Racial Discrimination of Cisgender African American Women in Sexual and Reproductive Health

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Loretta Ross, also referred to as the founding mother of reproductive justice, once said "Our ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice in the United States" (Taylor, 2021). Injustices in the United States have perpetuated inadequate medical care of African American women for many years. From past to present, cisgender African American women have experienced injustice in sexual and reproductive healthcare. The pattern of mistreatment must be acknowledged to create health system wide changes to ensure health equity. Involuntary experimentation of enslaved women, forced sterilization, discriminatory related stress induced disorders, social determinants of health, and provider unconscious bias must all be recognized in order for change to be implemented in systems and relationships through various techniques. These techniques include healthcare provider education, the shared decision-making model, and increasing the proportion of African American providers. As healthcare providers acknowledge their position in these arguably uncomfortable topics, change will be catalyzed to form a more inclusive healthcare system. Thus, historical and current forms of racial discrimination against cisgender African American women in healthcare must be comprehended by providers for change to be implemented in healthcare systems and relationships.

Historical Forms of Medical Racial Discrimination Against African Americans

Involuntary Experimentation on Enslaved Women

One of the foundations of medical racism lies in the involuntary experimentation of enslaved African American women. For 346 years during slavery and the Jim Crow law periods, enslaved African American women had very little control over their own bodies. They endured

genital mutilation, rape, painful gynecological surgeries, and sterilization (Prather et al., 2018). In addition, enslaved African American women were forced to bear children for slave owners (Taylor, 2021). They did not have a choice in this matter. If women could not conceive children for their slave owners, they were physically abused (Taylor, 2021). Additionally, if a woman was not conceiving when the owner wanted them to, they were force bred or threatened to be sold off (Taylor, 2021). This instilled a deep fear in many African American women. During this time, in some states, laws against rape only protected Caucasian women (Taylor, 2021). Thus, Caucasian men placed disproportionate expectations of intercourse and childbearing on African American women versus Caucasian women.

Not only did this abuse affect enslaved women, but their children were also affected. Their children ultimately became the property of the owners as soon as they were born (Taylor, 2021). Profits of the slave owners were increased by five to six percent from this action (Taylor, 2021). In the 1850s, the infant mortality rate for children born to African American women was twice that of Caucasian women (Taylor, 2021). Less than two thirds of children born to African American women lived to 10 years old (Taylor, 2021). These children were born at a large disadvantage compared to their free, White counterparts.

One historical figure recognized in gynecological studies, who performed involuntary experimentations on African American women for many years was Nathan Bozeman. Bozeman not only conducted invasive surgeries on enslaved women, but also commanded other slaves to restrain the women undergoing surgery. This experimentation was very painful for the enslaved women, especially because most of the techniques used were not proven methods. Their genitalia and reproductive organs were mutilated through cuts and stitches by Bozeman, who did not have any empathy for their pain. Although anesthesia was developed in the 1800s (Robinson &

Toledo, 2012), it was not used during the experimentation (Taylor, 2021). Instead, morphine was overused to decrease the women's screams during the surgeries. Morphine is an opioid, which when overused can cause intoxication. Effects of intoxication include depressed respiratory function, muscle and skin damage, and in extreme cases can lead to a coma (Townsend & Morgan, 2021). When these symptoms of intoxication are not tended to, death can occur. This shows that Bozeman placed enslaved women at risk of losing their life, to conduct his experimentation. Although this abuse led to advancements in gynecological studies, they were only utilized to heal White women (Taylor, 2021). African American women were mutilated against their will, and not one treatment discovered was used to heal them. One specific experimentation Nathan Bozeman conducted was on an eighteen-year-old woman named Kitty who suffered from vesicovaginal fistula, a condition that is typically developed after prolonged labor (Taylor, 2021). After Bozeman experimented on her, she was bedridden for two months, could no longer bear children, and could not return to work. This experimentation was so invasive and misconducted that the rest of her life was spent confined to a stool with a hole in it to collect uncontrollable urine leaks (Taylor, 2021). She was used by Bozeman to learn more about potential treatments for vesicovaginal fistulas, and in return her condition was only worsened. No one tended to her condition after the experimentation.

Forced Sterilization of Black Women

In the 1970s and 1980s, some Black women were sterilized either unknowingly or without their consent (Nuriddin et al., 2020). During this time in the United States, federal funding supported this sterilization process (Prather et al., 2018). Teamwork was seen between physicians, social workers, and members of state eugenics boards to sterilize Black women of low socioeconomic class with the intention of reducing the total number of people eligible for

welfare (Taylor, 2021). Many Black women were even threatened to be denied medical care or public financial assistance if they chose to not be sterilized (Prather et al., 2018). Forced sterilization was not confined to any specific geographic region. Unauthorized hysterectomies were also documented in Boston City Hospital and New York Municipal Hospital (Taylor, 2021). Although these hysterectomies were unauthorized, there were no policies requiring informed consent during this time (Taylor, 2021). The act of reducing the number of children born to a certain race is ethically wrong, and detrimental to the mental health of African American women. This is one reason why some African American women became mistrustful of the United States government.

During the Roe versus Wade trial, a young Black woman who was pregnant was partaking in civil rights activism in North Carolina. She was arrested, convicted, and threatened to have a forced abortion as her punishment (Taylor, 2021). The National Counsel of Negro Women responded to this situation in conjunction with Roe versus Wade with the following: "'Choice' ignores the fact that economic and institutional barriers restrict the 'choices' of Black women" (Taylor, 2021). The Roe versus Wade trial had a very narrow focus of reproductive rights. This focus did not include the barriers that Black women face every day. Like the gynecological advancements that were made with involuntary experimentation on enslaved women, this advancement in civil law still did not benefit Black women as much as it benefitted White women. Currently, Black women are more likely than White women, both of low socioeconomic class, to be recommended by their healthcare providers for contraception (Prather et al., 2018). Although this is less invasive than hysterectomies, it is a continuation of the historical legacy of forced sterilization.

Current Forms of Medical Racial Discrimination Against Black Women

Racial Inequality in Medical Care in Sexual and Reproductive Health

In many cases today, Black women receive a lower standard of medical care compared to all other races. When medical care is standardized, all patients should be receiving the same amount of beneficence from their healthcare providers. However, a lower standard of care is seen among Black women when being treated for breast cancer, orthopedic problems, pain, cardiovascular disease, and end of life care (Nelson et al., 2015). According to the Centers for Disease Control and Prevention, Black women are more likely to experience maternal mortality, infant mortality, and STIs (Prather et al., 2018). In fact, Black women are 2.8 to 3.7 times more likely to die from pregnancy related complications than all other races (Prather, 2016). This is true regardless of socioeconomic status, as even White women who never finish high school are still less likely than Black women to die of these causes (Prather, 2016). This proves that in some instances race can be solely responsible for poor health outcomes and treatments. For Black women between the ages of 15 to 34, pregnancy complications are in the top ten leading causes of death (Prather, 2016). In a survey conducted by the National Partnership for Women and Families it was found that Black women were forty percent more likely to be given a cesarean section than White women (Taylor, 2021). This is significant because for any healthy pregnant woman, the rates of maternal mortality and morbidity are three times higher for a cesarean section than a vaginal delivery (Taylor, 2021). If a Black woman is more likely to be given a cesarean section, this places them at an even higher risk of experiencing mortality or morbidity from the adverse effects of a cesarean section. This same organization conducted a separate survey in 2018 that showed better medical treatment is provided to Caucasian women, English speakers, and patients who are covered by private health insurance (Taylor, 2021). There is a

level of privilege if one falls under any three of these categories. This should not be the case. In order for healthcare to be truly standardized, the relevance of these categories must be removed from the system.

Kira Johnson was a young African American female, whose experience with healthcare during the delivery of her second child shows the devasting outcomes of racial discrimination in reproductive health. Kira had a healthy pregnancy and was able to attend all her prenatal appointments. On April 12, 2016, Kira Johnson gave birth to her second child at Cedars-Sinai Medical Center through a cesarean section. This hospital prides itself on being one of the best medical facilities in the United States. During her recovery, Kira and her husband had noticed blood in her catheter. It took seven hours for a medical professional to assess and act on this issue that Kira and her husband were desperately crying for help for. It was then discovered that Kira has lost three liters of blood, causing death related to postpartum hemorrhage (Taylor, 2021). Death related to postpartum hemorrhage is incredibly preventable. After delivery, hospital policies will typically require a nurse to assess the mother every fifteen minutes during the first hour after delivery, every thirty minutes the second hour, every 4 hours for the next twenty-two hours, and then every shift the next day (Durham & Chapman, 2019). If these assessments were done, the blood should have been noted and immediately tended to. If postpartum hemorrhage was suspected, Kira's nurse would have massaged her uterus until it felt firm (Durham & Chapman, 2019). If the massage was unsuccessful, the nurse would have then used a standing order placed by a physician to administer oxytocin to stimulate uterine contractions and stop any bleeding (Durham & Chapman, 2019). These are common protocols that should have been carried out to ensure the safety of Kira. Because of the lack of attention by the medical

professionals at Cedars-Sinai Medical Center, Kira Johnson will not be able to see her sons grow up, nor will her sons have their mother to guide them in their life journeys.

Effects of Social Determinants of Health on African Americans

Social determinants of health in the United States contribute to the disproportionality of discrimination during care. Social determinants of health are conditions that directly relate to health risks and outcomes. This includes financial stability, quality education access, quality healthcare access, communities, and the built environment (Healthy People 2030, n.d.). Disproportionate racial health disparities are created by differences and inequalities in employment, housing, and socioeconomic class (Nurridin et al., 2020). According to Massey's biosocial model of racial stratification, residential segregation based on race combined with socioeconomic inequality leads to pockets of poverty and violence-stricken areas (Peek et al., 2010). These residents are more likely to experience coronary artery disease, inflammation disorders, and cognitive impairment (Peek et al., 2010). This strongly correlated with the African American population due to structural and institutional racism (Peek et al., 2010). The Aspen Institute defines structural racism as "a system where public policies, institutional practices, and cultural representation work to reinforce and perpetuate racial inequity" (Taylor, 2021). Peek et al. (2010) describes institutional racism as "differential access to goods, services, and opportunities by race". Institutional racism includes current societal practices that are objectively better for White members of a society than Black members. Peek et al. (2010) notes that institutional and structural racism may cause delays in the Black population in the utilization of medical care, and nonadherence to treatment. Similarly, Prather et al. (2018) notes that African American women are more likely to have delayed HIV treatment from providers compared to

other races. Racism itself is not a social determinant of health. However, it influences many social determinants of health that lead to negative health outcomes.

Many African Americans lack access to preventative reproductive screening (Prather et al., 2018). The Affordable Care Act, or ACA, was created to expand access to these preventative screening services among other non-reproductive related services (Prather et al., 2018). The ACA also increased maternity coverage and funding to community health centers which are usually located in communities serving high populations of African Americans (Prather et al., 2018). States that have expanded their Medicaid programs to include the ACA have their income threshold adjusted up to 130% of the federal poverty level (Taylor, 2021). This means that individuals or families that make $17,238 per year are eligible for Medicaid (Taylor, 2021). The income threshold for non-expansion states is forty percent of the federal poverty level (Taylor, 2021). This means that a family of three can make no more than $8,532 per year to qualify for Medicaid (Taylor, 2021). If a state has not adopted the ACA, many families still face challenges of finding health coverage. Non-expansion states put a higher burden on low-income families of color who often lack sufficient income to pay out of pocket costs for medical care. These non-expansion states are also concentrated in the Southern part of the United States, which have a high population of people of color (Taylor, 2021). The rates of African Americans insured in non-expansion states and in expansion states is fourteen percent and eight percent respectively (Taylor, 2021). This differs greatly from the uninsured rate of White Americans where ten percent are uninsured in non-expansion states, and six percent are uninsured in expansion states (Taylor, 2021). There is a greater number of insured Black women in states that have adopted the ACA, which has allowed these women to have more access to sexual and reproductive preventative health.

Discriminatory Related Stress Induced Disorders

Racial discrimination can lead to psychological stress which has the potential to create negative health outcomes. The National Americans Changing Lives organization claims that 47% of African Americans reported experiencing racial or ethnic discriminatory treatment in their lives (Taylor et al., 2007). Racism fosters many social factors that increase the chance of experiencing stress. Stress adversely affects an individual's immunologic function and may contribute to negative health behaviors. African American women who experienced adverse life events are 11.6 times more likely to develop breast cancer (Taylor et al., 2007). In a study conducted by Taylor et al. (2007), the incidence of breast cancer increased by twenty percent for African American women who reported facing racial discrimination in their work life. This study also showed that African American women who reported racial discrimination in policing, housing, and their work life were 31% more likely to develop breast cancer than women who reported no experience with racial discrimination (Taylor et al., 2007). Racial discrimination leads to feelings of stress, which in turn will lead to negative health outcomes. Massey's biosocial model of racial stratification also applies in this circumstance. Due to racial stratification, African Americans are more likely to live in relatively impoverished areas that are violence stricken. This living condition can cause a lot of stress in many of the residents, which would then lead to negative health outcomes.

Strategies to Diminish Racial Discrimination

Combating Provider Unconscious Bias with Education

To eradicate racial discrimination against African American women in sexual and reproductive health, awareness should be increased among patients, healthcare providers, policy makers, and communities so that they may implement change in the healthcare system and

dissolve social disparities. Healthcare providers are always at risk for using stereotypes as cognitive shortcuts due to time pressure, high demand, and limited supplies (Peek et al., 2010). This unconscious bias leads to delays in sexual and reproductive health such as HIV treatment adherence, pap smears, and mammograms (Prather, 2016). Peek et al. (2010) discovered that many physicians are very likely to assume their African American patients are less educated, more likely to have substance abuse issues, and less likely to adhere to treatments compared to other patients (Peek et al., 2010). Racial awareness is one strategy that has potential to diminish unconscious provider bias. Nelson et al. (2015) created a study which evaluated the effectiveness of racial awareness training for healthcare providers. This study consisted of three courses. The first course involved curriculum about race, the second course involved curriculum about racism, and the third course involved curriculum about whiteness. A five-point Likert scale was given to all participants before and after the courses to determine the effectiveness of the training. The scale consisted of the following scores a participant could give: 1 – strongly disagree, 2 – disagree, 3 – neutral, 4 – agree, 5 – strongly agree. After the completion of the course, one hundred percent of the participating physicians either agreed or strongly agreed that racism affects healthcare delivery (Nelson et al., 2015). What was most striking was that although racial awareness increased in all participants, residents of color had learned the most (Nelson et al., 2015). This may be because most of these residents were immigrants who potentially had different experiences with racism. The participants also experienced that their feelings of effectiveness in providing equitable care had decreased as their awareness of the issue increased (Nelson et al., 2015). This may lead many providers to change the way they practice, providing more equitable care. This study by Nelson et al. (2015) is evidence that awareness training improves provider knowledge and attitudes toward unconscious bias. Awareness training is the

first step for providers to address their own unconscious bias. Once they are aware of their biases, providers can modify and adapt their practices to provide more equitable care.

Shared Decision-Making Model

Another strategy to reduce racial discrimination in healthcare is the Shared Decision-Making Model. In this model, the relationship between the providers and the patients is addressed. The providers need to focus on their interpersonal skills to create meaningful communication and relationships with their patients. Some methods of strengthening patient-provider relationships include involving the patient in their care plans or actively listening to the patient's description of their situation (Peek et al., 2010). The shared decision-making model addresses feelings of mistrust, as the providers and patients will begin to work together as a team rather than a superior and inferior.

Increasing the Proportion of African American Providers

Lastly, ensuring a diverse, culturally competent healthcare team will promote a healthcare system that acknowledges the needs of African Americans. Research shows that healthcare providers of color who take care of patients with a similar cultural background tend to have better patient outcomes and experiences (Taylor, 2021). However, in 2016, only eleven percent of OBGYNs in the United States were providers of color (Taylor, 2021). Increasing the proportion of providers of color will allow for African Americans to experience higher quality healthcare.

Discussion

Once the historical implications of African American women's experiences with medical care have been recognized, actions such as education, fostering a more trusting patient-provider relationship, and creating a more diverse healthcare team may be implemented to decrease

current discrimination. Adjusting multiple levers in the healthcare system can be done if many lever movers that contribute to the healthcare system are willing to make change.

Historical Implications of Racial Discrimination

For hundreds of years, cisgender African American women have endured negligent and malicious medical practices that have led to pain and negative health outcomes. Not only were individuals affected by this torment, but generations of their families also experienced the effects. As time went on, instilled mistrust of the government and healthcare system increasingly grew. This was, and still is, exacerbated by forced sterilization.

Present Implications of Racial Discrimination

Currently, African American women are still being discriminated against in the healthcare system. This discrimination lies in social determinants of health, provider unconscious bias, and discriminatory related stress induced disorders. Access to healthcare is one social determinant of health that can be targeted to diminish discrimination. Expanding the Affordable Care Act to more states that offer Medicaid will allow for more African American women to receive adequate sexual and reproductive health.

Strategical Implementations in Healthcare

Effective methods that a healthcare system can use to diminish racial discrimination include provider education, the use of the shared decision-making model, and increasing the proportion of African American providers. Although discrimination that has been carried out in the past cannot be erased, we can stop the continuation today by learning from our history. These three strategies will create a more comfortable healthcare experience for African American women, which will in turn encourage many to be seen by a healthcare provider for their benefit.

Including healthcare provider education about race, racism, and whiteness is seen as allowing providers the opportunity to change the way they practice. Nelson et al. (2015) showed how well a course on racism can make providers critically think about how they were providing care to different races and ways they can improve. All healthcare providers should be educated on ways they can improve medical care, including eradicating racism.

The shared decision-making model is very effective in creating a respectful encounter between a healthcare provider and a patient of African American decent. This communication technique allows both parties to be involved in the individualized care process. When providers are more open to listening to what their patients have to say about their own current health and health history, better plans of care can be implemented. This will contribute to better health outcomes for African American patients.

The last implementation to be discussed is increasing the proportion of African American providers. As forementioned, providers who serve patients with similar cultural backgrounds will see better patient outcomes. When a patient is collaborating with a provider who has a similar cultural background to them, increased comfort is seen. Encouraging and supporting young African Americans to go into the medical field is the best way to increase the proportion of African American providers. This is a task that needs to be completed by all members of society to be effective. Even though more people need to participate in this implementation, it is still an action that has an attainable goal.

Suggestions for Future Research

The topics discussed herein only scratch the surface of healthcare inequities for African American women. The existence of stories like Kira Johnson's emphasizes the pressing need to further investigate overlooked healthcare inequalities. In Nelson et al.'s (2015) study, all of the

providers recognized that unconscious racism influences their practice. Additional considerations need to be made as the research of discrimination of cisgender African American women in sexual and reproductive health is continued. Generational effects is one aspect that has powerful implications on healthcare experiences and outcomes. Focusing research on how involuntary experimentation on enslaved women and forced sterilization has affected future generations of these women will show us the lasting consequences of racial discrimination.

Lastly, the study of the need for reparations for the medical mistreatment of African American women must be considered. As mentioned, the experimental procedures of Bozeman advanced gynecology at the expense of African American women's rights over their own bodies, and without benefits to them. As another example, Henrietta Lacks was an African American patient at John Hopkins Hospital with cervical cancer (Nurridin et al., 2020). The hospital took a sample of her cells, which were later named HeLa cells, to research (Nurrudin et al., 2020. Her cells lead to advancements in research areas such as immunology, oncology, and the development of the polio vaccine (Nurridin et al., 2020). However, there was no financial compensation for Henrietta Lacks or for her family (Nurridin et al., 2020). To fully rectify historical racism and its modern demonstrations, the healthcare community must commit itself to repaying the people that advanced its practice.

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