Black Maternal and Infant Health: Historical Legacies of Slavery

The legacies of slavery today are seen in structural racism that has resulted in disproportionate maternal and infant death among African Americans.

The deep roots of these patterns of disparity in maternal and infant health lie with the commodification of enslaved Black women's childbearing and physicians' investment in serving the interests of slaveowners. Even certain medical specializations, such as obstetrics and gynecology, owe a debt to enslaved women who became experimental subjects in the development of the field.

Public health initiatives must acknowledge these historical legacies by addressing institutionalized racism and implicit bias in medicine while promoting programs that remedy socially embedded health disparities. (*Am J Public Health.* 2019;109:1342–1345. doi:10.2105/AJPH.2019.305243)

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See also Brown, p. 1309.

In February 2019, embattled Virginia governor Ralph Northam referred to Virginia's racist past by connecting it to the assumed healing power of medicine. Shortly after conservative political rivals published a racially offensive photo allegedly of Northam and a medical school friend in blackface, the governor responded, "Right now Virginia needs someone who can heal. There's no better person to do that than a doctor."

As a pediatric neurosurgeon, Governor Northam relied on the language of healing and the presumed belief that many Americans have that doctors are committed to curing what ails us all. Surely anti-Black racism, if thought of as a disorder, as Northam suggested, should be cured by neurosurgeons who are charged to rehabilitate disorders affecting the brain. In light of the medical field's racist past, can we trust physicians and surgeons such as Governor Northam with such an important task? More specifically, as historians who work on the effects of racism on Black people's bodies, especially women, we focus much of this commentary on how reproductive justice and birthing justice must be attained by and for Black women systemically.

MEDICINE'S RELATIONSHIP TO US CHATTEL SLAVERY

Any honest examination of racism as a widespread affliction of American medical practice must acknowledge that the medical profession was entangled in the institution of slavery from its beginnings. From the earliest origins of chattel slavery in North America, Europeans with medical training served the interests of slaveowners rather than enslaved patients.

Some transatlantic slave traders hired surgeons for the horrific Middle Passage in hopes of preserving their human "cargo" for maximum profit.[1] In the slave markets of the antebellum South, physicians inspected the bodies of enslaved men, women, and children before signing certificates of "soundness" for buyers or sellers. These distorted priorities were reflected in an 1858 medical journal article by Savannah Medical College professor Juriah Harriss, who declared that the ability to accurately determine the market value of Black bodies was one of the key professional competencies needed by southern doctors. Insurance companies too hired White doctors to examine enslaved men and women before issuing life insurance policies to protect slaveholders' financial well-being.[2]

Finally, Black bodies continued to be disrespected and commodified after death when used as teaching "material" in the form of cadavers and medical specimens in the dissecting rooms and medical museums of White medical schools.[3,4] White physicians in 18th- and 19th-century slave societies built their reputations by "medicalizing Blackness" in their professional writing. Racialized medical thought reached beyond proslavery practitioners and became part of the language of the broader profession.[5] This early history of physicians, slavery, and racial theory belies the notion that medicine is a value-neutral profession devoid of the toxicity of racism.

ENSLAVED WOMEN'S CHILDBEARING

Legal and medical attention to enslaved women's bodies played an especially important role in the entrenchment of American racism and its manifestation as a public health crisis today. As far back as 1662, colonial Virginia legislators made Black women's childbearing a centerpiece of the system of chattel slavery when they passed a law stating that the

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status of a child would follow that of his or her mother. This principle, known as *partus sequitur ventrem*, legalized chattel slavery as an inheritable status applied to Africans and their descendants. Seventeenth-century European exploration literature also depicted African women, in comparison with European women, as especially capable of both childbearing and field labor.[6,7] The principle of *partus* thus not only defined legal slavery but also carved out a racial distinction. Continuing up through the Civil War, White women's childbearing built free patriarchal lineages while southern laws forced enslaved Black women to bear children who would build capital for enslavers.

When both Britain and the United States banned the transatlantic slave trade in 1807–1808, cutting off the sources of African captives, slaveholders began to bank their future increasingly on the fertility of enslaved women. Medical journals and planter records in the British West Indies and the United States reveal growing attention paid by White physicians to enslaved women's reproductive lives. Although enslaved midwives and nurses supplied much of the daily plantation health care, slaveowners called upon White physicians for cases such as assisting difficult births with forceps, examining the causes of an enslaved woman's infertility, or investigating cases of infant mortality.[8] Infant mortality in plantation settings remained high, however. In the South, an estimated 50% of enslaved infants were stillborn or died within the first year of life.[9]

Without a well-developed field of pediatrics, White physicians had little to offer. Consequently, they often blamed enslaved mothers and midwives, using harsh gendered and racist language, for infant deaths that were more likely a result of mothers' hard labor and poor nutrition.[10] Beyond these verbal attacks, antebellum US physicians also began to use their access to Black and enslaved bodies to expand their scientific knowledge and build their professional reputations.

The impact of racialized science on the field of medicine today is painfully illustrated by the deep linkages that American gynecology has with slavery. Many of the field's most pioneering surgical techniques were developed on the sick bodies of enslaved women who were experimented on until they either were cured or died. A slaveholding surgeon, François Marie Prevost, pioneered cesarean section surgeries on American enslaved women's bodies through repeated experimentation. James Marion Sims, another famed 19th-century gynecologist, created the surgical technique that repaired obstetrical fistula by experimenting on a group of Alabama enslaved women.

That gynecology advanced from American slavery means that Black people have always had a precarious relationship to the field and its practitioners.[11] How does a community learn to trust doctors whose forefathers were interested only in repairing and restoring Black women's reproductive health so that slavery could be perpetuated? How can doctors learn to be more sensitive to the concerns, both personal and cultural, of Black people who still hold secrets about the forced sterilizations that older southern members of their families endured? How does the medical profession unlearn a pattern of dismissing Black women's self-reported pain when that pattern is rooted in centuries-old soil?

CONTEMPORARY MATERNAL AND INFANT MORTALITY

These questions acquire pressing urgency in the face of the continuing disparities in the health and survival of Black mothers and children today. Distressingly, although infant death rates overall have plummeted since the 19th century, the disparity between Black and White infant deaths today is actually greater than it was under antebellum slavery. Historical demographers estimate that, in 1850, enslaved infants died before 1 year of age at a rate 1.6 times higher than that of White infants (340 vs 217 deaths per 1000 live births).[12] In comparison, Centers for Disease Control and Prevention figures from 2016 show that today non-Hispanic Black infant mortality is 2.3 times higher than mortality among non-Hispanic White babies (11.4 deaths and 4.9 deaths, respectively).[13]

In addition, although Black women live longer lives now, the effects of racism have reverberated in their lives and those of their children in damaging and fatal ways. Since 1994, maternal mortality has dropped by almost 50% worldwide. Yet, between 2000 and 2013, high Black maternal death rates placed the United States second worst in maternal mortality among 31 Organisation for Economic Co-operation and Development nations.[14] In the United States, pregnancy-related mortality is three to four times higher among Black women than among White women.[15]

Since the 1990s, research on maternal and infant death disparities has increasingly pointed to structural racism in society at large as a stressor that harms African American women at both physiological and genetic levels.[16,17] Conditions such as hypertension, which have been linked to the stress of living in a racist society, contribute to disparities in pregnancy-related complications such as eclampsia.[18] These detrimental health effects of daily life are then further compounded by racial discrimination and disregard within medical institutions.[19]

Yet, as reproductive justice groups such as the Black Mamas Matter Alliance point out, expecting and new Black mothers often find their self-reports of painful symptoms overlooked or minimized by their practitioners.[20] It seems that, rather than addressing systemic racism in obstetrics and gynecology, medical practitioners have instead to some extent emphasized all of the ways Black women allegedly make themselves prone to being ill during their pregnancies. Black pregnant women and non–gender binary folks are told their fatness, advanced age, dietary choices, and lack of prenatal care have increased their chances of dying during childbirth. Yet, whereas Black pregnant people and mothers are made into culprits and the initiators of their deaths, doctors, nurses, and the hospitals they run are not looked at as critically as they should be.

ANTIRACIST PUBLIC HEALTH INTERVENTIONS

Public health professionals are charged with preventing illness

and injuries before they occur, so how do we use the framework of prevention to eradicate medical racism? Two projects launched in the Civil Rights and Black Power movements of the 1960s and 1970s offer models of community health care informed by antiracist political analyses. The health activists involved in these projects sought to address deep societal inequalities and empower their clientele by transforming the spaces and hierarchies of traditional medicine.

The Tufts-Delta Health Center, established in 1965 in the all-Black town of Mound Bayou, Mississippi, offered comprehensive health care funded by federal Office of Economic Opportunity grants. Local leadership on the advisory committee, as well as practitioners, administrators, and outreach workers hired from the local population, helped to overcome the well-justified distrust of medical facilities. In the Mississippi Delta, infant mortality among Black families was three times higher than that among Whites. Local input gathered through many hours of community organizing ensured that women's and children's health would be central to the center's mission. As a result, attention to clean water sources, food security, and safe shelter complemented the center's obstetrics and gynecology services. Still, some radical health activists argued that their local efforts did not truly transform American health care or the inequality endemic in the broader society.[21]

The People's Free Medical Clinics, founded by the Black Panther Party, embraced a more autonomous model of community health as part of their revolutionary politics. Required by 1970 in each local chapter, the Black Panther Party opened clinic spaces in or near their offices that sought to empower patients and demystify both medical procedures and medical authority. As noted by historian Alondra Nelson, the white coat in the clinics became a sign of radical access to health as a human right rather than a dreaded symbol of racist abuse.

Free clinics made up one component of the Black Panther Party's "serve the people" programs that especially attended to mothers' and children's health through free breakfast programs, sickle-cell screening, well-baby checkups, and gynecological exams. Although stretched for funds and space, the clinics became "sites of social change" that supported, celebrated, and empowered Black life.[22] The health activists associated with both the Tufts-Delta Health Center and the People's Free Medical Clinics challenged the idea of race as a causal determinant of poor health outcomes by exposing the impact of racism and poverty on Black health and well-being.

Historical examples such as these can show us possible alternatives, but deeply embedded health disparities today require new frameworks of understanding and systemwide interventions. Given how damaging and violent racism is in the lives of pregnant people and infants, public health investigators must work alongside scholars of race studies and medical personnel to eradicate the structural racism in medicine that is killing Black women and Black people more broadly. In a 2010 article published in this journal, public health and race studies scholars Chandra Ford and Collins Airhihenbuwa argued that the application of critical race theory and racial equity models could move the field toward an "antiracist praxis."[23] Dayna Bowen Matthew, a University of Virginia law professor, complements this perspective by offering an ambitious remedy from the perspective of civil rights law. Matthew calls for critical self-reflection within medical professions and legal reform of Title VI legislation that would create a structure of legal accountability for implicit bias and unconscious racism.[24]

Despite the merit of these incisive proposals, the effects of structural racism on Black lives are still decimating Black communities. We need bold, concrete plans to move forward. Medical professionals know the impact of racism but seem to think it is not fully applicable to the way they manage their hospitals and treat patients. They are aware of the unfair burden placed on medical staff at hospitals who are overworked, sometimes practice lax routines around hygiene and sanitation, do not have sufficient access to continued education and training, and still seem to believe that poorer patients, many of whom are Black, are not trustworthy, are heavy drug users, are ignorant, and are to blame for their illnesses.

It is not surprising, for example, that in Brooklyn, a borough with an overwhelmingly large Black and brown poor population, more Black women and their children die from pregnancy- and delivery-related conditions than anywhere in the state. In fact, they are eight times more likely than White women to die from either pregnancy or delivery. The crisis is so deleterious that, in July 2018, New York City mayor Bill de Blasio launched a four-point plan with an investment of $12.8 million over the subsequent three years. This plan would implement implicit bias training for city public and private health care providers, support more effective data tracking and analysis of maternal mortality and morbidity rates for better prevention, improve maternal health care at city hospitals and other health care locations, and create a partnership with community-based organizations to expand public education on issues of maternal health.[25]

This is one of the most comprehensive and progressive plans that incorporates an antiracist public health model. It recognizes that the system is broken and does not rely on the centuries-old practice of blaming victims. New York officials also looked to California, which took the lead in working to dismantle structural racism in maternal medicine: "Established in 2006, the California Maternal Quality Care Collaborative (CMQCC) has used data-driven approaches in an attempt to understand the root causes of maternal mortality."[26(p51)] The CMQCC has, in 13 years, reduced the maternal mortality rate from 16.9 per 100 000 population to 7.3.[26] In large part, it is demonstrating for Americans how a commitment to antiracism work can save lives and acknowledging that any system built on the backs of the enslaved needs repairing.

Black people have a right to be suspicious of an institution that has historically victimized their ancestors for centuries. It is up to all of us, but especially medical doctors and public health professionals, to decolonize obstetrics and gynecology specifically, and American medicine more broadly, and to apply comprehensive antiracist policies in the prevention of Black people's deaths. Harkening back to Governor Northam's statement that there is no better person to heal illness than a doctor, perhaps doctors, and all medical

personnel—including those in public health—should accept that they need healing too. AJPH

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Both authors contributed equally to this commentary.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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