/2960399.
———. 1996. “‘Race Coding’ and White Opposition to Welfare.” *The American Political Science Review* 90 (3): 593–604. doi:10.2307/2082611.
———. 2000. *Why Americans Hate Welfare: Race, Media, and the Politics of Antipoverty Policy*. Chicago: University of Chicago Press.
Ginsburg, Faye D., and Rayna Rapp. 1995. *Conceiving the New World Order: The Global Politics of Reproduction*. University of California Press.
Giscombé, Cheryl L., and Marci Lobel. 2005. “Explaining Disproportionately High Rates of Adverse Birth Outcomes Among African Americans: The Impact of Stress, Racism, and Related Factors in Pregnancy.” *Psychological Bulletin* 131 (5): 662–83. doi:10.1037/0033-2909.131.5.662.
Gleissner, John Dewar. 2010. *Prison & Slavery - A Surprising Comparison*. Outskirts Press.
Glenn, Evelyn. 1993. *Mothering: Ideology, Experience, and Agency*. Psychology Press.
Glenn, Evelyn nakano. 1985. “Racial Ethnic Women’s Labor: The Intersection of Race, Gender and Class Oppression.” *Review of Radical Political Economics* 17 (3): 86 –108. doi:10.1177/048661348501700306.
Goldenberg, Robert L., Suzanne P. Cliver, Francis X. Mulvihill, Carol A. Hickey, Howard J. Hoffman, Lorraine V. Klerman, and Marilyn J. Johnson. 1996. “Medical, Psychosocial, and Behavioral Risk Factors Do Not Explain the Increased Risk for Low Birth Weight among Black Women.” *American Journal of Obstetrics and Gynecology* 175 (5): 1317–24. doi:10.1016/S0002-9378(96)70048-0.

Goldenberg, Robert L., and Jennifer F. Culhane. 2007. "Low Birth Weight in the United States." *The American Journal of Clinical Nutrition* 85 (2): 584S–590S.
Goldsby, J. 2006. *A Spectacular Secret: Lynching in America Life and Literature.* Chicago: University of Chicago Press.
Gonzalez-Calvo, Judith, Jacqueline Jackson, Centhy Hansford, and Connie Woodman. 1998. "Psychosocial Factors and Birth Outcome: African American Women in Case Management." *Journal of Health Care for the Poor and Underserved* 9 (4): 395–419.
Gordon, Edmund. 2006. "The Austin School Manifesto: An Approach to the Black or African Diaspora." *Cultural Dynamics* 19 (1): 93–97.
Gore, Dayo, Jeanne Theoharis, and Komozi Woodard, ed. 2009. *Want to Start a Revolution: Radical Women in the Black Freedom Struggle*. New York: New York University Press.
Gortmaker, Steven L., and Paul H. Wise. 1997. "The First Injustice: Socioeconomic Disparities, Health Services Technology, and Infant Mortality." *Annual Review of Sociology* 23 (January): 147–70. doi:10.2307/2952547.
Group, Brixton Black Women's. 1984. "Black Women Organizing." *Feminist Review*, no. 17: 84. doi:10.2307/1395018.
Guendelman, Sylvia, Gilberto Chavez, and Roberta Christianson. 1994. "Fetal Deaths in Mexican-American, Black, and White Non-Hispanic Women Seeking Government-Funded Prenatal Care." *Journal of Community Health* 19 (5): 319–30. doi:10.1007/BF02260402.
Guy-Sheftall, Beverly. 1995. *Words of Fire: An Anthology of African-American Feminist Thought*. New York: The New Press.
Hagiwara, Nao, Louis A. Penner, Richard Gonzalez, Susan Eggly, John F. Dovidio, Samuel L. Gaertner, Tessa West, and Terrance L. Albrecht. 2013. "Racial Attitudes, Physician–patient Talk Time Ratio, and Adherence in Racially Discordant Medical Interactions." *Social Science & Medicine* 87 (June): 123–31. doi:10.1016/j.socscimed.2013.03.016.
Hammonds, Evelyn. 2004. "Black Wholes and the Geometry of Black Female Sexuality." In *The Black Studies Reader*, edited by Jacqueline Bobo, Cynthia Hudley, and Claudine Michel. Psychology Press.
Harff, Barbara. 1986. "Genocide as State Terrorism." In , edited by M. Stohl and G.A. Lopez. New York: Greenwood Press.
Harley, Sharon, and Black Women and Work Collective. 2002. *Sister Circle: Black Women and Work*. Rutgers University Press.
Harrell, Jules P., Sadiki Hall, and James Taliaferro. 2003. "Physiological Responses to Racism and Discrimination: An Assessment of the Evidence." *American Journal of Public Health* 93 (2): 243–48. doi:10.2105/AJPH.93.2.243.
Harrison, Faye Venetia, and Association of Black Anthropologists. 1997. *Decolonizing Anthropology: Moving Further toward an Anthropology of Liberation*. Arlington, Va.: Association of Black Anthropologists, American Anthropological Association.
Hartman, Saidiya V. 2007. *Lose Your Mother: A Journey Along the Atlantic Slave Route*. 1st ed. New York: Farrar, Straus and Giroux.
Hartman, Saidya. 1997. *Scenes of Subjection: Terror, Slavery, and Self-Making in Nineteenth Century America.* New York: Oxford University Press.
Hauck, Fern R., Kawai O. Tanabe, and Rachel Y. Moon. 2011. "Racial and Ethnic Disparities in Infant Mortality." *Seminars in Perinatology* 35 (4): 209–20. doi:10.1053/j.semperi.2011.02.018.

Haynes, Rosetta R., and Ebooks Corporation Limited. 2011. *Radical Spiritual Motherhood Autobiography and Empowerment in Nineteenth-Century African American Women*. Baton Rouge: LSU Press. http://www.UTXA.eblib.com/patron/FullRecord.aspx?p=647943.

Hazuda, Helen P., Steven M. Haffner, Michael P. Stern, and Clayton W. Eifler. 1988. "Effects of Acculturation and Socioeconomic Status on Obesity and Diabetes in Mexican Americans the San Antonio Heart Study." *American Journal of Epidemiology* 128 (6): 1289–1301.

Health, National Institutes of. *National Health Dispartities Strategic Plan*. http://www.nimhd.nih.gov/about_ncmhd/index2.asp.

"Here Are The Best And Worst States For Infant Mortality." 2012. *Huffington Post*. September 26. http://www.huffingtonpost.com/2012/09/26/the-best-and-worst-states_n_1891298.html.

Hernandez, Daisy, and Bushra Rehman, ed. 2002. *Colonize This! Young Women of Color on Today's Feminism*. New York: Seal Press.

Hill, Shirley Ann. 2005. *Black Intimacies: A Gender Perspective On Families And Relationships*. Rowman Altamira.

Hoffman, Susie, and Maureen C. Hatch. 1996. "Stress, Social Support and Pregnancy Outcome: A Reassessment Based on Recent Research." *Paediatric and Perinatal Epidemiology* 10 (4): 380–405. doi:10.1111/j.1365-3016.1996.tb00063.x.

Hoggatt, Katherine, Marie Flores, Rosa Solorio, Michelle Wilhelm, and Beate Ritz. 2012. "The 'Latina Epidemiologic Paradox' Revisited: The Role of Birthplace and Acculturation in Predicting Infant Low Birth Weight for Latinas in Los Angeles, CA." *Journal of Immigrant and Minority Health* 14 (5): 875–84. doi:10.1007/s10903-011-9556-4.

Hogue, Carol J. Rowland, and J. Douglas Bremner. 2005. "Stress Model for Research into Preterm Delivery among Black Women." *American Journal of Obstetrics and Gynecology* 192 (5, Supplement): S47–S55. doi:10.1016/j.ajog.2005.01.073.

Hogue, Carol J. Rowland, and Cynthia Vasquez. 2002. "Toward a Strategic Approach for Reducing Disparities in Infant Mortality." *American Journal of Public Health* 92 (4): 552–56. doi:10.2105/AJPH.92.4.552.

Holland, Margaret L., Harriet Kitzman, and Peter Veazie. 2009. "The Effects of Stress on Birth Weight in Low-Income, Unmarried Black Women." *Women's Health Issues* 19 (6): 390–97. doi:10.1016/j.whi.2009.07.005.

Holland, Sharon Partricia. 2000. *Raising the Dead: Readings of Death and Black Subjectivity.*

Homer, Caroline S, Deborah V Matha, Lesley G Jordan, Jo Wills, and Gregory K Davis. 2001. "Community-Based Continuity of Midwifery Care versus Standard Hospital Care: A Cost Analysis." *Australian Health Review* 24 (1): 85–93.

hooks, bell. 1999. *Black Looks: Race and Representation*. South End Press.

Hooks, Bell. 1981. *Ain't I a Woman: Black Women and Feminism*. Boston MA: South End Press.

———. 1989. *Talking Back: Thinking Feminist, Thinking Black*. Cambridge: South End Press.

———. 1990. *Yearning : Race, Gender, and Cultural Politics.* Toronto, Canada: Between the Lines.

———. 2000. *Feminism Is For Everybody: Passionate Politics*. Boston MA: South End Press.

———. 2004. *Choosing the Margin as a Place of Radical Openness In:The Feminist Standpoint Theory Reader:Intellectual and Political Controversies*. Edited by Sandra Harding. New York: Routledge.

———. 2008. *Sisters of the Yam: Black Women and Self-Recovery*. Massachusettes: South End

Press.
Hortense Spillers. 2003. “Interstices: A Small Drama of Words.” In *Black, White, and in Color: Essays on American Literature and Culture*. Chicago: THe University of Chicago Press.
Howard, David L., Susan S. Marshall, Jay S. Kaufman, and David A. Savitz. 2006. “Variations in Low Birth Weight and Preterm Delivery Among Blacks in Relation to Ancestry and Nativity: New York City, 1998–2002.” *Pediatrics* 118 (5): e1399–e1405. doi:10.1542/peds.2006-0665.
Hull, Gloria, Barbara Smith, and P. Bell Scott, ed. 1982. *All the Women Are White, All the Blacks Are Men, But Some of Us Are Brave: Black Women’s Studies*. New York: The Feminist Press.
Hummer, Robert A., Monique Biegler, Peter B. De Turk, Douglas Forbes, W. Parker Frisbie, Ying Hong, and Starling G. Pullum. 1999. “Race/Ethnicity, Nativity, and Infant Mortality in the United States.” *Social Forces* 77 (3): 1083–1117. doi:10.2307/3005972.
HUMPHREY, DAVID C. 2010. “AUSTIN, TX [TRAVIS COUNTY].” June 9. http://www.tshaonline.org/handbook/online/articles/hda03.
Hunt, Linda M, Suzanne Schneider, and Brendon Comer. 2004. “Should ‘acculturation’ Be a Variable in Health Research? A Critical Review of Research on US Hispanics.” *Social Science & Medicine* 59 (5): 973–86. doi:10.1016/j.socscimed.2003.12.009.
Hunt, Matthew O., Pamela Braboy Jackson, Brian Powell, and Lala Carr Steelman. 2000. “Color-Blind: The Treatment of Race and Ethnicity in Social Psychology.” *Social Psychology Quarterly* 63 (4): 352–64. doi:10.2307/2695845.
Huynh, M., and A. Maroko. 2014. “Gentrification and Preterm Birth in New York City, 2008-2010.” *Journal of Urban Health* 91 (1): 211–20. doi:10.1007/s11524-013-9823-x.
I Am Your Sister: Collected and Unpublished Writings by Audre Lorde. 2011. New York and Oxford: Oxford University Press.
III, Frank B. Wilderson. 2008. *Incognegro: A Memoir of Exile and Apartheid*. South End Press.
———. 2010. *Red, White & Black: Cinema and the Structure of U.S. Antagonisms*. Duke University Press Books.
Jackson, Fleda Mask, Mona Taylor Phillips, Carol J. Rowland Hogue, and Tracy Y. Curry-Owens. 2001. “Examining the Burdens of Gendered Racism: Implications for Pregnancy Outcomes Among College-Educated African American Women.” *Maternal and Child Health Journal* 5 (2): 95–107. doi:10.1023/A:1011349115711.
James, Joy. 1996a. “Radicalizing Language and Law: Genocide, Discrimination, and Human Rights.” In *Resisting State Violence: Radicalism, Gender, and Race in U.S. Culture*, 44–59. Minneapolis: University of Minnesota Press.
———. 1996b. *Resisting State Violence: Radicalism, Gender, and Race in U.S. Culture*. Minneapolis: University of Minnesota Press.
———. 2002. *Shadowboxing: Representations of Black Feminist Politics*. New York: Palgrave.
James, Joy, and T Sharpley-Whiting, ed. *The Black Feminist Reader*. Malden, MA: Blackwell Publishers Inc.
James, Sherman A. 1993. “Racial and Ethnic Differences in Infant Mortality and Low Birth Weight A Psychosocial Critique.” *Annals of Epidemiology* 3 (2): 130–36. doi:10.1016/1047-2797(93)90125-N.
———. 2003. “Confronting the Moral Economy of US Racial/Ethnic Health Disparities.” *American Journal of Public Health* 93 (2): 189–189. doi:10.2105/AJPH.93.2.189.
Janack, Marianne. 1997. “Standpoint Epistemology Without the ‘Standpoint’?: An Examination

of Epistemic Privilege and Epistemic Authority." *Hypatia* 12 (2): 125–39. doi:10.1111/j.1527-2001.1997.tb00022.x.
Jarett-Macauley, Delia. 1995. *Reconstructing Womanhood, Deconstructing Feminism: Writings on Black Women*. New York: Routledge.
Jasienska, Grazyna. 2009. "Low Birth Weight of Contemporary African Americans: An Intergenerational Effect of Slavery?" *American Journal of Human Biology* 21 (1): 16–24. doi:10.1002/ajhb.20824.
Johnson, E. Patrick, and Mae G. Henderson. 2005. *Black Queer Studies: A Critical Anthology*. Duke University Press Books.
Jones, Jacqueline. 2009. *Labor of Love, Labor of Sorrow: Black Women , Work, and the Family, from Slavery to the Present*. Basic Books.
Jung, Moon-Kie, Joao Costa Vargas, and Eduardo Bonilla-Silva, ed. 2011. *State of White Supremacy: Racism, Governance, and the United States*. Stanford University Press.
Kaplan, George A., Kristine Siefert, Nalini Ranjit, Trivellore E. Raghunathan, Elizabeth A. Young, Diem Tran, Sandra Danziger, Susan Hudson, John W. Lynch, and Richard Tolman. 2005. "The Health of Poor Women Under Welfare Reform." *American Journal of Public Health* 95 (7): 1252–58. doi:10.2105/AJPH.2004.037804.
Kashef, Ziba. 2003. *Persistent Peril: Why African American Babies Have the Highest Infant Mortality Rate in the Developed World*. http://www.arc.org/racewire/030210z_kashef.html.
Keating, Analouise. 2002. *This Bridge We Call Home: Radical Visions for Transformation*. Edited by Gloria Anzaldua. New York and London: Routledge.
Kelley, Robin D.G. 2003. *Freedom Dreams: The Black Radical Imagination*. New edition. Beacon Press.
Khanani, Intisar, Jon Elam, Rick Hearn, Camille Jones, and Noble Maseru. 2010. "The Impact of Prenatal WIC Participation on Infant Mortality and Racial Disparities." *American Journal of Public Health* 100 (S1): S204–S209. doi:10.2105/AJPH.2009.168922.
Kim, Professor Claire Jean. 2003. *Bitter Fruit: The Politics of Black-Korean Conflict in New York City*. Yale University Press.
King, William D. 2003. "Examining African Americans' Mistrust of the Health Care System: Expanding the Research Question. Commentary on 'Race and Trust in the Health Care System'." *Public Health Reports* 118 (4): 366.
Kingdon, John W, and James A Thurber. 2011. *Agendas, Alternatives, and Public Policies*. Boston: Longman.
Kitzinger, Sheila. 2012. "Rediscovering the Social Model of Childbirth." *Birth: Issues in Perinatal Care* 39 (4): 301–4. doi:10.1111/birt.12005.
Kleinman, Joel C., and Samuel S. Kessel. 1987. "Racial Differences in Low Birth Weight." *New England Journal of Medicine* 317 (12): 749–53. doi:10.1056/NEJM198709173171207.
Koh, Howard K., Sarah C. Oppenheimer, Sarah B. Massin-Short, Karen M. Emmons, Alan C. Geller, and K. Viswanath. 2010. "Translating Research Evidence Into Practice to Reduce Health Disparities: A Social Determinants Approach." *American Journal of Public Health* 100 (S1): S72–S80. doi:10.2105/AJPH.2009.167353.
Kramer, M.s., L. Séguin, J. Lydon, and L. Goulet. 2000. "Socio-Economic Disparities in Pregnancy Outcome: Why Do the Poor Fare so Poorly?" *Paediatric and Perinatal Epidemiology* 14 (3): 194–210. doi:10.1046/j.1365-3016.2000.00266.x.
Kramer, Michael S., Lise Goulet, John Lydon, Louise Séguin, Helen McNamara, Clément Dassa,

Robert W. Platt, et al. 2001. “Socio-Economic Disparities in Preterm Birth: Causal Pathways and Mechanisms.” *Paediatric and Perinatal Epidemiology* 15: 104–23. doi:10.1046/j.1365-3016.2001.00012.x.

Krieger, Nancy, Jarvis T. Chen, Pamela D. Waterman, David H. Rehkopf, and S.V. Subramanian. 2005. “Painting a Truer Picture of US Socioeconomic and Racial/Ethnic Health Inequalities: The Public Health Disparities Geocoding Project.” *American Journal of Public Health* 95 (2): 312–23. doi:10.2105/AJPH.2003.032482.

Kritek, Phyllis Beck, Martha Hargraves, Ernestine H. Cuellar, Florence Dallo, Donna M. Gauthier, Christi A. Holland, Connie Ilkiw, Jane W. Swanson, and Reid Swanson. 2002a. “Eliminating Health Disparities Among Minority Women: A Report on Conference Workshop Process and Outcomes.” *American Journal of Public Health* 92 (4): 580–87. doi:10.2105/AJPH.92.4.580.

———. 2002b. “Eliminating Health Disparities Among Minority Women: A Report on Conference Workshop Process and Outcomes.” *American Journal of Public Health* 92 (4): 580–87. doi:10.2105/AJPH.92.4.580.

Krysan, Maria. 2000. “Prejudice, Politics, and Public Opinion: Understanding the Sources of Racial Policy Attitudes.” *Annual Review of Sociology* 26 (January): 135–68. doi:10.2307/223440.

Kulis, Stephen, Flavio Francisco Marsiglia, and Tanya Nieri. 2009. “Perceived Ethnic Discrimination versus Acculturation Stress: Influences on Substance Use among Latino Youth in the Southwest.” *Journal of Health and Social Behavior* 50 (4): 443–59. doi:10.1177/002214650905000405.

Kumbani, Lily, Gunnar Bjune, Ellen Chirwa, Address Malata, and Jon Øyvind Odland. 2013. “Why Some Women Fail to Give Birth at Health Facilities: A Qualitative Study of Women’s Perceptions of Perinatal Care from Rural Southern Malawi.” *Reproductive Health* 10 (1): 9–20. doi:10.1186/1742-4755-10-9.

Kuper, Leo. 1981. *Genocide: Its Political Use in the Twentieth Century.* New Haven: Yale University Press.

Landale, Nancy S., R. S. Oropesa, and Bridget K. Gorman. 2000. “Migration and Infant Death: Assimilation or Selective Migration among Puerto Ricans?” *American Sociological Review* 65 (6): 888–909. doi:10.2307/2657518.

Landale, Nancy S., R. S. Oropesa, Daniel Llanes, and Bridget K. Gorman. 1999. “Does Americanization Have Adverse Effects on Health?: Stress, Health Habits, and Infant Health Outcomes among Puerto Ricans.” *Social Forces* 78 (2): 613–41. doi:10.1093/sf/78.2.613.

Lantz, Paula M., John W. Lynch, James S. House, James M. Lepkowski, Richard P. Mero, Marc A. Musick, and David R. Williams. 2001. “Socioeconomic Disparities in Health Change in a Longitudinal Study of US Adults: The Role of Health-Risk Behaviors.” *Social Science & Medicine* 53: 29–40.

Lara, Marielena, Cristina Gamboa, M. Iya Kahramanian, Leo S. Morales, and David E. Hayes Bautista. “Acculturation and Latino Health in the United States.” In *Race, Ethnicity, and Health: A Public Health Reader*, edited by Thomas A. LaVeist and Lydia A. Isaac, 215–51. http://books.google.com/books?hl=en&lr=&id=84J0o4sBFTUC&oi=fnd&pg=PA215&dq=prenatal+care+culture+u.s.&ots=TfqW1wjFgQ&sig=fjjf9yzORh9NPj7Vvc7Bjwn2jBk#v=onepage&q=prenatal%20care%20culture%20u.s.&f=false.

LaVeist, Thomas A., and Tamyra Carroll. 2002. "Race of Physician and Satisfaction with Care among African-American Patients." *Journal of the National Medical Association* 94 (11): 937.
LaVeist, Thomas A., and Lydia A. Isaac. 2012. *Race, Ethnicity, and Health: A Public Health Reader*. John Wiley & Sons.
LaVeist, Thomas A., and Amani Nuru-Jeter. 2002. "Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care?" *Journal of Health and Social Behavior* 43 (3): 296–306. doi:10.2307/3090205.
LaVeist, Thomas A., Amani Nuru-Jeter, and Kiesha E. Jones. 2003. "The Association of Doctor-Patient Race Concordance with Health Services Utilization." *Journal of Public Health Policy* 24 (3/4): 312–23. doi:10.2307/3343378.
Lebrun, Lydie A, Leiyu Shi, Jinsheng Zhu, Ravi Sharma, Alek Sripipatana, A Seiji Hayashi, Charles A Daly, and Quyen Ngo-Metzger. 2013. "Racial/ethnic Differences in Clinical Quality Performance among Health Centers." *The Journal of Ambulatory Care Management* 36 (1): 24–34. doi:10.1097/JAC.0b013e3182473523.
Lechtig, Aaron, Jean-Pierre Habicht, Hernán Delgado, Robert E. Klein, Charles Yarbrough, and Reynaldo Martorell. 1975. "Effect of Food Supplementation During Pregnancy on Birthweight." *Pediatrics* 56 (4): 508–20.
Lee, Valerie. 1996. *Granny Midwives and Black Women Writers: Double-Dutched Readings*. New York: Routledge.
Leslie, Jennie C., Shelley L. Galvin, Sandra J. Diehl, Trude A. Bennett, and Paul A. Buescher. 2003. "Infant Mortality, Low Birth Weight, and Prematurity among Hispanic, White, and African American Women in North Carolina." *American Journal of Obstetrics and Gynecology* 188 (5): 1238–40. doi:10.1067/mob.2003.348.
"LESSONS; Linking Infant Mortality To Schooling and Stress." 2013. *New York Times*. Accessed December 12. http://www.nytimes.com/2002/02/06/nyregion/lessons-linking-infant-mortality-to-schooling-and-stress.html.
Lieberman, Robert C. 2007. *Shaping Race Policy the United States in Comparative Perspective*. Princeton, N.J.; Woodstock: Princeton University Press. http://site.ebrary.com/id/10478248.
Lillie-Blanton, M, P E Parsons, H Gayle, and A Dievler. 1996. "Racial Differences in Health: Not Just Black and White, But Shades of Gray." *Annual Review of Public Health* 17 (1): 411–48. doi:10.1146/annurev.pu.17.050196.002211.
Lipsitz, George. 2006. *The Possessive Investment in Whiteness: How White People Profit from Identity Politics, Revised and Expanded Edition*. Rev Exp. Temple University Press.
Lobel, Marci, Christine Dunkel-Schetter, and Susan C. Scrimshaw. 1992. "Prenatal Maternal Stress and Prematurity: A Prospective Study of Socioeconomically Disadvantaged Women." *Health Psychology* 11 (1): 32–40. doi:10.1037/0278-6133.11.1.32.
Lorch, Scott A., Charlan D. Kroelinger, Corinne Ahlberg, and Wanda D. Barfield. 2012. "Factors That Mediate Racial/Ethnic Disparities in US Fetal Death Rates." *American Journal of Public Health* 102 (10): 1902–10. doi:10.2105/AJPH.2012.300852.
Lord, Audre. 1988. "I Am Your Sister." *Women & Therapy* 6 (4): 25–30. doi:10.1300/J015V06N04_03.
Lorde, Audre. 1982. *Zami, a New Spelling of My Name*. Random House Digital, Inc.
Love, Catherine, Richard J. David, Kristin M. Rankin, and James W. Collins. 2010. "Exploring Weathering: Effects of Lifelong Economic Environment and Maternal Age on Low Birth

Weight, Small for Gestational Age, and Preterm Birth in African-American and White Women." *American Journal of Epidemiology* 172 (2): 127–34. doi:10.1093/aje/kwq109.
Lu, M. C., V. Tache, G. R. Alexander, M. Kotelchuck, and N. Halfon. 2003. "Preventing Low Birth Weight: Is Prenatal Care the Answer?" *Journal of Maternal-Fetal and Neonatal Medicine* 13 (6): 362–80.
Lu, Michael C., and Belinda Chen. 2004. "Racial and Ethnic Disparities in Preterm Birth: The Role of Stressful Life Events." *American Journal of Obstetrics and Gynecology* 191 (3): 691–99. doi:10.1016/j.ajog.2004.04.018.
Lu, Michael C., Milton Kotelchuck, Jennifer F. Culhane, Calvin J. Hobel, Lorraine V. Klerman, and John M. Thorp Jr. 2006. "Preconception Care Between Pregnancies: The Content of Internatal Care." *Maternal and Child Health Journal* 10 (1): 107–22. doi:10.1007/s10995-006-0118-7.
MacDorman, Marian F. 2011. "Race and Ethnic Disparities in Fetal Mortality, Preterm Birth, and Infant Mortality in the United States: An Overview." *Seminars in Perinatology* 35 (4): 200–208. doi:10.1053/j.semperi.2011.02.017.
MacDorman, Marian F., and T. J. Mathews. 2010. "Behind International Rankings of Infant Mortality: How the United States Compares with Europe." *International Journal of Health Services* 40 (4): 577–88. doi:10.2190/HS.40.4.a.
MacDorman, Marian F., and T.J. Matthews. 2008. *Data Briefs - Number 9 - October 2008-Recent Trends in Infant Mortality in the United States*. http://www.cdc.gov/nchs/data/databriefs/db09.htm.
MacDorman, MF, and TJ Mathews. 2011. *Understanding Racial and Ethnic Disparities in U.S. Infant Mortality Rates. NCHS Data Brief, No 74.* http://www.cdc.gov/nchs/data/databriefs/db74.htm#source.
Mackey, Marlene C., Carol A. Williams, and Cecilia M. Tiller. 2000. "Stress, Pre-Term Labour and Birth Outcomes." *Journal of Advanced Nursing* 32 (3): 666–74. doi:10.1046/j.1365-2648.2000.01526.x.
Mackinnon, Catherine A. 1989. *Toward a Feminist Theory of the State.* Massachusettes and London: Harvard University Press.
Mainstreaming Midwives: The Politics of Change. 2006. New York: Routledge.
Malat, Jennifer, and Mary Ann Hamilton. 2006. "Preference for Same-Race Health Care Providers and Perceptions of Interpersonal Discrimination in Health Care." *Journal of Health and Social Behavior* 47 (2): 173–87. doi:10.1177/002214650604700206.
Marable, M. 2012. "Beyond Racial Identity Politics: Towards a Liberation Theory for Multicultural Democracy." *Race & Class* 35 (1): 113–30.
Marable, Manning. 1999. *How Capitalism Underdeveloped Black America, Updat: Problems in Race, Political Economy, and Society*. Updated. South End Press.
Massey, Douglas S. 2008. *Categorically Unequal: The American Stratification System*. Russell Sage Foundation Publications.
Massey, Zohar, Sharon Schindler Rising, and Jeannette Ickovics. 2006. "CenteringPregnancy Group Prenatal Care: Promoting Relationship-Centered Care." *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 35 (2): 286–94. doi:10.1111/j.1552-6909.2006.00040.x.
"Maternal, Infant, and Child Health - Healthy People." 2013. Accessed November 5. http://healthypeople.gov/2020/topicsobjectives2020/nationalsnapshot.aspx?topicId=26.
Matthews, T.J., and Marian F. MacDorman. 2012. "Infant Mortality Statistics From the 2008

Period Linked Birth/Infant Death Data Set". Volume 60, Number 5. Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_05.pdf.

———. 2013. "Intant Mortality Statistics from the 2009 Period Linked Birth/Infant Death Data Set". Volume 61, Number 8. Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_08.pdf.

Mayer, Kenneth H., Judith B. Bradford, Harvey J. Makadon, Ron Stall, Hilary Goldhammer, and Stewart Landers. 2008. "Sexual and Gender Minority Health: What We Know and What Needs to Be Done." *American Journal of Public Health* 98 (6): 989–95. doi:10.2105/AJPH.2007.127811.

Mays, Vickie M. 1995. "Black Women, Work, Stress, and Perceived Discrimination: The Focused Support Group Model as an Intervention for Stress Reduction." *Cultural Diversity and Mental Health* 1 (1): 53–65. doi:10.1037/1099-9809.1.1.53.

Mays, Vickie M., Lerita M. Coleman, and James S. Jackson. 1996. "Perceived Race-Based Discrimination, Employment Status, and Job Stress in a National Sample of Black Women: Implications for Health Outcomes." *Journal of Occupational Health Psychology* 1 (3): 319–29. doi:10.1037/1076-8998.1.3.319.

McClain, Carol Shepherd. 1989. *Women as Healers: Cross-Cultural Perspectives*. Rutgers University Press.

McClaurin, Irma, ed. 2001. *Black Feminist Anthropology: Theory, Politics, Praxis, and Poetics*. New Brunswick: Rutgers University Press.

McDonald, Jill, Katherine Suellentrop, Leonard Paulozzi, and Brian Morrow. 2008. "Reproductive Health of the Rapidly Growing Hispanic Population: Data from the Pregnancy Risk Assessment Monitoring System, 2002." *Maternal and Child Health Journal* 12 (3): 342–56. doi:10.1007/s10995-007-0244-x.

McKittrick, Katherine. 2006. *Demonic Grounds: Black Women and the Cartographies of Struggle*. Minneapolis: University of Minnesota Press.

Mendez, Dara D., Vijaya K. Hogan, and Jennifer Culhane. 2011. "Institutional Racism and Pregnancy Health: Using Home Mortgage Disclosure Act Data to Develop an Index for Mortgage Discrimination at the Community Level." *Public Health Reports* 126 (Supplement 3): 102–26.

Merighi, Miriam Aparecida Barbosa, and Dulce Maria Rosa Gualda. 2009. "Mothers'health in Brazil and Recovering the Training of Midwives for Care in the Birth Process." *EL CUIDADO DE LA SALUD MATERNA EN BRASIL Y EL RESCATE DE LA ENSEÑANZA DE OBSTETRAS PARA ASISTENCIA AL PARTO.* 17 (2): 265–70.

Mikell, Gwendolyn. 1997. *African-Feminism: The Politics of Survival in Sub-Saharan Africa*. Philadelphia: Temple University Press.

Miles, Toni P. 2012. *Health Care Reform and Disparities: History, Hype, and Hope*. Santa Barbara, Calif.: Praeger.

Miller, Kristen Gretchen. 2009. "Birth Cohorts and Social Change Examining Relative Mortality Risk by Race."

Miller, Seumas. 2012. "Social Institutions." In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Fall 2012. http://plato.stanford.edu/archives/fall2012/entries/social-institutions/.

Mohanram, Rahdika. 1999. *Black Body: Women, Colonialism, and Space*. Minneapolis: University of Minnesota Press.
Mohanty, Chandra T. 2003. *Feminism Without Borders: Decolonizing Theory, Practicing Solidarity*. Durham: Duke University Press.
Moore, Mignon R. 2011. *Invisible Families: Gay Identities, Relationships, and Motherhood among Black Women*. Berkeley, Calif: University of California Press.
Morgan, Jennifer. 2011. *Laboring Women: Reproduction and Gender in New World Slavery*. University of Pennsylvania Press.
Moten, Fred. 2003. *In The Break: The Aesthetics Of The Black Radical Tradition*. 1st ed. Univ Of Minnesota Press.
Mottl-Santiago, Julie, Catherine Walker, Jean Ewan, Olivera Vragovic, Suzanne Winder, and Phillip Stubblefield. 2008. "A Hospital-Based Doula Program and Childbirth Outcomes in an Urban, Multicultural Setting." *Maternal and Child Health Journal* 12 (3): 372–77. doi:10.1007/s10995-007-0245-9.
Murphy, Frederick G., Terrell M. Bond, Rueben C. Warren, and Sandy D. Maclin Jr. 2008. "Twenty-First Century Globalization: Impact of Gentrification on Community Health." *American Journal of Health Studies* 23 (2): 66–73.
Mustillo, Sarah, Nancy Krieger, Erica P. Gunderson, Stephen Sidney, Heather McCreath, and Caterina I. Kiefe. 2004. "Self-Reported Experiences of Racial Discrimination and Black–White Differences in Preterm and Low-Birthweight Deliveries: The CARDIA Study." *American Journal of Public* 94 (12): 2125–31.
Naples, Nancy. 1997. *Community Activism and Feminist Politics: Organizing Across Race, Class, and Gender*. Psychology Press.
Nash, Jennifer C. 2008. "Re-Thinking Intersectionality." *Feminist Review* 89 (1): 1–15. doi:10.1057/fr.2008.4.
Nelson, Jennifer. 2003. *Women of Color and the Reproductive Rights Movement*. New York: New York University Press.
Neubeck, Kenneth J, and Noel A Cazenave. 2001. *Welfare Racism: Playing the Race Card against America's Poor*. New York: Routledge.
Nnaemeka, Obioma, ed. 1998. *Sisterhood: Feminisms and Power: From Africa to the Diaspora*. Trenton, NJ: AFrica World Press.
Noh, Samuel, and Violet Kaspar. 2003. "Perceived Discrimination and Depression: Moderating Effects of Coping, Acculturation, and Ethnic Support." *American Journal of Public Health* 93 (2). Racial/Ethnic Bias and Health. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.2.232.
Norbeck, Jane S., Jeanne F. DeJoseph, and Renée T. Smith. 1996. "A Randomized Trial of an Empirically-Derived Social Support Intervention to Prevent Low Birthweight among African American Women." *Social Science & Medicine* 43 (6): 947–54. doi:10.1016/0277-9536(96)00003-2.
Norbeck, Jane S., and Virginia Peterson Tilden. 1983. "Life Stress, Social Support, and Emotional Disequilibrium in Complications of Pregnancy: A Prospective, Multivariate Study." *Journal of Health and Social Behavior* 24 (1): 30–46. doi:10.2307/2136301.
Nuru-Jeter, Amani, Tyan Parker Dominguez, Wizdom Powell Hammond, Janxin Leu, Marilyn Skaff, Susan Egerter, Camara P. Jones, and Paula Braveman. 2009. "'It's The Skin You're In': African-American Women Talk About Their Experiences of Racism. An Exploratory Study to Develop Measures of Racism for Birth Outcome Studies." *Maternal*

and Child Health Journal 13 (1): 29–39. doi:10.1007/s10995-008-0357-x.
Oakley, Ann. 1985. "Social Support in Pregnancy: The 'soft' Way to Increase Birthweight?" *Social Science & Medicine* 21 (11): 1259–68. doi:10.1016/0277-9536(85)90275-8.
Oakley, Ann, Lynda Rajan, and Adrian Grant. 1990. "Social Support and Pregnancy Outcome." *BJOG: An International Journal of Obstetrics & Gynaecology* 97 (2): 155–62. doi:10.1111/j.1471-0528.1990.tb01741.x.
Oestergaard, Mikkel Zahle, Mie Inoue, Sachiyo Yoshida, Wahyu Retno Mahanani, Fiona M. Gore, Simon Cousens, Joy E. Lawn, Colin Douglas Mathers, on behalf of the United Nations Inter-agency Group for Child Mortality Estimation, and the Child Health Epidemiology Reference Group. 2011. "Neonatal Mortality Levels for 193 Countries in 2009 with Trends since 1990: A Systematic Analysis of Progress, Projections, and Priorities." *PLoS Med* 8 (8): e1001080. doi:10.1371/journal.pmed.1001080.
Okpomeshine, Christine. 2011. "Traditional Birthing Practices in Igbo Land, Nigeria." *International Journal of Interdisciplinary Social Sciences* 6 (2): 193–97.
Omi, Michael. 1994. *Racial Formation in the United States: From the 1960s Tothe 1990s*. 2nd ed. New York: Routledge.
Omise'eke, Natasha Tinsley. 2008. "Black Atlantic/Queer Atlantic."
"Opening Reception for Black Citizens Task Force Collection." 2013. *Austin Public Library*. Accessed September 18. http://library.austintexas.gov/press-release/opening-reception-black-citizens-task-force-collection.
Organista, Pamela Balls, Kurt C. Organista, and Karen Kurasaki. 2003. "The Relationship between Acculturation and Ethnic Minority Health." In *Acculturation: Advances in Theory, Measurement, and Applied Research*, edited by K. M. Chun, P. Balls, and G. Mar, 139–61. Washington, DC, US: American Psychological Association.
Paneth, N S. 1995. "The Problem of Low Birth Weight." *The Future of Children / Center for the Future of Children, the David and Lucile Packard Foundation* 5 (1): 19–34.
Papadakis, Elim. 1992. "Public Opinion, Public Policy and the Welfare State." *Political Studies* 40 (1): 21–37. doi:10.1111/j.1467-9248.1992.tb01758.x.
Pappas, Gregory, Susan Queen, Wilbur Hadden, and Gail Fisher. 1993. "The Increasing Disparity in Mortality Between Socioeconomic Groups In the United States, 1960 and 1986." *The New England Journal of Medicine* 329 (2): 103–9.
Parker, Jennifer D., Kenneth C. Schoendorf, and John L. Kiely. 1994. "Associations between Measures of Socioeconomic Status and Low Birth Weight, Small for Gestational Age, and Premature Delivery in the United States." *Annals of Epidemiology* 4 (4): 271–78. doi:10.1016/1047-2797(94)90082-5.
Parker-Pope, Tara. 2009. *How Cultural Background Affects Health*. http://well.blogs.nytimes.com/2009/07/16/how-cultural-background-impacts-health/.
Pascoe, Elizabeth, and Laura Smart Richman. 2009. "Perceived Discrimination and Health: A Meta-Analytic Review." *Psychological Bulletin* 135 (4): 531–54. doi:10.1037/a0016059.
Patternson, Orlando. 1982. *Slavery and Social Death: A Comparative Study.* Cambridge: Harvard University Press.
Patterson, William. 1970. "We Charge Genocide: The Historic Petition to the United Nations for Relief from a Crime of the United States Government against the Negro People." International Publishers.
Pearl, Michelle, Paula Braveman, and Barbara Abrams. 2001. "The Relationship of Neighborhood Socioeconomic Characteristics to Birthweight Among 5 Ethnic Groups in

California." *American Journal of Public Health* 91 (11): 1808–14.
Penner, Louis A., John F. Dovidio, Tessa V. West, Samuel L. Gaertner, Terrance L. Albrecht, Rhonda K. Dailey, and Tsveti Markova. 2010. "Aversive Racism and Medical Interactions with Black Patients: A Field Study." *Journal of Experimental Social Psychology* 46 (2): 436–40. doi:10.1016/j.jesp.2009.11.004.
"Perceptions of Racial Discrimination and the Risk of Preterm... : Epidemiology." 2013. Accessed July 29. http://journals.lww.com/epidem/Fulltext/2002/11000/Perceptions_of_Racial_Discrimination_and_the_Risk.8.aspx.
Petterson, Karen Odberg. 2007. "Major Challenges of Midwifery in Africa." *British Journal of Midwifery* 15 (8): 470–74.
Ph.D, Tyan Parker Dominguez, Christine Dunkel Schetter Ph.D, Roberta Mancuso Ph.D, Christine M. Rini Ph.D, and Calvin Hobel M.d. 2005. "Stress in African American Pregnancies: Testing the Roles of Various Stress Concepts in Prediction of Birth Outcomes." *Annals of Behavioral Medicine* 29 (1): 12–21. doi:10.1207/s15324796abm2901_3.
Piven, Frances Fox, and Richard A Cloward. 1979. *Poor People's Movements: Why They Succeed, How They Fail*. New York: Vintage books.
———. 1993. *Regulating the Poor: The Functions of Public Welfare*. New York: Vintage Books.
Preston-Whyte, Eleanor, and Maria Zondi. 1989. "To Control Their Own Reproduction: The Agenda of Black Teenage Mothers in Durban." *Agenda* 4 (4): 47–68. doi:10.1080/10130950.1989.9675048.
Price, Melanye T. 2009. *Dreaming Blackness: Black Nationalism and African American Public Opinion*. New York: New York University Press.
Pulido, Laura. 2006. *Black, Brown, Yellow, and Left: Radical Activism in Los Angeles*. University of California Press.
Quadagno, Jill S. 1996. *The Color of Welfare How Racism Undermined the War on Poverty*. New York: Oxford University Press. http://public.eblib.com/EBLPublic/PublicView.do?ptiID=716691.
"Quality of Life for Blacks in Austin: Going Beyond Midtown." 2013. Accessed September 18. http://www.austinchronicle.com/news/2005-04-01/264998/.
Rai, D. K., and R. K. Thiara. 1997. "Re-Defining Spaces The Needs of Black Women and Children in Refuge Support Services and Black Workers in Women's Aid."
Ramshaw, Emily. 2010. "Texas Considers Medicaid Withdrawal." *The New York Times*, November 6, sec. U.S. / Politics. http://www.nytimes.com/2010/11/07/us/politics/07ttmedicaid.html.
"Read About Two Bryan-College Station Women Denied Health Care Because Of Extreme New Texas Law." 2013. Accessed September 18. http://www.burntorangereport.com/diary/14078/read-about-two-texas-women-denied-health-care-because-of-the-new-antiabortion-law.
Reconceiving Midwifery. 2004. Montréal: McGill-Queen's University Press.
Reid, Jacquelyn. 2007. "Centering Pregnancy®: A Model for Group Prenatal Care." *Nursing for Women's Health* 11 (4): 382–88. doi:10.1111/j.1751-486X.2007.00194.x.
"Religious Leaders Urge Funding for Family Planning, Birth Control." 2013. Accessed October 1. http://www.statesman.com/news/news/state-regional-govt-politics/religious-leaders-

urge-funding-for-family-planning/nWgrj/.
"Rent Growth Levels Regain Momentum (for Now) in Austin [Video]." 2014. Accessed April 1. http://www.propertymanagementinsider.com/rent-growth-levels-regain-momentum-in-austin-video.html.
Rich-Edwards, Janet, Nancy Krieger, Joseph Majzoub, Sally Zierler, Ellice Lieberman, and Matthew Gillman. 2001. "Maternal Experiences of Racism and Violence as Predictors of Preterm Birth: Rationale and Study Design." *Paediatric and Perinatal Epidemiology* 15: 124–35. doi:10.1046/j.1365-3016.2001.00013.x.
Rich-Edwards, Janet W., and Tarayn A. Grizzard. 2005. "Psychosocial Stress and Neuroendocrine Mechanisms in Preterm Delivery." *American Journal of Obstetrics and Gynecology* 192 (5, Supplement): S30–S35. doi:10.1016/j.ajog.2005.01.072.
Ridley-Kerr, Abigail, Rachel Wilf | May 2, and 2012. 2013. "The Top 10 Benefits Women of Color Are Seeing Under Obamacare." *Name*. Accessed October 3. http://www.americanprogress.org/issues/race/news/2012/05/02/11570/the-top-10-benefits-women-of-color-are-seeing-under-obamacare/.
Rising, Sharon Schindler. 1998. "CENTERING PREGNANCY: An Interdisciplinary Model of Empowerment." *Journal of Nurse-Midwifery* 43 (1): 46–54. doi:10.1016/S0091-2182(97)00117-1.
Rising, Sharon Schindler, Holly Powell Kennedy, and Carrie S. Klima. 2004. "Redesigning Prenatal Care Through CenteringPregnancy." *The Journal of Midwifery & Women's Health* 49 (5): 398–404. doi:10.1111/j.1542-2011.2004.tb04433.x.
Roberts, Dorothy. 1999. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Vintage Books.
———. 2003. *Shattered Bonds: The Color of Child Welfare*. New York: Basic Cavitas Books.
Roberts, Dorothy E. 1993a. "Racism and Patriarchy in the Meaning of Motherhood." *American University Journal of Gender and the Law* 1: 1.
———. 1993b. "Value of Black Mothers' Work, The." *Connecticut Law Review* 26: 871.
———. 1995. "Race and the New Reproduction." *Hastings Law Journal* 47: 935.
———. 1996. "Unshackling Black Motherhood." *Michigan Law Review* 95: 938.
Robinson, Cedric J. 2000. *Black Marxism: The Making of the Black Radical Tradition*. The University of North Carolina Press.
Robinson, Sharon A. 1984. "A Historical Development of Midwifery in the Black Community: 1600–1940." *Journal of Nurse-Midwifery* 29 (4): 247–50. doi:10.1016/0091-2182(84)90128-9.
Romero, Camila X, Jodi K Duke, Dana Dabelea, Tomas E Romero, and Lorraine G Ogden. 2012. "Does the Epidemiologic Paradox Hold in the Presence of Risk Factors for Low Birth Weight Infants among Mexican-Born Women in Colorado?" *Journal of Health Care for the Poor and Underserved* 23 (2): 604–14. doi:10.1353/hpu.2012.0065.
Rooks, Judith P. 1999. "The Midwifery Model of Care*." *Journal of Nurse-Midwifery* 44 (4): 370–74. doi:10.1016/S0091-2182(99)00060-9.
Rossi, Alice S, and American Sociological Association. 1985. *Gender and the Life Course*. New York: Aldine Pub. Co.
Rothenberg, Paula S. 2007. *White Privilege*. Macmillan.
Rousseau, Nicole. 2009. *Black Woman's Burden: Commodifying Black Reproduction*. 1st ed. New York: Palgrave Macmillan.
Rowley, Diane L., and Vijaya Hogan. 2012. "Disparities in Infant Mortality and Effective,

Equitable Care: Are Infants Suffering from Benign Neglect?" *Annual Review of Public Health* 33 (1): 75–87. doi:10.1146/annurev-publhealth-031811-124542.
Rumbaut, Rubén, and John Weeks. 1996. "Unraveling a Public Health Enigma: Why Do Immigrants Experience Superior Perinatal Health Outcomes?" http://papers.ssrn.com/abstract=1886684.
Sable, Marjorie R., and Deborah Schild Wilkinson. 2000. "Impact of Perceived Stress, Major Life Events and Pregnancy Attitudes on Low Birth Weight." *Family Planning Perspectives* 32 (6): 288–94. doi:10.2307/2648197.
Saenz, Rogelio, and Trinidad Morales. 2012. "The Latino Paradox." In *The Demography of the Hispanic Population: Selected Essays*, edited by Richard R. Verdugo. The Hispanic Population in the United States. Information Age Publishing Inc.
Sauls, Donna J. 2002. "Effects of Labor Support on Mothers, Babies, and Birth Outcomes." *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 31 (6): 733–41. doi:10.1177/0884217502239209.
Sawyer, Linda M. 1999. "Engaged Mothering: The Transition to Motherhood for a Group of African American Women." *Journal of Transcultural Nursing* 10 (1): 14–21. doi:10.1177/104365969901000110.
Schempf, Ashley H., Amy M. Branum, Susan L. Lukacs, and Kenneth C. Schoendorf. 2007. "The Contribution of Preterm Birth to the Blackâ€"White Infant Mortality Gap, 1990 and 2000." *American Journal of Public Health* 97 (7): 1255–60. doi:10.2105/AJPH.2006.093708.
Schram, Sanford. 2002. *Praxis for the Poor: Piven and Cloward and the Future of Social Science in Social Welfare*. New York: New York University Press.
Schwartz, Marie Jenkins. 2010. *Birthing a Slave: Motherhood and Medicine in the Antebellum South*. 1st ed. Harvard University Press.
Sexton, Jared. 2008. *Amalgamation Schemes: Antiblackness and the Critique of Multiracialism*. U of Minnesota Press.
———. 2010. "People-of-Color-Blindness Notes on the Afterlife of Slavery." *Social Text* 28 (2 103): 31–56. doi:10.1215/01642472-2009-066.
Shapiro, Robert Y., and John T. Young. 1989. "Public Opinion and the Welfare State: The United States in Comparative Perspective." *Political Science Quarterly* 104 (1): 59–89. doi:10.2307/2150988.
Shiono, P H, V A Rauh, M Park, S A Lederman, and D Zuskar. 1997. "Ethnic Differences in Birthweight: The Role of Lifestyle and Other Factors." *American Journal of Public Health* 87 (5): 787–93. doi:10.2105/AJPH.87.5.787.
Singh, G K, and S M Yu. 1995. "Infant Mortality in the United States: Trends, Differentials, and Projections, 1950 through 2010." *American Journal of Public Health* 85 (7): 957–64. doi:10.2105/AJPH.85.7.957.
———. 1996. "Adverse Pregnancy Outcomes: Differences between US- and Foreign-Born Women in Major US Racial and Ethnic Groups." *American Journal of Public Health* 86 (6): 837–43. doi:10.2105/AJPH.86.6.837.
Singh, Gopal K., and Michael D. Kogan. 2007. "Persistent Socioeconomic Disparities in Infant, Neonatal, and Postneonatal Mortality Rates in the United States, 1969–2001." *Pediatrics* 119 (4): e928–e939. doi:10.1542/peds.2005-2181.
Sister/Outsider: Essays and Speeches by Audre Lourde. 1984. Freedom, CA: The Crossing Press.
Smith, Barbara. 1983. *Home Girls: A Black Feminist Anthology*. New York: Kitchen Table

Press.
Smith, Valerie. 1998. *Not Just Race, Not Just Gender: Black Feminist Readings*. New York: Routledge.
Spillers, Hortense. 1987. "Mama's Baby, Papa's Maybe: An American Grammar Book." *Culture and Countermemory: The American Connection* 17 (2): 65–81.
Staff, A. B. S. 2013. "Leaders Look For Answers to Austin's Shrinking Black Population." *Atlanta Black Star*. Accessed September 18. http://atlantablackstar.com/2013/05/07/leaders-look-for-answers-to-austins-shrinking-black-population/.
Stall, Susan, and Randy Stoecker. 1998. "COMMUNITY ORGANIZING OR ORGANIZING COMMUNITY? Gender and the Crafts of Empowerment." *Gender & Society* 12 (6): 729–56. doi:10.1177/089124398012006008.
Sterling, Dorothy, ed. 1997. *We Are Your Sisters: Black Women in the Nineteenth Century*. New York and London: W.W. Norton and Company.
Stuart Hall: Critical Dialogues in Cultural Studies. 1996. Comedia. London ; New York: Routledge.
Sudbury, Julia. 1998. *"Other Kinds of Dreams": Black Women's Organizations and the Politics of Transformation.* New York: Routledge.
———. 2001. "(Re)constructing Multiracial Blackness: Women's Activism, Difference and Collective Identity in Britain." *Ethnic and Racial Studies* 24: 29–49.
Sundquist, Jan, and Marilyn Winkleby. 2000. "Country of Birth, Acculturation Status and Abdominal Obesity in a National Sample of Mexican–American Women and Men." *International Journal of Epidemiology* 29 (3): 470–77. doi:10.1093/ije/29.3.470.
Tate, Katherine. 2010. *What's Going on? Political Incorporation and the Transformation of Black Public Opinion*. Washington, D.C.: Georgetown University Press.
Tavernise, Sabrina, and Robert Gebeloff. 2013. "Millions of Poor Are Left Uncovered by Health Law." *The New York Times*, October 2, sec. Health. http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html.
"Texas Relays." 2013. *Wikipedia, the Free Encyclopedia*. http://en.wikipedia.org/w/index.php?title=Texas_Relays&oldid=553771111.
Thackrah, Rosalie D, and Sandra C Thompson. 2013. "Confronting Uncomfortable Truths: Receptivity and Resistance to Aboriginal Content in Midwifery Education." *Contemporary Nurse: A Journal for the Australian Nursing Profession* 46 (1): 113–22. doi:10.5172/conu.2013.46.1.113.
"The Color of Affordable Care." 2013. *Economix Blog*. Accessed October 9. http://economix.blogs.nytimes.com/2013/10/07/the-color-of-affordable-care/.
"'The Most Dangerous Place for an African-American Is in the Womb': Black Politician Criticises Anti-Abortion Billboard." 2014. *Mail Online*. Accessed March 8. http://www.dailymail.co.uk/news/article-1360125/The-dangerous-place-African-American-womb-Black-politician-criticises-anti-abortion-billboard.html.
Thomas, Lynn M. 2003. *Politics of the Womb: Women, Reproduction, and the State in Kenya*. University of California Press.
"Top Ten Demographic Trends in Austin, Texas." 2014. Accessed March 10. http://www.austintexas.gov/page/top-ten-demographic-trends-austin-texas.
Torres, Lucas, and David Rollock. 2007. "Acculturation and Depression among Hispanics: The

Moderating Effect of Intercultural Competence." *Cultural Diversity and Ethnic Minority Psychology* 13 (1): 10–17. doi:10.1037/1099-9809.13.1.10.
Turner, R. Jay, Carl F. Grindstaff, and Norman Phillips. 1990. "Social Support and Outcome in Teenage Pregnancy." *Journal of Health and Social Behavior* 31 (1): 43–57. doi:10.2307/2137044.
Umberson, Debra, and Jennifer Karas Montez. 2010. "Social Relationships and Health A Flashpoint for Health Policy." *Journal of Health and Social Behavior* 51 (1 suppl): S54–S66. doi:10.1177/0022146510383501.
Unger, Jennifer B., and Seth J. Schwartz. 2012. "Conceptual Considerations in Studies of Cultural Influences on Health Behaviors." *Preventive Medicine* 55 (5): 353–55. doi:10.1016/j.ypmed.2012.09.024.
Vargas, Joao. 2005. "Genocide in the African Diaspora: United States, Brazil, and the Need for a Holistic Research and Political Method." *Cultural Dynamics* 17 (3): 267–90.
Vargas, Joao H. Costa. 2006. *Catching Hell In The City Of Angels: Life And Meanings Of Blackness In South Central Los Angeles*. 1st ed. Univ Of Minnesota Press.
———. 2010. *Never Meant to Survive: Genocide and Utopias in Black Diaspora Communities*. 1st ed. Rowman & Littlefield Publishers.
Vega, William A., and Hortensia Amaro. 1994. "Latino Outlook: Good Health, Uncertain Prognosis." *Annual Review of Public Health* 15 (1): 39–67. doi:10.1146/annurev.pu.15.050194.000351.
Villar, Maria Elena, Maritza Concha, and Rodrigo Zamith. 2012. "Health Beliefs and Attitudes of Latino Immigrants: Rethinking Acculturation as a Constant." *Journal of Immigrant and Minority Health* 14 (5): 885–89. doi:10.1007/s10903-012-9579-5.
Viruell-Fuentes, Edna A. 2007. "Beyond Acculturation: Immigration, Discrimination, and Health Research among Mexicans in the United States." *Social Science & Medicine (1982)* 65 (7): 1524–35. doi:10.1016/j.socscimed.2007.05.010.
Viruell-Fuentes, Edna A, Patricia Y Miranda, and Sawsan Abdulrahim. 2012. "More than Culture: Structural Racism, Intersectionality Theory, and Immigrant Health." *Social Science & Medicine (1982)* 75 (12): 2099–2106. doi:10.1016/j.socscimed.2011.12.037.
Volscho, Thomas W. 2011. "Racism and Disparities in Women's Use of the Depo-Provera Injection in the Contemporary USA." *Critical Sociology* 37 (5): 673–88. doi:10.1177/0896920510380948.
Vyagusa, Dismas B., Godfrey M. Mubyazi, and Melchiory Masatu. 2013. "Involving Traditional Birth Attendants in Emergency Obstetric Care in Tanzania: Policy Implications of a Study of Their Knowledge and Practices in Kigoma Rural District." *International Journal for Equity in Health* 12 (1): 83–108. doi:10.1186/1475-9276-12-83.
Wade-Gayles, Gloria. 2002. *My Soul Is a Witness: African-American Women's Spirituality*. Beacon Press.
Waldenström, Ulla, and Deborah Turnbull. 1998. "A Systematic Review Comparing Continuity of Midwifery Care with Standard Maternity Services." *BJOG: An International Journal of Obstetrics & Gynaecology* 105 (11): 1160–70. doi:10.1111/j.1471-0528.1998.tb09969.x.
Waldstein, Anna. 2010. "Popular Medicine and Self-Care in a Mexican Migrant Community: Toward an Explanation of an Epidemiological Paradox." *Medical Anthropology* 29 (1): 71–107. doi:10.1080/01459740903517386.
Walker, Alice. 1985. *Chain Chain Change: For Black Women Dealing with Physical and*

Emotional Abuse. Seattle: Seal Press.
Washington, Teresa N. 2010. “Nickels in the Nation Sack: Continuity in Africana Spiritual Technologies.” *Journal of Pan African Studies* 3 (5): 5–28.
Webster, Joan, John W.J. Linnane, Linda M Dibley, Janis K Hinson, Suzanne E Starrenburg, and Janice A Roberts. 2000. “Measuring Social Support in Pregnancy: Can It Be Simple and Meaningful?” *Birth* 27 (2): 97–101. doi:10.1046/j.1523-536x.2000.00097.x.
Wedin, Kathe, Johan Molin, and Elizabeth L. Crang Svalenius. 2010. “Group Antenatal Care: New Pedagogic Method for Antenatal Care—a Pilot Study.” *Midwifery* 26 (4): 389–93. doi:10.1016/j.midw.2008.10.010.
Weigers, Margaret E., and Margaret S. Sherraden. 2001. “A Critical Examination of Acculturation: The Impact of Health Behaviors, Social Support and Economic Resources on Birth Weight among Women of Mexican Descent1.” *International Migration Review* 35 (3): 804–39. doi:10.1111/j.1747-7379.2001.tb00042.x.
Weisbord, Robert G. 1975. *Genocide?: Birth Control and the Black American*. Greenwood Press.
Wekker, Gloria. 2006. *The Politics of Passion: Women’s Sexual Culture in the Afro-Surinamese Diaspora*. Columbia University Press.
Wertz, Richard W. 1977. *Lying-in: A History of Childbirth in America*. New York: Free Press.
“What Nobody Says About Austin.” 2013. *Texas Monthly*. Accessed October 29. http://www.texasmonthly.com/story/what-nobody-says-about-austin.
White, Deborah Gray. 1999. *Too Heavy a Load: Black Women in Defense of Themselves, 1894-1994*. W. W. Norton & Company.
White, E. Frances. 2001. *Dark Continent of Our Bodies: Black Feminism and the Politics of Respectability*. Philadelphia: Temple University Press.
“Whites’ Racial Policy Attitudes: The Role of White Racism. - A119.pdf.” 2013. Accessed September 18. http://www.issr.ucla.edu/sears/pubs/A119.pdf.
Wilkie, Laurie A. 1995. “MAGIC AND EMPOWERMENT ON THE PLANTATION: AN ARCHAEOLOGICAL CONSIDERATION OF AFRICAN-AMERICAN WORLD VIEW.” *Southeastern Archaeology* 14 (2): 136–48.
———. 2003. *Archaeology of Mothering: An African-American Midwife’s Tale*. New York: Routledge.
———. 2013. “Expelling Frogs and Binding Babies: Conception, Gestation and Birth in Nineteenth-Century African-American Midwifery.” *World Archaeology* 45 (2): 272–84. doi:10.1080/00438243.2013.799043.
“Will Austin Welcome the Texas Relays This Year? - 2012-Mar-27.” 2013. *CultureMap Austin*. Accessed September 18. http://austin.culturemap.com/news/scene/03-27-12-14-19-will-austin-welcome-the-texas-relays-this-year/.
Williams, Carmen Braun, Marsha Wiggins Frame, and Evelyn Green. 1999. “Counseling Groups for African American Women: A Focus on Spirituality.” *The Journal for Specialists in Group Work* 24 (3): 260–73. doi:10.1080/01933929908411435.
Williams, David R. 2002. “Racial/Ethnic Variations in Women’s Health: The Social Embeddedness of Health.” *American Journal of Public Health* 92 (4): 588–97.
Wilson, Dawn K. 2012. “Commentary: Important Advances in Understanding the Relationship Between Acculturation and Risk for Obesity.” *Journal of Pediatric Psychology*, June. doi:10.1093/jpepsy/jss074. http://jpepsy.oxfordjournals.org/content/early/2012/06/18/jpepsy.jss074.

Wilson, William Julius. 2001. *The Bridge over the Racial Divide: Rising Inequality and Coalition Politics*. University of California Press.

Winter, Nicholas J. G. 2008. *Dangerous Frames How Ideas about Race and Gender Shape Public Opinion*. Chicago: University of Chicago Press. http://public.eblib.com/EBLPublic/PublicView.do?ptiID=432315.

Woolf, Steven H., Robert E. Johnson, George E. Fryer, George Rust, and David Satcher. 2008. "The Health Impact of Resolving Racial Disparities: An Analysis of US Mortality Data." *American Journal of Public Health* 98 (Supplement_1): S26–S28. doi:10.2105/AJPH.98.Supplement_1.S26.

Yoon, Enju, Kimberly Langrehr, and Za Ong Lee. 2011. "Content Analysis of Acculturation Research in Counseling and Counseling Psychology: A 22-Year Review." *Journal of Counseling Psychology* 58 (1): 83–96. doi:10.1037/a0021128.

Zane, Nolan, and Winnie Mak. 2003. "Major Approaches to the Measurement of Acculturation among Ethnic Minority Populations: A Content Analysis and an Alternative Empirical Strategy." In *Acculturation: Advances in Theory, Measurement, and Applied Research.*, edited by Kevin M. Chun, Pamela Balls Organista, and Gerardo Marín, 39–60. Washington, DC US: American Psychological Association.

Zhang, Shun, Kathryn Cardarelli, Ruth Shim, Jiali Ye, Karla L Booker, and George Rust. 2012. "Racial Disparities in Economic and Clinical Outcomes of Pregnancy Among Medicaid Recipients." *Maternal and Child Health Journal*, October. doi:10.1007/s10995-012-1162-0.