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Community-informed models of perinatal and reproductive health services provision: A justice-centered paradigm toward equity among Black birthing communities

Zoë Julian, MD, MPH[a,*], Diana Robles, MD[b], Sara Whetstone, MD, MHS[b], Jamila B. Perritt, MD, MPH[c], Andrea V. Jackson, MD, MAS[b], Rachel R. Hardeman, PhD, MPH[d], and Karen A. Scott, MD, MPH[b]

[a]*Department of Obstetrics and Gynecology and Department of Medicine, University of Alabama at Birmingham School of Medicine, Birmingham, AL*
[b]*Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Francisco School of Medicine, San Francisco, CA*
[c]*Independent Reproductive Health and Family Planning Specialist, Washington, DC, United States*
[d]*Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis, MN*

ABSTRACT

Perinatal health outcomes in the United States continue to worsen, with the greatest burden of inequity falling on Black birthing communities. Despite transdisciplinary literature citing structural racism as a root cause of inequity, interventions continue to be mostly physician-centered models of perinatal and reproductive healthcare (PRH). These models prioritize individual, biomedical risk identification and stratification as solutions to achieving equity, without adequately addressing the social and structural determinants of health. The objective of this review is to: (1) examine the association between the impact of structural and obstetric racism and patient-centered access to PRH, (2) define and apply reproductive justice (RJ) as a framework to combat structural and obstetric racism in PRH, and (3) describe and demonstrate how to use an RJ lens to critically analyze physician-led and community-informed PRH models. We conclude with recommendations for building a PRH workforce whose capacity is aligned with racial equity. Institutional alignment with a RJ praxis creates opportunities for advancing PRH workforce diversification and development and improving PRH experiences and outcomes for our patients, communities, and workforce.

*Corresponding author.
E-mail address: zjulian@uabmc.edu (Z. Julian).

https://doi.org/10.1016/j.semperi.2020.151267
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Introduction

Perinatal health outcomes for birthing people in the United States continue to worsen, with the most significant burden of inequity falling on Black birthing communities.[1,2] Given these unethical outcomes, professional organizations across the perinatal and reproductive health spectra call for policy change and practice transformation that prioritizes equity.[3–6] Moreover, in a recent position statement, the Society of Maternal Fetal Medicine strongly encourages all maternal fetal medicine specialists to ultimately work towards a goal of racial health equity in perinatal health outcomes.[7] Public health practitioners, midwives, health system administrators, policymakers, data analysts, nurses, researchers, educators, and physicians in general and subspecialty practices are tasked with radically reimagining models of care provision, perinatal and reproductive healthcare (PRH) workforce diversification, and health systems development toward equitable social and clinical experiences and outcomes.

Despite evidence describing the relationship between structural racism, health outcomes and healthcare care experiences in the literature by transdisciplinary experts in the social sciences, humanities, legal studies, public health, and health services research,[8-10] knowledge construction by obstetricians, perinatologists, and gynecologists about the impact of structural racism on PRH inequity is lacking.[11] Structural racism is characterized by policies and practices across political sectors that award white people with unearned access to opportunities and resources denied to communities of color on the sole basis of racial identity.[8] Hallmarked by systems-level factors related to– yet distinct from– interpersonal racism,[12] structural racism increases mortality and reduces overall health and well-being.[13,14] Both traditional and novel measures of structural racism, such as neighborhood-level segregation[15–18] and county-level disparities in incarceration and elected officials,[19] have been shown to correlate with poorer perinatal health outcomes for Black birthing people. In a retrospective analysis of ~4700 Black women using census track data linked to electronic medical record data, high levels of neighborhood-level segregation were independently associated with higher odds of spontaneous preterm birth, even after controlling for neighborhood poverty, insurance status, parity, and maternal medical conditions.[18] Therefore, there is a clear need for models of care and interventions that target structural racism if inequity is to be eliminated systematically, with both scientific and cultural rigor,[20] relevance, and responsiveness.

Despite this evidence, physician-centered models of PRH identify biomedical risk identification and stratification,[21] prioritizing individual behavioral interventions and proximal determinants over structural and social determinants of health. As a result, our current models are insufficient in mitigating structurally rooted racial health inequities. Physician-centered models are incongruent with community-generated, evidence-based recommendations and standards of ethical care provision for Black birthing people, which assert the expertise of affected communities in care transformation.[20,22–26] Conversely, community-informed models of PRH, rooted in the reproductive justice (RJ) framework,[27] aim to meet the individual and community-identified needs of Black birthing people in a collaborative, transparent, and reciprocal manner. Simultaneously, community-informed models of PRH acknowledge historical and contemporary harm in PRH service provision and create opportunities for focusing on structural benchmarks and mechanisms for advancing equity in health systems innovations.

Therefore, in this review, we (1) examine the association between the impact of structural and obstetric racism and patient-centered access to PRH; (2) define and apply RJ as a framework to combat structural and obstetric racism in PRH, and (3) critically analyze physician-led and community-informed PRH models through an RJ lens. We conclude with recommendations for building workforce capacity toward PRH equity. Institutional alignment with an RJ praxis creates opportunities for advancing PRH workforce diversification and development and improving PRH experiences and outcomes for our patients, communities, and workforce. A glossary of terms is provided in Table 1 to support the reader's understanding, and engagement with concepts referenced throughout our review.

Obstetric racism and perinatal health outcomes

Articulated by Dr. Dána-Ain Davis, obstetric racism (Table 1) describes the phenomena of social and clinical neglect, mistreatment, disrespect, and harm that occurs in sites of PRH services provision, threatening positive birth outcomes and experiences in hospital settings among Black birthing communities.[28] An ethnographic analysis of highly educated Black women's experiences during perinatal care provision illustrates obstetric racism, as participants name racially motivated indices of presumed incompetence and disrespect while undergoing painful procedures and interventions without consent.[28] Davis' work aligns with decades of qualitative data in fields outside of obstetrics and perinatology that describe the various types of harms to Black people's bodily autonomy.[10,29,30] Recent clinical research demonstrating persistent Black-white racial disparities in preterm birth amongst highly educated, privately insured birthing people[31] can be situated within the discourse of obstetric racism. Doing so provides a more comprehensive understanding of the persistence of PRH inequity among Black birthing people despite social and clinical protective factors such as higher education, marriage, higher income, and adequate prenatal care utilization. As such, shifting focus from racial identity to racism as a risk factor for poor clinical outcomes and patient experiences amongst Black birthing people in PRH can disrupt pathologizing mother-blame narratives[32-34] in care provision. Likewise, shifting the focus from modifyng indidividual behaviors to addressing inequitable distributions of health, wealth, and life expectancy provides opportunities to optimize clinical outcomes and positive care experiences.

Table 1 – Glossary of key terms and abbreviations.

Perinatal and reproductive healthcare (PRH)	Health care services, within and outside of hospital settings, that pertain to the following: pregnancy, labor, birth, post-birth, stillbirth, neonatal loss, lactation, miscarriage/pregnancy loss, (in)fertility, contraception, and abortion.
Black birthing people*	A gender-inclusive term is referring to people who identify racially as Black and have the physiologic capacity for pregnancy and childbirth. This includes, but is not limited to, Black cisgendered women, Black transgendered men, as well as Black gender non-conforming, Black genderqueer, and Black non-binary individuals.
Structural racism	Macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups. Mechanisms of structural racism do not require the actions or intent of individuals.[13]
Interpersonal racism	Personally-mediated racism; prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race.[12]
Obstetric racism	An occurrence and analytic that best captures the unique experiences and conditions of Black mothers and birthing people's reproductive and perinatal care during pregnancy, labor, and birth at the intersections of obstetric violence and medical racism; a threat to positive birth outcomes T.he intersection of medical racism (patient's race influences medical professionals' perceptions, treatments, and/or diagnostic decisions) and obstetric violence.[28]
Obstetric violence	A form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated *because* they are obstetric patients. The term suggests that institutional violence and violence against women coalesces during pregnancy, childbirth, and postpartum.[28]
Reproductive justice (RJ)	An intersectional human rights framework articulated by Black women scholars grounded in the following four principles: (1) Every person has the right to decide if and when to become pregnant and to determine the optimal conditions under which they will birth. (2) Every person has the right to prevent or end a pregnancy and can do so. (3) Individuals have the right to parent children they already have with dignity and with the necessary social supports in safe, affordable, and sustainable environments. (4) Individuals have the right to disassociate sex from reproduction, and that healthy sexuality and pleasure are essential components to whole and full human life.[47]

*Of note, we refer to "women" within this review in alignment with research studies that specifically define their study populations with such a term. Otherwise, we aim to use gender-inclusive language.

Structural racism, obstetric racism, and patient-centered perinatal and reproductive healthcare access

As reported by the Institute of Medicine in several landmark reports,[35,36] physician-centered health care delivery perpetuates inequities, and therefore care delivery systems need to be reorganized and centered on patient needs and values.[35] According to Levesque et al.,[37] patient-centered access to care is defined as an opportunity to identify healthcare needs, to seek healthcare services, to reach, obtain or use health care services, and to have a need for health care services fulfilled. Health systems that ensure patient-centered access prioritize approachabiliy, acceptability, availability, accommodation, affordability, and appropriateness.[37] Investigations into PRH delivery systems demonstrate how current models exacerbate inequity through barriers to these elements, including insurance limitations, geographic consolidation of services, as well as racial, cultural, and language discordance between patients and providers.[38] In addition, structural and obstetric racism directly threaten patient-centered access to PRH through inequitable practices and policies, as evident in

treatment access and experiences of Black people seeking to avoid or terminate a pregnancy, to establish and sustain a pregnancy, to birth, and/or to parent with lives affected by stressors including housing instability, mental health challenges, and substance use.

There is robust evidence supporting opioid agonist pharmacotherapy for treatment of opioid use disorder in pregnancy.[39] However, access to and utilization of licensed and trained providers are limited. Many are primarily located in urban areas, leaving patients outside of these catchment areas unable to benefit from this resource.[40] Furthermore, 23 out of 50 states consider substance use in pregnancy criminal child abuse,[41] thereby criminalizing the act of seeking treatment for opiate use disorder while pregnant. Despite comparable rates of substance use in pregnancy amongst Black and white reproductive-aged individuals, Black people in need of treatment are less likely to receive it,[42] likely, in part, because of the threat of criminalization via inequitable treatment by the carceral system[30] and increased suspision and sureillance by health care systems with regard to dispropriate use of child protective services (CPS) referrals and law enforcement.[43] In an exploratory mixed methods analysis of nearly 8500 women, Black newborns were four times more likely than white infants to be referred to CPS at delivery despite similar rates of alcohol and illicit drug use identified in Black and White women undergoing universal prenatal substance use screening.[43] Researchers in this study cite structural racism as an explanatory mechanism for the persistence of these inequities.

Additionally, structural racism directly threatens patient-centered PRH access through coercive practices in the field of family planning. Coercive practices of sterilization,[10] contraceptive counseling and provision,[44] and drafted legislation requiring contraception for access to social services,[30] are just a few examples of injustices violating bodily autonomy of Black birthing people. Unsurprisingly, due to these historical and current practices, evidence shows more distrust and less comfort with clinician-controlled contraceptive methods amongst Black birthing people compared to their White counterparts, affecting equitable contraceptive use.[45,46] These examples illustrate how structural and obstetric racism compromise opportunities for Black birthing people to obtain or use PRH services free from the fear or experience of harm and coercion.

Reproductive justice as health services praxis

While structural and obstetric racism negatively impact patient-centered access to PRH, RJ promotes equitable PRH access for Black birthing people. Coined by twelve Black women scholars and activists in 1994, RJ encompasses Black feminist ideology, reproductive rights, and social justice to contextualize reproductive health within an intersectional human rights framework.[27] Here, we rearticulate the grounding principles of RJ for the purposes of our analysis of PRH models of care:

(1) Every person has the right to decide if and when to become pregnant and to determine the optimal conditions under which they will birth *with equitable access and utilization of culturally relevant options and opportunities for pregnancy, labor, birth, and postpartum.*
(2) Every person has the right to prevent or end a pregnancy *and can do so via options that are accessible, approachable, acceptable, available and accommodating, affordable, and appropriate.*
(3) Individuals have the right to parent children they already have with dignity and with the necessary social supports in safe, affordable, and sustainable environments *and healthy, thriving communities without fear or threat of violence, intimidation, coercion, or control from individuals or the government.*
(4) Individuals have the right to disassociate sex from reproduction and that healthy sexuality and pleasure are essential components to whole and full human life.[20,47]

Through these principles, RJ provides clear standards for transforming power structures and dynamics in care provision toward the expertise of Black birthing communities, and challenges the hierarchy of medicine that prioritizes physician knowledge and specialty training over community wisdom and experiential knowledge in PRH services provision. Therefore, RJ-rooted models of PRH directly dismantle structural and obstetric racism in service provision and improve patient-centered access toward equity. As such, we analyze physician-centered and community-informed models of PRH using a RJ lens.

Physician-centered models of perinatal and reproductive healthcare delivery

Physician-centered models of PRH center care delivery in \clinics or hospital settings prioritize identification of individual level risk factors for poor health outcomes. Within obstetrics, individual outpatient visits with physicians, nurse practitioners, or certified-nurse midwives focus on risk assessment and reduction at specific gestational milestones and their associated screening, diagnostic, and therapeutic interventions.[48] Outpatient antepartum visits serve to mitigate maternal and/or fetal risk during hospital-based intrapartum and postpartum care and prevent poor clinical outcomes. Similarly, family planning service provision within physician-centered models aims to ensure patient clinical safety through risk identification and stratification of individual medical comorbidities and social factors prior to pharmacologic or procedural intervention. Institutional and physician reliance, and perpetuation of the false notion that race is a biologically based health determinant, further undermine the humanity and dignity of Black birthing people, diverting attention and investment away from structural analyses and solutions to advance equity, thereby reinforcing structural and obstetric racism in PRH service provision. Table 2 compares key elements of physician-centered and community-informed models of care. These limitations compromise the human right to determine the optimal conditions under which one prevents or achieves pregnancy, births, or ends a pregnancy, and continue to undermine the advancement of RJ for Black birthing people. Furthermore, physician-centered models rarely address social, structural, and clinical determinants of health simultaneously, therefore eroding the right to birth and/or parent in safe, affordable, and

Table 2 – Comparison of community-informed and physician-centered models of perinatal and reproductive health care delivery.

	Community-informed PRH care models	Physician-centered PRH care models
Provider type	CNM, CPM, LM, NP, RN, MD	MD, NP, CNM, RN
Care setting	Home, birth center, clinic, outpatient surgical center, and/or hospital	Clinic, outpatient surgical center, and/or hospital
Assumption	Power differences determine differential access, capacity, and opportunity for health beyond individual patient/provider behavior or attribute	Individual physiology, individual behavior, and provider knowledge/skill determine maternal and/or fetal health outcomes.
Primary goal	Pursuit of social justice, liberation, and collective autonomy and self-determination in care experiences	Clinical health risk mitigation Knowledge accumulation
Intervention focus	Broad systems and institutions of inequality and inequity, upstream forces	Individual behavior and proximal causes
Position to community	Engaged subjectivity, reflexivity, reciprocity, collaborative partnership	Affective neutrality, objectivity, hierarchal, mother blame
Care team concordance to Black birthing people	Often	Limited
Individual v. group care delivery	Individual and group care	Individual, less commonly group care
Team education and expertise	Experiential learning Institutionalized learning Multidisciplinary (i.e., midwifery, public health, early childhood, nursing, mental health, social services, creative arts, medicine, lactation, humanities, social sciences, legal studies, finance, tech)	Institutionalized learning Homogeneity in clinical disciplines (i.e., medicine, nursing)
Address structural and social determinants of health	Often	Rarely
Address clinical determinants of health	Often	Often
Framework	Human rights Social justice Reproductive justice Birth justice Sex positivity Sacred birth Racism, not Race Social construction of race and gender	Atheoretical Biomedical paradigm Mother blame Structural racism Gendered racism Obstetric racism

MD = medical doctor, CNM = certified nurse midwife, CPM = certified professional midwife, LM = lay midwife, NP = nurse practitioner, RN=registered nurse.

sustainable environments, with the necessary social and clinical supports.

Community-informed models of perinatal and reproductive healthcare delivery

Common elements across successful community-informed models include team-based care that centers the person seeking services,[49] promotion of racial/cultural/language concordance between care-seeking individual and health care team,[50,51] promotion of co-located PRH services,[52] and integration of clinical and social services to address structural, social, and clinical determinants of health.[53] In contrast to physician-centered models, community-informed models support the human rights articulated in the RJ framework. Community-informed models, including midwifery-led community-based care,[50] doula-supported care,[54-60] and home visit nursing programs,[53] aim to achieve collective autonomy and self-determination in care experiences, while simultaneously promoting positive clinical outcomes. Furthermore, community-informed models demonstrate racial health equity, with improved clinical perinatal health outcomes for Black birthing people, including lower rates of preterm birth, low birth weight infants, neonatal intensive care unit admission, and increased rates contraception uptake.[49,53] As such, community-informed models grounded in RJ are better positioned to achieve and sustain equitable experiences and outcomes for patients, communities, and PRH systems given the high degree of authentic engagement, trust, collaboration, transparency, reciprocity, and accountability.[51]

Call to action: workforce capacity toward perinatal and reproductive health equity

To meaningfully integrate with and support community-informed models toward racial equity, the OBGYN physician workforce requires significant capacity building through (1) racial and epistemological diversification, (2) a reckoning with the professional legacy of racism in medical education, and (3) innovation in interprofessional, transdisciplinary, and community collaboration.

A recently updated ACOG report provides an analysis of the landscape of the OBGYN workforce – highlighting strengths, weaknesses, and trends in the available OBGYN workforce from 2011 to 2017.[61] From this report, it becomes evident that achieving and advancing PRH continues to be threatened by the following:

- Feminization of the workforce without a concomitant equitable racial/ethnic diversification of the workforce
- Geographic maldistribution of the workforce and services in rural areas, urban areas, and areas adjacent to urban centers
- Absence of any OBGYN physicians in nearly half of U.S. counties due to the shortage or absence of a hospital with obstetric care and/or obstetric provider (i.e., maternal care desert)
- Lack of racial concordance between the workforce and the public, particularly in rural areas, urban areas, and areas adjacent to urban centers in the Midwest and Southern regions

As such, racial workforce diversification is a necessary initial step toward equity. Given physicians of color are more likely to serve in medically underserved areas, racial diversification can improve geographical physician distribution[62] and broaden patient-centered access to PRH. Additionally, evidence suggests that when physicians and patients share the same race or ethnicity, patient experience in systems of care, adherence to medical recommendations, and preventive screening improves.[63]

In addition to workforce diversification, rethinking our current systems of physician supremacy and individual-level risk reduction in medical education and service provision in PRH must be a priority. Individual and community experiences with PRH exist within a complex web of social, political, and historical context in which we live, work, worship, eat, play, and seek pleasure. Given the history of genocide and oppression rooted in organized medicine, we must begin by acknowledging that we cannot build therapeutic relationships with Black communities in systems that replicate oppression and further reinforce mistrust and inequity. Medical education's legacy of racism,[14] class exploitation and gender oppression[64] has led to limited training opportunities for aspiring Black physicians[65] and to the degradation of Black midwifery as an esteemed and essential profession and service,[66,67] particularly for minorized and marginalized birthing communities. Furthermore, we must replace systems of medical education that erroneously teach race as biologic determinant of health and Black bodies as broken with those that affirm the inherent value of Black bodies, lives, and communities.

Community-informed models of PRH have successfully improved PRH care experiences and outcomes for Black birthing people by aligning their assumptions, goals, relationship to patients, and interventions with an RJ praxis. To increase patient-centered access to community-informed models of PRH, medical education must follow suit and rely upon more expansive and inclusive approaches to increase institutional and provider awareness, acceptance, and utilization of justice-centered, racially congruent models of care. As such, innovations in medical education that prioritize real-time interprofessional education and collaboration at the bedside during PRH service provision are critical. While interprofessional collaboration and education are not new concepts, they have received renewed attention within OB/GYN clinical training. Broadening interprofessional training to community-based settings, Black and Indigenous midwifery models of care, along with inclusion of social sciences, humanities, bioethics, and public health, will bring new teachers, practices, and pedagogies to PRH. As such, we need to build new accountability measures and mechanisms between educators, researchers, clinicians, and Black birthing communities, engaging in a continued practice of critical institutional and individual self-reflection about our professional past, present, and future. Through these mechanisms and others, we can shift power to Black birthing communities and begin to prepare the current and future OBGYN workforce to more equitably serve the public with dignity and cultural rigor.

Disclosures

The authors report no proprietary or commercial interest in any product mentioned or concept discussed in this article. No grant funding was used to support the writing of this review.

REFERENCES

1. Petersen EE. *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morbidity and Mortality Weekly Report*, 68. Center for Disease Control and Prevention; 2019.
2. Bryant AS, Worjoloh A, Caughey AB, Washington AE. Racial/Ethnic disparities in obstetrical outcomes and care: prevalence and determinants. *Am J Obstet Gynecol*. 2010;202(4):335–343.
3. American College of Nurse-Midwives. ACNM Position Statement: Social Justice. Published May 2018. Accessed March 1, 2020.
4. ACOG Committee on Health Care for Underserved Women. ACOG Committee Opinion No. 729: Importance of social determinants of health and cultural awareness in the delivery of reproductive health care. *Obstet Gynecol*. 2018;131(1):e43–e48.
5. American Publich Health Association. Research and intervention on racism as a fundamental cause of ethnic disparities in health. *Am J Public Health*. 2001;91(3):515–516.
6. Association of Women's Health, Obstetric and Neonatal Nurses. Access to health care. *J Obstet Gynecol Neonatal Nurs*. 2017;46(1):114–116. https://doi.org/10.1016/j.jogn.2016.11.005.
7. Society for Maternal Fetal Medicine. Racial disparities in health outcomes: An official position statement of The Society For Maternal-Fetal Medicine. https://s3.amazonaws.com/

cdn.smfm.org/media/1108/Racial_Disparities_-_Jan_2017.pdf. Published January 2017. Accessed March 1, 2020.
8. Metzl JM, Roberts DE. Structural competency meets structural racism: race, politics, and the structure of medical knowledge. *AMA J Ethics*. 2014;16(9):674–690.
9. Phelan SM, Burke SE, Cunningham BA, et al. The effects of racism in medical education on students' decisions to practice in underserved or minority communities. *Acad Med*. 2019;94(8):1178–1189.
10. Davis DA. *Reproductive injustice: racism, pregnancy, and premature birth*. *Reproductive Injustice: Racism, Pregnancy, and Premature birth*. New York: NYU Press; 2019.
11. Eichelberger KY, Doll K, Ekpo GE, Zerden ML. Black lives matter: claiming a space for evidence-based outrage in obstetrics and gynecology. *Am J Public Health*. 2016;106(10):1771–1772.
12. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212–1215.
13. Gee GC, Ford CL. Structural racism and health inequities. *Du Bois Rev: Soc Sci Res Race*. 2011;8(1):115–132.
14. Hardeman RR, Medina EM, Kozhimannil KB. Structural racism and supporting black lives — the role of health professionals. *N Engl J Med*. 2016;375(22):2113–2115.
15. Sealy-Jefferson S, Mustafaa FN, Misra DP. Early-life neighborhood context, perceived stress, and preterm birth in African American Women. *SSM - Popul Health*. 2019;7:100362.
16. Chambers BD, Arabia SE, Arega HA, et al. Exposures to structural racism and racial discrimination among pregnant and early post-partum Black women living in Oakland, California. *Stress Health*. 2020;36(2):213–219: n/a(n/a).
17. Mehra R, Boyd LM, Ickovics JR. Racial residential segregation and adverse birth outcomes: a systematic review and meta-analysis. *Soc Sci Med*. 2017;191:237–250.
18. Salow AD, Pool LR, Grobman WA, Kershaw KN. Associations of neighborhood-level racial residential segregation with adverse pregnancy outcomes. *Am J Obstet Gynecol*. 2018;218(3):351.
19. Chambers BD, Erausquin JT, Tanner AE, Nichols TR, Brown-Jeffy S. Testing the association between traditional and novel indicators of county-level structural racism and birth outcomes among black and white women. *J Rac Ethn Health Dispar*. 2018;5(5):966–977.
20. Scott KA, Bray S, McLemore MR. First, do no harm: why philanthropy needs to *re*-examine its role in reproductive equity and racial justice. *Health Equity*. 2020;4(1):17–22.
21. Roberts D. *Fatal invention: how science, politics, and big business re-create race in the twenty-first century*. Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-first Century. New York: New Press; 2011.
22. Muse S, Gay ED, Aina AD, et al. Setting the standard for holistic care of and for Black women. Black Mammas Matter Alliance. http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf. Published April 2018. Accessed Febrary 22, 2020.
23. Oparah JC, Arega H, Hudson D, Jones L, Oseguera T. *Battling over birth: black women and the maternal health care crisis*. Battling Over Birth: Black Women and the Maternal Health Care Crisis. Amarillo: Praeclarus Press; 2017.
24. Scott K, Bray S, Asiodu I, McLemore MR. An inconvenient truth: you have no answer that Black women don't already possess. Black Women Birthing Justice. https://www.blackwomenbirthingjustice.org/single-post/2018/10/31/An-inconvenient-truth-You-have-no-answer-that-Black-women-don't-already-possess. Published October 2018. Accessed Feb 20, 2020.
25. McLemore MR, Asiodu I, Crear-Perry J, et al. Race, research, and women's health: best practice guidelines for investigators. *Obstetr Gynecol*. 2019;134(2):422–423.
26. Scott KA. Redesigning perinatal quality improvement: community driven measures, meanings, and methods. Brooklyn Grows. https://www.brooklyngrows.com/blog/2019/11/3/redesigning-perinatal-quality-improvement-community-driven-measures-meanings-and-methodsnbsp. Published November 2019. Accessed March 1, 2020.
27. Ross L, Derkas E, Peoples W, Roberts L, Bridgewater P, eds. *Radical reproductive justice: foundation, theory, practice, critique*. Radical Reproductive Justice: Foundation, Theory, Practice, Critique. New York: Feminist Press at CUNY; 2017.
28. Davis DA. Obstetric racism: the racial politics of pregnancy, labor, and birthing. *Med Anthropol*. 2019;38(7):560–573.
29. Washington HA. *Medical apartheid: the dark history of medical experimentation on Black Americans from colonial times to the present*. Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present. New York: Doubleday; 2006.
30. Roberts DE. *Killing the black body: race, reproduction, and the meaning of liberty*. Killing the Black Body: Race, Reproduction, and the Meaning of Liberty. New York: Vintage Books; 1999.
31. Johnson J, Green C, Vladutiu C, Manuck T. Abstract 44: Racial disparities in prematurity persist among women of high socioeconomic status (SES). *Am J Obstetr Gynecol*. 2020;222(1):S37–S38.
32. Eichelberger KY, Alson JG, Doll KM. Should race be used as a variable in research on preterm birth? *AMA J Ethics*. 2018;20(3):296–302.
33. Scott KA, Britton L, McLemore MR. The ethics of perinatal care for Black women: dismantling the structural racism in "Mother Blame" narratives. *J Perinat Neonatal Nurs*. 2019;33(2):108–115.
34. McLemore MR. To prevent women from dying in childbirth, first stop blaming them. *Sci Amer*. 2019;320(5):48–51.
35. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press; 2001.
36. Smedley BD, Stith AY, Nelson AR. eds. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington DC: National Academies Press (US); 2003.
37. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(18).
38. Sigurdson K, Mitchell B, Liu J, et al. Racial/Ethnic disparities in neonatal intensive care: a systematic review. *Pediatrics*. 2019;144(2).
39. American College of Obstetrics and Gynecology. American Society of Addiction Medicine. Committee Opinion No. 711: Opioid use and opioid use disorder in pregnancy. *Obstet Gynecol*. 2017;130(2):e81.
40. Hollander MAG, Jarlenski MP, Donohue JM, Cole ES, Kelley D, Krans EE. Medical specialty of buprenorphine prescribers for pregnant women with opioid use disorder. *Am J Obstet Gynecol*. 2019;220(5):502–503.
41. Guttmacher Institute. *Substance Use during Pregnancy*. Guttmacher Institute; 2016 https://www.guttmacher.org/print/state-policy/explore/substance-use-during-pregnancy. Accessed March 1, 2020.
42. Martin CE, Scialli A, Terplan M. Unmet substance use disorder treatment need among reproductive age women. *Drug Alcohol Depend*. 2020;206:107679.
43. Roberts SCM, Nuru-Jeter A. Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *J Behav Health Serv Res*. 2012;39(1):3–16.
44. Brandi K, Woodhams E, White KO, Mehta PK. An exploration of perceived contraceptive coercion at the time of abortion. *Contraception*. 2018;97(4):329–334.

45. Thorburn S, Bogart LM. Conspiracy beliefs about birth control: barriers to pregnancy prevention among African Americans of reproductive age. *Health Educ Behav*. 2005;32(4):474–487.
46. Jackson AV, Karasek D, Dehlendorf C, Foster DG. Racial and ethnic differences in women's preferences for features of contraceptive methods. *Contraception*. 2016;93(5):406–411.
47. McLemore M, Scott KA. *What is Reproductive Justice?* Hollywood, Health, and Society; 2019 https://youtu.be/I4mwQhKLBiM, Accessed March 1, 2020 [Video educational tool].
48. Kilpartick SJ, Papile LA. Guidelines for Perinatal Care. 8th ed. Washington, D.C: American College of Obstetrics and Gynecology; 2017.
49. Josephs J. The JJ Way™ model of maternity care. https://commonsensechildbirth.org/jjway/. Accessed February 20, 2020.
50. Hardeman RR, Karbeah JM, Almanza J, Kozhimannil KB. Roots community birth center: a culturally-centered care model for improving value and equity in childbirth. *Healthcare*. 2019;8(1):100367.
51. Hardeman RR, Karbeah JM, Kozhimannil KB. Applying a critical race lens to relationship-centered care in pregnancy and childbirth: an antidote to structural racism. *Birth*. 2020;47(1):3–7.
52. CHOICES: Memphis Center for Reproductive Health. https://memphischoices.org/. Accessed March 3, 2020.
53. Thorland W, Currie DW. Status of birth outcomes in clients of the nurse-family partnership. *Matern Child Health J*. 2017;21(5):995–1001.
54. Hardeman RR, Kozhimannil KB. Motivations for entering the doula profession: perspectives from women of color. *J Midwifery Womens Health*. 2016;61(6):773–780.
55. Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C, O'Brien M. Doula care, birth outcomes, and costs among medicaid beneficiaries. *Am J Public Health*. 2013;103(4):e113–e121.
56. McLemore MR, Warner Hand Z. Making the case for innovative reentry employment programs: previously incarcerated women as birth doulas - a case study. *Int J Prison Health*. 2017;13(3–4):219–227.
57. Chor J, Hill B, Martins S, Mistretta S, Patel A, Gilliam M. Doula support during first-trimester surgical abortion: a randomized controlled trial. *Am J Obstet Gynecol*. 2015;212(1):45.e1–45.e6.
58. Chor J, Lyman P, Tusken M, Patel A, Gilliam M. Women's experiences with doula support during first-trimester surgical abortion: a qualitative study. *Contraception*. 2016;93(3):244–248.
59. Stanley D, Sata N, Oparah JC, McLemore MR. Evaluation of the East Bay Community Birth Support Project, a community-based program to decrease recidivism in previously incarcerated women. *J Obstet Gynecol Neonatal Nursing*. 2015;44(6):743–750.
60. Southern Birth Justice Network. Southern Birth Justice Network: Birth Workers in Action. https://southernbirthjustice.org/. Accessed Feb 26, 2020.
61. Rayburn WF. *The obstetrician-gynecologist workforce in the United States: facts, figures, and implications*. Washington, DC: The American Congress of Obstetricians and Gynecologists; 2017.
62. Xierali IM, Castillo-Page L, Conrad S, Nivet MA. Analyzing physician workforce racial and ethnic composition associations: geographic distributions. AAMC Analysis in Brief. 2014; 14(9). https://www.aamc.org/system/files/reports/1/aug2014aibpart2.pdf. Published August 2014. Accessed February 26, 2020.
63. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med*. 1999;159(9):997–1004.
64. Cooper Owens D. *Medical bondage: race, gender, and the origins of American Gynecology*. Medical Bondage: Race, Gender, and the Origins of American Gynecology. Athens, GA: University of Georgia Press; 2017.
65. Ward TJ. *Black physicians in the Jim Crow South*. Black Physicians in the Jim Crow South. Fayetteville, AK: University of Arkansas Press; 2003.
66. Stache LC, Craven C, Christa. Craven, Crista. *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement*. *Women Stud Commun*. 2012;35(2):228–230.
67. Manton WP. The role of obstetrics in preventative medicine. *J Am Med Assoc*. 1910;55(6):459–463.