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Historical Claims Literature Review Paper:

Black Maternal Health

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Abstract

Mistrust among Black women toward the medical system is evident across many eras of reproductive history, and the generational mistreatment of their reproductive health continues to harm their mental well-being and family health in the 21st century. Even with the advancement of modern medicine, Black women and babies are dying at a higher rate than other ethnic groups. Medicine has long been used to stereotype Black women's physical and emotional resilience, sexuality, and capacity for motherhood. The interplay of race, socioeconomic power, and institutional knowledge has worked to preserve an inequitable and oppressive framework governing Black women's reproductive rights. This article reviews literature on the history of reproduction as it relates to Black women, as well as studies examining culturally sensitive approaches aimed at improving provider–patient interactions and reducing maternal and infant mortality. The results indicate that historical constructions of race and the persistence of racial stereotypes continue to shape the practices of today's medical professionals. By understanding how these stereotypes developed and how they intersect with race and socioeconomic status, we can foster new frameworks that improve outcomes for Black women and their families.

Introduction

Throughout history there has been an exploitation of Black women's reproductive rights, a generational impact of scientific racism that has fostered deep mistrust in the medical system, and vast negative effects on Black maternal health. The historical exploitation of Black women's reproductive rights, how race has shaped biomedical knowledge and clinical practice, and the generational impact of scientific racism has fostered deep mistrust in the medical system. The reproductive health struggles of Black women have persisted as a deeply rooted and often overlooked issue since the forced transportation of African people to the New World. Within this broader context, the topic of Black maternal health has received even less attention, remaining under-researched and underrepresented across social and advocacy platforms.

American history is stained by the abuse of Black women's bodies, from forced reproduction to generate wealth, using the Black body for experimentation in acquiring knowledge, to the push of sterilization in the need to reclaim a "pure race." Medicine has been used to stereotype the Black woman's physical and emotional endurance, sexuality, and ability to mother.[1] Understanding the disparities experienced by African American women is crucial for creating effective interventions, breaking systemic patterns of medical neglect, and developing supportive systems. Maternal mental health plays a vital role in shaping the well-being of both African American mothers and their families.

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Historical Claims of Wealth, Knowledge, and Race: the White Man's Claim to Reproduction

Wealth

With the abolition of the trans-Atlantic slave trade in 1808, slaveholders were confronted with a new challenge: how to sustain and expand the enslaved labor force without continued importation from African nations. Roughly three to four million Africans survived the Middle Passage and settled in the southern states of America.[2]

During this period, the early nineteenth century, the reproductive health of enslaved African women became an area of intense interest and control. The concept of reproductive property gave rise to the practice known as "slave breeding," further entrenching the dehumanization of African people as chattel. Enslaved women were routinely sexually exploited and forced to bear children.[3] Childbearing of slave women became the primary source of fortifying new field hands. Under American law, the child inherited the status of their mother, thus even children born of the slave master's blood became an enslaved person.[4] The legalization of slave breeding under the principle "partus sequitur ventrem" not only actualized the inheritance but guaranteed that status to their descendants as well.[5] The legal system also absolved enslavers of rape, stating this act was not illegal given the property status of slave women. Washington[4] writes that President Thomas Jefferson stated he considered breeding slave women who could produce a child once a year just as profitable as a field hand. In the late 1800s, women of childbearing age (those of menstruating years as young as 12) were sold on the slave block for as much as $1,600, modern-day equivalent of $45,000-60,000.[6] While family births were typically written in the family bible, the births of enslaved babies were recorded in the salve holder’s plantation business records.[3]

Knowledge

Midwifery, once a role traditionally held by women, began to shift into the hands of White male physicians. Initially, men viewed childbirth as a private, female-centered domain; however, as economic motives intertwined with medical practice, increasing numbers of White men entered the field.[4] These physicians became integral figures within slaveholding communities, recognizing the financial and political benefits of their involvement. Physicians in this new field began as personal doctors to plantation owners. The Black woman's body became an integral part of medical science, feeding American research, medical training, practices, and theories.[7] Reproductive medicine thus became deeply embedded in the institution of American slavery. Enslaved women's bodies were subjected to invasive and experimental medical procedures without consent. These experiments included studies on pubescent menstruation, cesarean deliveries, surgical repair of vaginal tears during childbirth, removal of uterine cancers, and treatments for internal injuries caused by sexual violence.[7]

James Marion Sims, often called the "father of gynecology," is recognized for founding the first women's hospital, developing surgical techniques to repair vaginal fistulas, and addressing complications that hindered childbirth.[8] Sims conducted his experiments on twelve enslaved women, some as young as fourteen, performing repeated procedures without anesthesia. Francois Marie Prevost developed the cesarean section, a procedure done when a vaginal birth is not optimal, through continued experimentation on enslaved Black women in America.[8]

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Medical doctrine of the 18th and 19th centuries from the British West Indies was a significant platform for the treatment of the enslaved women of childbearing age. Scottish physician James Grainger, a colonial physician in the British West Indies, wrote essays on the women of the "Ibbo" country. His essays were contradictory in nature: Graniger described this group of women as incurable, barren, less fertile than "White" women, and with many disorders. However, he also concluded that Black women were less susceptible to complications during birth.[9] Infant mortality was a primary focus for many physicians; many White doctors blamed the high infant mortality rate on the enslaved women and not the unsanitary conditions throughout pregnancy and birth. In the Southern states of America, a probable 50% of enslaved infants died within the first year of life.[5] Physician Robert Thomas of the West Indies wrote that Black women were unsafe in their decision-making, thus needing "supervision" to avoid endangering their newborn child. Thomas, in his writing, further perpetuated the idea of immorality and hypersexuality of Black women, suggesting they carry disease in their blood because of prostitution.[5]

"Practical Rules for the Management and Medical Treatment of Negro Slaves, the Sugar Colonies," written by Dr. Collins in 1803, was used by plantation owners throughout the West Indies and the Americas. Collins' assumptions of how to treat the health of Black women created an attitude of dismissiveness in the birthing room of the slave woman.[9] By the late 1800s, doctrine and treaties fortified the stigma of Black women in these key areas[8]:

- Hypersexuality and promiscuity,
- Having a high tolerance for pain,
- Requiring less need for medical care,
- Considered lazy in their parenting,
- Incompetent,
- Irresponsible, and
- Requiring management and oversight of their reproductive health.

The post-emancipation South ushered in a new era of racial dominance through the establishment of Jim Crow laws. These legislative measures institutionalized the rigid segregation of White and Black Americans, reinforcing a deeply divided society. Furthermore, such laws perpetuated the systematic disenfranchisement of Black citizens, depriving them of fundamental civil and political rights. A woman who was once valued for her ability to produce children for economic gain became vilified for that same capacity.[3] As this shift occurred, a campaign for the sterilization of Black mothers began. Margaret Sanger, the founder of the American Birth Control League and a celebrated feminist and birth control advocate has been identified as an underlying proponent of the sterilization of Black women.[3,4] Sanger also endorsed the pseudoscientific theory of eugenics. Eugenics posited that intelligence and personality traits were determined by genetics, reinforcing the belief that racial characteristics were hereditary and fixed. Through so-called physiological evidence, eugenics was used to justify the perceived inferiority of Black people.[4]

These ideas profoundly influenced legislation and justified government involvement in the reproductive lives of Black women.[4] Birth control pills were distributed to poor Black women at little to no cost through reproductive health clinics (like Planned Parenthood) concentrated in Black neighborhoods. By the 1960s, organizations such as the NAACP and leaders within the

Black Power movement began denouncing birth control initiatives, viewing them as instruments of racial genocide.[4] Additional forms of birth control were imposed upon Black women, including the intrauterine device (IUD), a contraceptive implant that thickens the uterine lining to prevent fertilization. The IUD became known as a "silent killer," as research revealed that Black women were disproportionately affected by fibroids, endometriosis, and cancer. Rather than alleviating these health issues, the IUD often worsens them, leading to infections and infertility.[4] Seeking to guarantee the sterilization of Black women, in 1993 Governor William Schaefer of Maryland proposed that Norplant (another long-acting birth control method inserted into the arm) be implanted in every woman on welfare as a mandate.[3]

Race

It is a striking contradiction that Black women were considered capable of nurturing and raising White children, yet were viewed as unfit to care for their own. Following the Emancipation Proclamation of 1863, which declared enslaved people in Confederate states free, this paradox became even more pronounced. Since the Victorian era, enslaved African women have been portrayed as hypersexual and excessively fertile compared to White women.[3] These racist stereotypes shaped the perception of the Black family, suggesting that Black women's supposed sexual promiscuity made them dangerous in their mothering, and that they would pass on hypersexual behaviors to their children, destabilize the Black family structures, and incite Black men to sexually assault White women.[3]

Divorce rates in the antebellum South escalated as adultery became a primary reason for the White wife to petition the court. Molloy writes that White women unknowingly or knowingly played a part in the degradation of Black women.[10] It was not an uncommon practice for slaveholders to rape or have adulterous relationships with their enslaved women; this was known to the White woman as she witnessed these dealings in her own upbringing, oftentimes playing with her "mulatto" siblings. Further solidifying herself in the racial hierarchy, White women used terminology in their court appeals, reinforcing the hypersexual stereotypes and placing blame on the Black woman for the sexually abusive relationships they were forced into. Petitions encompassed verbiage such as "wench," "mulattress," and "prostitute." The use of this language contributed to the culture of rape of Black women, whilst diminishing the responsibility of the perpetrator, the White man.[10]

In 1910, Abraham Flexner was commissioned by the Carnegie Foundation to assess the educational components of medical school in America and Canada. The goal was to streamline medical professionals' teaching practices, produce practitioners with better technical and clinical knowledge, and reduce the number of poorly educated physicians.[11] What seemed like an assessment to streamline the medical education field really alienated persons based on race, region, and gender. Flexner's report sought to define a single type of person qualified for the medical field: the Northern, affluent, White male. In 1908, there were 150 medical schools in the United States and Canada, and after his assessment, only 31 institutions were deemed of standard. Of the seven programs for Black students, Flexner considered only two sufficient: Meharry Medical College in Nashville, TN, and Howard Medical School in Washington, D.C.[11] Flexner did not believe Black men specifically should be educated to practice medicine with all groups, but rather to treat Black Americans in the area of community health. Flexner, in his report, did not even consider Black women to be optimal candidates for admission to medical school

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Sterilization has long functioned as a central mechanism of reproductive control in the United States. This was evident during the "crack baby" era of the 1980s and early 1990s, when many pregnant women were incarcerated and subsequently subjected to involuntary sterilization.[3] Similar patterns emerged during the Clinton administration, when welfare reforms implicitly encouraged the use of birth control through changes to eligibility requirements and the introduction of time limits. Despite rising numbers of employed and college-educated Black women, sterilization rates remain disproportionately high: 9.7% of Black women have been sterilized compared to 5.6% of White college-educated women.[3] Today, Black women face additional reproductive injustices, including significantly elevated risks of maternal and infant mortality. In the United States, Black women are four times more likely than White women to die during labor and delivery, even when experiencing comparable medical conditions.[12]

Historical Intersections in Current Day Practice: the Continued Silencing of the Black Mother

A 2022 article titled *"I Just Want to Be Heard"* highlighted concerns among a group of 31 Black women. Participants described consistent experiences of being ignored or met with negativity and a lack of empathy from physicians and nurses during various stages of pregnancy, including the perinatal, delivery, and postpartum periods.[13] Many reported feeling dismissed when voicing any concern. The women also discussed mental health challenges, noting experiences of depression and anxiety during and after pregnancy. They shared the difficulty of managing household responsibilities while coping with postpartum depression, emphasizing that their interactions with healthcare providers often worsened their mental health.[13]

Montalmant and Ettinger conducted a literature review on the racial disparities in maternal mortality and the impact of racism and implicit bias.[14] The authors reviewed the literature dating back to 1946 to improve obstetric outcomes. They detail that, while the American medical institution recognized the disparities in health outcomes amongst women of color compared to White women, little has changed throughout the decades. Key findings in the literature review focused on pain management, poor communication, implicit bias in treatment plans and outcomes, and a lack of ownership from the practitioners of their racial behaviors and bias. One study reviewed found that 63% percent of Black women receive an epidural for pain management compared to white women at 74% - the results suggested that the anesthesiologist took longer to initiate the procedure. Further information gathered found that medical students and residents held false narratives of biological difference between Black and White women, including the idea of their threshold for pain; this is congruent with the historical perspective stemming from slavery. Due to this bias, health care professionals are prone to disregarding pain complaints, thus providing deficient treatment.[14]

Montalmant and Ettinger also reviewed a study of the *"Listening to Mothers II survey."*[14] It found that Black women experienced more challenges with communication in their prenatal care. Reports stated that physicians were more verbally dominant in their conversations with Black women compared to White women, and appointment times were 33% shorter. Black women also reported being advised on permanent contraceptive measures regardless of their number of children. Other studies noted doctors were surveyed on disparities in their practice, with most denying implicit bias and racist behaviors affecting how they care for their patients.[14]

In 2022, the Women's Health Report published an article titled "*Clinicians' Perspectives on Racism and Black Women's Maternal Health."* The study examined the views of sixteen White

maternal health practitioners, focusing on inequities in maternal care between Black and White women in the San Francisco Bay Area.[15] Findings revealed that stereotypes and racial biases about Black mothers influenced the quality of care they received. Some healthcare facilities reported that these beliefs affected the medical options offered to Black women after childbirth. Additionally, practitioners acknowledged that racial biases hindered their ability to actively listen to Black patients, leading to instances where patients were dismissed or excluded from discussions about their own care. While participants recognized that racial ideologies have historically shaped reproductive health practices, many struggled to identify how their own implicit biases affected their treatment of patients.[15]

Absence of Black Physicians and Health Care Providers

In the United States, African Americans represent only about 5% of practicing physicians.[1] This underrepresentation extends across other healthcare professions, including psychiatry and therapy. Although African Americans make up roughly 14–15% of the US population, their presence in the mental health field remains disproportionately low. Addressing the Underrepresentation of African American Mental Health Professionals reports that African Americans comprise just 2% of psychiatrists, 4% of psychologists, and 22% of social workers, with additional studies noting that only 4% of social workers are licensed counseling professionals.[16] A 2024 study using data from the Association of American Medical Colleges further identified racial and gender disparities in obstetrics residencies.[17] In 2021, the number of female residents increased overall; however, White women experienced an 8% increase in applications, compared with a 3% increase among African American women. Meanwhile, male representation declined by 15% across all racial groups.[17]

Practice, Policy Advocacy, or Community Engagement

The health of Black women has been profoundly and persistently harmed by the actions and systems established by White Americans. Throughout history, science, medicine, genetics, and sociology have been misused to promote false narratives that served economic and political interests. The resulting mistrust Black women hold toward the medical establishment is rooted in these repeated injustices across multiple eras of reproductive history. The question, for decades, remains: how do we make sustainable change?

Many articles describe similar systematic approaches to improve maternal health outcomes for Black women and their infants. The key findings suggest[18]:

- Training in culturally responsive, individualized, patient-centered care;
- The establishment of healthier patient-provider relationships; and
- Providers engaging with the communities they serve.

The findings also highlighted the need to increase patient education and awareness within the healthcare system, along with diversifying the maternal healthcare system.[14]

A New Way Forward: Black Professionals in the Rooms

In Cleveland, Ohio, a nonprofit, Black-owned organization opened a practice called Birthing Beautiful Communities (BBC). The BBC's structural understanding focused on the impact of historical trauma, systemic racism, and inequities in Black communities.[19] The organization's

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goal is to reduce the infant mortality rate for Black women. The program provides pregnant women with a Perinatal Support Professional (PSP) who follows them through pregnancy, birth, and up to one-year postpartum.[19] Analytical results from BBC interviews found that PSP helped bridge the communication gap between patients and providers. Women reported that PCPs helped them better understand medical terminology, assisted with translating and clarifying difficult information, helped create a space to ask more informed questions, and improved overall understanding of treatment and diagnoses. The women reported that PSPs helped them be seen and heard by the medical profession by providing encouragement, advocating on their behalf, and empowering them to have a say in their care. Lastly, the women reported a trusting relationship with their PSP. These relationships created a safe space and addressed the women's needs holistically.[19] Interviewees noted a dramatic difference in interactions with the physician when the PSP did not attend, further suggesting the implicit bias that practitioners hold toward patients.

For Us By US: Building Our Own Programs

The Healthy Birth Initiative Program (HBI) of Portland, Oregon, a program like BBC, has expanded its services into the homes and communities of its Black pregnant patients. This program provides services from pregnancy through the child's 18th month.[20] It includes in-home case management, home nurse visits, mental health services, and other health care specialists in the areas of breastfeeding, coordination with community services, and material support. The program uses a culturally specific approach to advocacy.[20] An added benefit of the HBI program is its ability to triage health complications, promote prenatal care, teach women how to engage with medical providers, and serve as a liaison team. Interviewees in this program shared similar experiences to the women in the BBC program: poor communication with health care providers, feeling exploited, lied to, disbelieved, and endorsed microaggressions from providers.[20] Interviewees shared that being part of a program where professionals looked like them reduced overall stress; these women felt understood and that the staff cared about their best interests. Dulas attending doctors' appointments had a successful impact on improving health outcomes. Recommendations from participants to add into the program were support groups to address stress related to racism, birthing trauma, and reduce isolation in a safe space.[20]

Limitations: Once Again, There Is Never Enough of Us

While this author would recommend policy changes that have a significant impact for Black women and that improve mortality rates for both mom and infant, I believe a boots-on-the-ground method would be the best approach to address this immediate crisis. The programs mentioned above appeared to have success with their predominantly represented and culturally specific methods for addressing maternal health disparities. While more of these programs should be replicated to test the success rate and overall improvement outcomes, limitations exist. Programs with all-Black staff may be complex to build in enough regions of America to reach this specific population of women. According to the literature, there is a lack of representation of Black providers in the field that would hinder the further development of these programs. The primary conclusion of most of the studies suggests an acknowledgement of the racial ideologies, practices, and beliefs held by White health care providers. Conclusive results suggested that White health care providers should engage in trainings that address racial and implicit bias.

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Conclusion

Europeans developed a system in which racism operated as a tool to uphold unequal power structures, ensuring that those at the top remain privileged at the expense of others. Race itself is a constructed idea, created by groups seeking to secure power and resources. Throughout history, literature and doctrine have promoted false narratives about African people to justify their oppression. The strategic misuse of medicine, science, and genealogy has been especially influential in manufacturing and reinforcing notions of superiority. The mistrust of the Black women in medicine can be seen through the many eras of reproductive history. The effects of generational mistreatment of Black women's reproductive health continue to have a negative effect on her mental and familial health. As a result, there continues to be a racial gap in the mortality rate of Black women and their babies.

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