Making Maternal Mortality Public: Racialized Reproduction in Medical Review,

Investigative Journalism, and Birth Justice Activism

by

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As public efforts to prevent maternal death in the U.S. intensify, racial disparities have become particularly salient—Black women and birthing people are two to three times more likely to die from pregnancy and childbirth complications than their White counterparts. Examining interrelated processes by which maternal mortality and racial disparities become public, this dissertation asks: How is maternal mortality made legible as an issue for public action? Rhetorical criticism of communication by public health and medical professionals, journalists, activists, and government officials, reveals how each approach illuminates some aspects of the problem while obscuring others. One case study explores how Maternal Mortality Review Committee (MMRC) data collection and assessment practices attune us to view pregnancy-related death as a physiological or medicalized phenomenon, in the process downplaying social determinants of health that may account for racial disparities. The ostensibly neutral evidentiary practice of excluding homicides and suicides from review may underestimate racial disparities in maternal mortality. The case of National Public Radio/ProPublica's "Lost Mothers Project" shows how media coverage can raise consciousness and make maternal mortality more actionable, even as it centers the norm of White motherhood by invoking entrenched figures of unhealthy/irresponsible Black bodies. A third case study focuses on how birth justice activists associated with the Black Mamas Matter Alliance strive to create a counterpublic that thematizes an alternative human rights framework for addressing the challenge. Rhetorical critique illuminates the relationship between

frames used for making maternal mortality publicly legible and the solutions proposed for preventing maternal death, yielding original insight with implications for scholarship in public health, rhetoric of health and medicine, and reproductive justice. This study finds that because race-neutral approaches obscure how the U.S. legacy of violence and oppression toward Black birthing people configure the Black maternal body as risky, they are less likely to benefit Black birthing people and thus ameliorate alarming racial disparities. In addition, Given that prevailing medical standards and notions of evidence are insufficient to account for the work of reproductive justice organizations, the study highlights an urgent need to integrate knowledge and experience from these groups into standards for birth equity.

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Preface

The day we first met to discuss my dissertation proposal, my advisor handed me a copy of a book called "Destination Dissertation: A Traveler's Guide to a Done Dissertation." Despite the cheesy title of Sonya Foss and Williams Waters' book, it was immensely helpful and the metaphor it uses is apt. The journey that led to this dissertation began long before I started writing, and I am confident that this project's journey is not over yet. I am grateful, however, for the opportunity to document this moment and to thank those who have been my companions and supports along the way so far.

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have the opportunity to experience that light.

1.0 Introduction

Each year, over 700 women and birthing people in the U.S. die from complications related to pregnancy or childbirth (Centers for Disease Control and Prevention 2020a). Over 50,000 more experience severe complications, such as heart attacks or hemorrhages. Despite spending more on healthcare than any other wealthy nation in the world, the maternal mortality rate in the U.S. has been rising for the last two decades (Centers for Disease Control and Prevention 2020b). Over two-thirds of pregnancy-related deaths are believed to be preventable. Black women and birthing people are bearing the brunt of this burden; they are at least two to three times more likely than their White counterparts to die due to complications of pregnancy and childbirth (Centers for Disease Control and Prevention 2020b).

American publics are becoming increasingly aware of this problem as maternal death is highlighted as a major public health issue. Since 2015, efforts to research and prevent maternal deaths across the country have intensified, and racial disparities in maternal health have repeatedly been thematized in mainstream media outlets (Martin and Montagne 2017b; Villarosa 2018). This is a critical time to attend to the ways maternal death is portrayed as a public issue. Yet, as anthropologist and law professor Khiara Bridges reminds us, these discourses are entering an ongoing conversation, since activists for racial justice have long "articulated that racial disparities in maternal mortality are a manifestation of broader systemic racism" (2020, 1233-4). Given our country's history of controlling and oppressing the reproductive lives of Black women and the legacy of institutional racism in medicine and public health, the knowledge being produced and circulated about racial disparities in maternal health (and the lack thereof) needs to be critically evaluated.

Further evidence documenting growing salience of the topic can be found in The Preventing Maternal Deaths Act, unanimously passed by the U.S. Senate and signed into law by President Donald Trump in 2018. The Preventing Maternal Deaths Act was the first U.S. legislation in many years to directly address the issue of maternal health. Specifically, the law provides $12 million annually over five years to state- and locally-based Maternal Mortality Review Committees (MMRCs). MMRCs review maternal deaths in their area and are expected to identify factors that contribute to individual deaths and develop recommendations for prevention (Creanga and Callaghan 2017; St. Pierre et al. 2018).

The passage of the Preventing Maternal Deaths Act was a notably bipartisan process in an otherwise politically divisive and contentious period. Alyson Northrup, Government Affairs Specialist for the Association of Maternal & Child Health Programs, writes that one reason the bill moved so quickly through the committee process was:

> It was a bipartisan effort. It supported the expansion of ongoing activities that were tested in the "laboratory of states." And national awareness and outrage over maternal mortality in the United States was growing. This increased awareness was fueled by significant national press attention, in particular, the NPR/ProPublica 2018 Pulitzer Prize finalist series "Lost Mothers." (Northrup 2018)

Northrup's comments highlight how public awareness is shaped by media projects, and how that public awareness in turn, figures in influencing public action around maternal mortality.

At the same time, however, Bridges (2020) points out that despite clear evidence that the problem of maternal mortality is a racial problem, the Preventing Maternal Deaths Act avoids the issue of race entirely. In fact, obstetrician and activist Dr. Joia Crear-Perry makes this observation in at the congressional hearing prior to the bill's passage: "Throughout the bill, there is no mention

of race, racism, or racial disparities. The inability to name this as a key focus to reduce RACIAL disparities in maternal mortality and morbidity will continue to exacerbate the problem" (Better Data and Better Outcomes: Reducing Maternal Mortlaity in the U.S. 2018, 65). Crear-Perry was at the hearing to represent two prominent birth justice organizations – the National Birth Equity Collaborative and the Black Mamas Matter Alliance – who are committed to centering the needs and experiences of women of color in order to improve maternal health in the U.S.

The erasure of race may have built bipartisan support for the Preventing Maternal Deaths Act, as Bridges argues: "Inattention to the fact that the United States is a dangerous place for *black* women to give birth probably accounts for why it was easy for lawmakers to reach across the aisle and find a point of agreement with lawmakers who shared different political commitments" (2020, 1297). Bridges goes on to note that this inattention to race in the early stages of the federal legislative process creates conditions, on state and local levels, for government officials and review committees to avoid addressing issues of structural and systemic racism. She points, for instance, to Louisiana's MMRC, which largely focused on how women's health behaviors led to pregnancy complications. The review committee recommended that "if the state was going to lower its maternal mortality rate, women needed stop smoking and lose weight" (1310). Rather than addressing glaring gaps and inequities in the state's healthcare system, Louisiana's MMRC blamed women for being unhealthy. Thus, Bridges argues, the existence of a state MMRC does not guarantee improved maternal health outcomes and can even result in adverse outcomes for Black women when recommendations are used to justify increased state surveillance.

This perspective on the Preventing Maternal Deaths Act foregrounds the fact that many stakeholders are attempting to publicly address maternal mortality in this country, and that each effort can illuminate some aspects of the problem while obscuring others. Although framed in the

idiom of scientific objectivity, knowledge produced and circulated by MMRCs is not neutral, and neither are the narratives in the news media that contribute to public awareness. Birth justice activists – like Dr. Joia Crear-Perry and her colleagues in the Black Mamas Matter Alliance – are acutely aware of the possibilities and risks of publicly sharing stories of Black birthing people. Each of these ways of making maternal mortality public has an impact on the kinds of collective action and solutions that are considered to be appropriate and effective. As Bridges writes: "if the general discourse that surrounds racial disparities in maternal mortality is impoverished, then we should expect that the solutions that observers propose to this problem will be impoverished as well" (2020, 1235). Rhetorical scholars have long attended to the process by which problems are taken up by society and the discussions and deliberation that occur as people decide on collective actions to take in response. My project brings this tradition to bear by asking: How is maternal mortality made legible as an issue for public action? In this dissertation, I specifically examine how maternal mortality is made public through three inter-related processes: medical review, investigative journalism, and birth justice activism.

In the rest of this introduction, I review three bodies of literature relevant to understanding how maternal mortality is made public and the role of race, racism, and racial disparities in that process. First, I survey public health scholarship on racial disparities in maternal mortality to inventory the range of perspectives on the problem growing out of the scientific literature. Second, I review ways that rhetoricians have conceptualized what it means for something to be public and for people to participate in publics, with special attention to the role of Black counterpublics. Finally, I turn to literature on reproductive justice in the communication discipline, which contributes to our understanding of the ways that the experiences and needs of marginalized women have been rendered invisible in the mainstream reproductive rights movement. In the

closing pages of the chapter, I detail the critical approach taken to explore the three case studies featured in the dissertation and preview the study's chapter structure.

1.1 Racial Disparities in Maternal Mortality

While there is debate and discussion in the literature as to the causes of racial disparities in maternal mortality, it is clear from the data that Black birthing people have, for many years, been much more likely than Whites to die due to pregnancy-related complications. Since the Centers for Disease Control and Prevention (CDC) began collecting data on maternal mortality in 1940, Black women have been found to be at least twice as likely to die than White women (Baudry et al. 2018, 16). Recent data indicates that Black women in the U.S. are three to four times as likely to die from pregnancy-related causes than White women (Centers for Disease Control and Prevention 2019; Petersen et al. 2019). In some locations, the disparity is even higher; in New York City, for instance, from 2006 to 2010, Black women were twelve times more likely than White women to die from pregnancy-related causes (Boyd et al. 2010, 9). This is likely due to recent efforts in the city to reduce maternal mortality overall, which have mostly led to improvements in outcomes for White women and thus widened the racial disparity (Baudry et al. 2018).

It is important to note before we proceed that, in addition to the drastic disparities between Black women and White women, there are also disparities between White women and women in other racial groups. Specifically, between 2011 and 2015 the maternal mortality ratio for indigenous women was 2.5 times as high as the rate among White women. The rate among

Asian/Pacific Islander women was slightly higher than that of White women (13.8 as opposed to 13.4 out of 100,000) (Centers for Disease Control and Prevention 2020b).

This dissertation, however, focuses on discourses about Black maternal health and Black maternal death because most of the conversation around racial disparities in maternal mortality in the last few years has focused on Black women. As Bridges notes, "the issue of maternal deaths has become associated with black women…maternal mortality – and racial disparities in maternal mortality – have been racialized in a particular way" (2020, 1238). Any effort to interrogate the ways maternal mortality is made public, then, must necessarily attend to ways that maternal mortality has been racialized as Black. Furthermore, as Bridges goes on to emphasize, while Black, Latinx, Asian, and indigenous people are all "racially unprivileged vis-à-vis white people," (1238) each of these groups has been racialized in a distinct way. Therefore, expanding the focus of the project to include all these groups together, for instance to write about "nonwhite women" or "women and birthing people of color" would problematically collapse together the experiences of a multiplicity of groups when it comes to maternal health.

The public health literature on racial disparities in maternal death is voluminous and features multiple hypotheses regarding possible causes of those dramatic disparities. Although this project is not designed to answer questions about the causality of high rates of maternal death or the drastic racial disparities in maternal health outcomes, it is likely that a combination of factors are having a significant impact. As a rhetorical scholar, I know that the specific causes emphasized will impact the kinds of solutions imagined. Therefore, I am interested in the role the information in the public health literature plays as maternal mortality is constructed as public problem. Below, I review a range of hypotheses that inform and animate processes by which maternal mortality is made public.

For many years, it was assumed that racial health disparities in general were a reflection of disparities in socio-economic class between racial groups. However, studies have found that racial disparities in maternal mortality persist across income levels and education status (Harper et al. 2004; Novoa and Taylor 2018). Many also point to higher rates of chronic conditions among women generally as a cause of the U.S.'s high rate of maternal death, but racial disparities in maternal mortality cannot be explained by higher rates of pre-existing chronic conditions (Bingham, Strauss, and Coeytaux 2011; Grobman et al. 2015; Howell et al. 2016). Other hypotheses public health researchers have posited as explanations for drastic racial disparities in maternal health include genetic theories of race, differing health behaviors, and larger social-environmental conditions.

Although genetic theories of race have been discredited, assumptions about the link between genetics and racial health disparities persist in the public health literature. The genetic approach to race "proposes that the groups that we consider to be races (i.e., Black, White, Asian, indigenous, etc.) exist as such because the individuals within each group are more genetically similar to one another than they are to individuals outside of their group" (Bridges 2020, 1253). Studies have found that race and ethnicity are poor proxies for genetic variation, there is minimal genetic variation between racial groups, and the genetic model does little to explain distributions of disease (Diez Roux 2012; Dressler, Oths, and Gravlee 2005). As legal scholar Dorothy Roberts points out: "It is implausible that one race of people evolved to have a genetic predisposition to heart failure, hypertension, infant mortality, diabetes, and asthma. There is no evolutionary theory that can explain why African ancestry would be genetically prone to practically every major common illness" (2011, 15).

Nevertheless, the racial-genetic model still persists and is embedded in some epidemiological approaches to studying racial disparities (Mendez and Spriggs 2008; Risch et al. 2002). Bridges writes that in her survey of this literature, she found that "even if an author ultimately rejects the idea that race has genetic or biological essence, she has to at least gesture to the possibility that black women's genes are killing them" (2020, 1255).

Another approach to explaining racial health disparities in general is the health behavior model, which emphasizes "differences between racial and ethnic groups in the distribution of individual behaviors related to health, such as diet, exercise and tobacco use" (Dressler, Oths, and Gravlee 2005, 234). While health behaviors can contribute to disease risk, differences in health behaviors have not made a significant contribution to understanding racial and ethnic health disparities (Dressler, Oths, and Gravlee 2005, 238). In addition, this approach continues to shift focus (and blame) to individual choices rather than more probable social and systemic explanations of racial health disparities (Krieger 2011, 153). In her ethnographic study of a women's health practice in a New York State public hospital, Bridges describes the way that concern about health behaviors has led to stringent requirements for receiving pre-natal care through Medicaid. As a condition of receiving Medicaid, Bridges writes,

> women were required to meet with a battery of professionals – namely social workers, health educators, nutritionists, and financial offers – who are legally obliged to inquire into areas of women's lives that frequently exceed the realm of the medical…Medicaid mandates intrusion into women's private lives and produces pregnancy as an opportunity for state supervision, management, and regulation of poor, otherwise uninsured women. (2011, 19)

For Bridges, excessive attention to individual's choices, lifestyles, and behaviors deflects attention from the macro-level factors that impact those decisions.

Some of the macro-level factors have been posited to help explain racial disparities in maternal mortality are poverty, race-based stress, and quality of care. As noted above, socio-economic class differences do not fully account for racial disparities in maternal mortality. That said, it is indisputable that a disproportionate number of Black people in the U.S. live in poverty, and that the health of people who live in poverty suffers because of it (Phipps 2003). People who live in poverty are more likely to be exposed to pollutants and toxins (Holifield 2001; Moody and Grady 2021) and are less likely to have easy access to high-quality nutritional foods (Hilmers, Hilmers, and Dave 2012). They are also likely to have a difficult time accessing health care. The National Center for Health Statistics data for 2014 indicated that 32% of people below poverty level, and 31% of those between 100%-200% of the poverty level were uninsured. For people above 200% percent of the poverty level, only 9% were uninsured (Center for Poverty and Inequality Research 2015). Although many poor pregnant women are eligible for Pregnancy-Related Medicaid to cover prenatal care and other services related to their pregnancy, it can also be difficult to physically reach providers who accept Medicaid insurance. There has been a nationwide trend in obstetrics practices closing in poor communities. Tara Wilson (2018), for instance, argues that the closure of obstetrics units in the poorest neighborhoods in Washington, D.C. has exacerbated the maternal mortality crisis there.

Race-based stress is another possible explanation for high rates of maternal death among Black women. Public health researcher Arline Geronimus (1987) first introduced the "weathering" theory in the early 1990s, after noting that Black women who gave birth at younger ages (in their teens and early twenties) had better health outcomes than their White counterparts, while Black

women who gave birth when they were older (in their thirties) had worse outcomes than their White counterparts. Geronimus's explanation for the inverse relationship between age and maternal health outcomes among Black in women in particular was chronic stress. Age, Geronimus suggested, could be viewed as "an indicator of the length of exposure to life conditions that either undermine health (as in the case of the disadvantaged) or promote it (in the case of the advantaged)" (Geronimus and Bound 1990, 464). Stress specifically is theorized as a social determinant of health, distinct from (but obviously related to) other determinants such as poverty or education. Chronic stress – measured in terms of an "allostatic load" – is thought to increase the speed at which bodies deteriorate. Geronimus uses the metaphor of "weathering" to describe the way this allostatic load creates a wear and tear on Black women's bodies. As she describes it:

> Weathering goes beyond the view that maternal age variables are proxies for social disadvantage to suggest that they be seen as reflections, on a population level, of the ways in which socioeconomic inequality, racial discrimination, or race bias in exposures to environmental hazards may affect differentially the health of women who will become mothers, not only in absolute terms, but also interactively with each other and *increasingly as women age*. (1992, 210)

According to the weathering hypothesis, the health of Black women will begin to deteriorate in early adulthood because their body has been exposed to prolonged chronic stress.

Geronimus and colleagues suggest that the intersection of racism and sexism is a particularly strong driver of chronic stress. Black women have been found to shoulder higher allostatic loads than Black men or White women, with the discrepancy particularly pronounced when comparing nonpoor Black women with nonpoor White women (Geronimus et al. 2006, 830). The research on the potential role of stress and racism is still in its early stages, and the mechanisms

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by which stress might impact maternal health is still unclear (Gadson, Akpovi, and Mehta 2017), but Geronimus's research and the weathering hypothesis have taken on a prominent role in explaining the high rates of maternal mortality and morbidity among Black birthing people.

Finally, many have pointed to inferior quality of care as a key explanation for racial disparities in maternal mortality. Some causes of maternal death – such as cardiovascular conditions, cardiomyopathy, and hemorrhage – occur frequently across racial groups. However, deaths from embolism, preeclampsia, and eclampsia are much more common among Black women than White women (Building U.S. Capacity to Review and Prevent Maternal Deaths 2018, 6). Deaths due to preeclampsia and eclampsia are highly preventable, as there are a number of clear warning signs and known treatments. The Building U.S. Capacity to Review and Prevent Maternal Deaths team points out that over a three-year period, only two people died from preeclampsia and eclampsia in the UK. While the CDC estimates that nearly 60% of all pregnancy-related deaths are preventable, the rate may be even higher for Black women, who are dying at a higher rate due to preventable complications like preeclampsia and eclampsia. Preventable deaths, of course, are prevented by high quality medical care.

Racial disparities in quality of healthcare have been widely reported – in 2003 the Institute of Medicine released the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, and Nelson 2003). The report concluded that people of color receive lower-quality health care than White people even when one controls for insurance status, income, age, and severity of conditions. Most scholars posit that these discrepancies are a result of implicit bias, not widespread bigotry amongst medical professionals. Regardless of intent, however, they still have a strong impact. Not only will patients of color receive lower quality treatment, but if they believe a doctor is treating them rudely, dismissing their concerns, or otherwise giving them

inferior care, their relationship with the provider will be damaged, and they may even avoid going to the doctor altogether. This in turn – the report suggests – may further exacerbate racial health disparities.

On a broader level, it is becoming apparent that the hospitals in which Black women deliver their babies tend to provide inferior quality care. Seventy-five percent of Black women in the U.S. deliver their babies at just twenty-five percent of the hospitals. Just eighteen percent of White women delivered in those hospitals (Howell 2018, 391). The rates of maternal death at hospitals that serve a large proportion of Black women are higher than those at "low Black serving hospitals" (Howell et al. 2016, 122). White patients who deliver at low Black-serving hospitals also have a lower rates of severe complications – 12.3 per 1000 deliveries. In contrast, Black patients at high-Black serving hospitals had a SMM of 20.5 per 1000 deliveries (Howell et al. 2016, 122). Both Black and White patients who delivered in high black-serving hospitals had a higher risk of severe maternal morbidity after accounting for patient characteristics (Howell et al. 2016, 122). The conclusion, overall, appears to be that the quality of care in high-Black serving hospitals is lower, likely as a result of poorer funding, training, and access to other resources. As Bridges notes, "a likely effective avenue to reducing or eliminating racial disparities in maternal mortality is to improve the quality of the care offered at the (functionally segregated) hospitals where black women find themselves giving birth in large numbers" (2020, 1266).

Public health literature suggests there are multiple ways to tell the story of racial disparities in maternal health. From problematic racial-genetic models, to individual health behaviors, to the systems that lead to poverty, exposure to racism, and inequalities in care, there is a wide range of explanations in the published scholarship. Although my study is not designed to answer questions about the causality of high rates of maternal death or the drastic racial disparities in maternal health

outcomes, it seems clear that a combination of factors is in play. The specific causes that are emphasized in public health literature, media, and other public discussions will have an impact on the kinds of solutions we are collectively able to imagine. In addition, historical, systemic, and institutional forces make certain kinds of solutions inherently easier to imagine than others. For example, there is already an infrastructure for providing additional training to hospital staff on medical issues. As a result, as rhetorical critics, it is important to focus on macro-level issues that are often dismissed as too difficult to address. These questions about the kinds of solutions we imagine are questions about publics and publicity, because these are decisions that will be made collectively by a wide variety of actors. Therefore, the next step in situating this project on how maternal mortality is made public is to examine the ways rhetorical scholars have thought about publics and publicity. What does it mean for something to be public and how do people participate in publics?

1.2 Publics and Counterpublics

Since its origins in ancient Greece, the practice of rhetoric has been intimately linked with public decision-making. The ability to speak convincingly was essential to participation in the emerging democracy at the time, and participation in social and political life was an expectation for all citizens. When it came to making collective decisions, Aristotle emphasized the role of rhetoric: "The duty of rhetoric is to deal with such matters as we deliberate upon without arts or systems to guide us…The subjects of our deliberation are such as seem to present us with alternative possibilities" (1357a). Of course, the means of communicating with large groups of people have proliferated since Aristotle's time, as various forms of media can circulate speech,

text, or video rapidly. While the means by which people communicate have become more complex, rhetoric still plays a key role in the collective participation in political, social, and cultural meaning-making.

Contemporary discussions about public deliberation tend to begin with Jürgen Habermas's (1989) *The Structural Transformation of the Public Sphere*, originally published in 1962 and translated into English in 1989. Habermas, examining political and social life in 18th-century France, argues that the bourgeois public sphere presents opportunities for elites to participate in political life by engaging in rational-critical debate about social issues. This public sphere is separate from other key institutions – such as the state, religion, or the market – and is necessary to decision-making in a participatory democracy. In the ideal public sphere Habermas uses as a benchmark to evaluate actually existing publics, debate and deliberation lead to consensus, and that consensus serves as a mandate for political action. Three criteria are necessary for the possibility of consensus: a disregard of status, a domain of common concern, and a practice of inclusivity. Habermas is concerned that the public sphere is being colonized by instrumental logics that subvert communicative rationality, a process accelerated by the spread of capitalism and rise of mass media conglomerates.

Rhetorical scholars have responded to Habermas's work by pointing out that the bourgeois public sphere he describes was not, in fact, the only public discourse in existence at the time. Rather, Nancy Fraser argues that his view of the public sphere "rests on a class- and gender-based notion of publicity, one which accepts at face value the bourgeois public's claim to be *the* public" (1990, 61). Furthermore, Fraser argues that the very norms for participation in the bourgeois public sphere were exclusionary. She writes: "discursive interaction within the bourgeois public sphere was governed by protocols of style and decorum that were themselves correlates and markers of

status inequality" (63). That is, there is no way to disregard status in the bourgeois public sphere, as Habermas suggests. Rather, the very rules of engaging in debate and deliberation in the public sphere served as a form of exclusion and domination of marginalized groups.

Fraser (1990) argues that in a structurally unequal society, our best chance to narrow the gap in public participation between dominant and subordinate groups is to form a network of multiple public spheres. Subordinated social groups, she points out, have always found it advantageous to form alternative publics in which they "invent and circulate counterdiscourses, which in turn permit them to formulate oppositional interpretations of their identities, interests, and needs" (1990, 67). Fraser refers to these alternative publics as subaltern counterpublics. Fraser advocates for discussion, debate, and contestation within and among both the dominant public and the subaltern counterpublics. One of the key issues of debate, for Fraser, should what constitutes a matter of public, or common, concern: "there are not naturally given, a priori boundaries here," she writes, "What will count as a matter of common concern will be decided precisely through discursive contestation" (71). Thus, Fraser highlights that we can discursively make certain issues public, that is, persuade others that they are matters of common concern that should be addressed collectively.

Other rhetorical theorists of publics and counterpublics largely agree that we should conceptualize public discourse as occurring within and across a network of spheres, and that one comprehensive public sphere neither exists nor would be beneficial for public life. Catherine Squires (2002) specifically aims to theorize how Black public spheres fit into the broader network of publics. She argues that a shared marginal identity, such as being recognized as Black, is not in and of itself enough to constitute a subaltern counterpublic. If, as she writes, a public sphere is "a set of physical or mediated spaces where people can gather and share information, debate opinions,

and tease out their political interests and social needs with other participants" (448), the Black public sphere will specifically "engage in common discourses and negotiations of what it means to be Black" and "pursue particularly defined Black interests" (454).

The specific contexts, goals, and desires of a given Black public will shape their interactions with other marginalized publics as well as the dominant public sphere. Squires provides three models: enclaves, counterpublics, and satellites. Enclaves focus on preserving Black culture, fostering resistance, and creating strategies for the future. They typically exist in conditions where the Black community is facing strong opposition and has few resources; therefore, their resistant discourse is largely hidden from the dominant public and the state. As overt oppression decreases and the Black community gains resources, Squires (2002) argues that counterpublic spheres are likely to emerge. Counterpublics aim to test their messaging by sharing previously hidden opinions, persuading members of the dominant public, and building alliances with other marginalized groups. Therefore, counterpublics have more face-to-face and mediated engagement with other publics. Finally, Squires points out that some Black publics may isolate themselves from other publics by choice: "In contrast to an enclaved public, where distance from wider publics is the result of oppression, satellite public spheres are formed by collectives that do not desire regular discourse or interdependency with other publics" (463). Satellite publics may only enter into wider public discussion when it directly benefits their interests or when their institutions or practices are causing conflict with other groups.

While Squires (2002) specifically writes about Black public spheres, her arguments can be extended to apply to other marginalized publics. Karma Chávez (2011), for instance, writes about the importance of enclaves for queer rights and migrant rights organizations. Chavez builds on Squires's argument about enclaves, noting that although enclaves can form because a marginalized

group needs to withdraw from the harsh treatment they experience in the dominant public, "such spaces are always a necessary part of movement activity regardless of the level of oppression or crisis that groups face" (2). Chávez demonstrates that enclaves are important sites of social movement activity, and that the meaning-making that is produced in enclaves can allow for coalition-building between social movement groups.

Other rhetorical theorists of publics and counterpublics concede that publics can be conceptualized as a network but emphasize that publics are not fixed entities. Both Gerard Hauser (1999) and Michael Warner (2002) argue that publics are emergences or processes. For Hauser, publics emerge through attention to a shared problem. When people engage in vernacular rhetoric – or everyday conversation – to address mutual problems and find reasonable solutions they are manifesting a public sphere. Hauser's approach to public spheres assumes "a lattice of interconnected, permeable spheres where participants engage in conversations in which they identify and discuss their opinions and interests as well as the ways in which differences in opinions and interests may be accommodated based on principles of reasonableness and tolerance" (1999, 60-1). Thus, people may participate in multiple, overlapping public spheres, depending on their identities, concerns, and interests.

Hauser acknowledges that some of these public spheres will involve marginalized groups, but argues that any claims made about "the roles and interactions of various public spheres [should be] discourse-based, that is, based on the discursive features of the exchange rather than a priori assumptions" (1999, 61). That is, rather than forming a conceptual model about how counterpublics function in relation to dominant public spheres, Hauser advocates that scholars attend to actual interactions in public spheres in order to make claims about how specific members of publics engage with one another. This reflects Hauser's overall focus on the way members of

the public engage with one another about shared problems, as opposed to spending time identifying and delineating specific public spheres. Hauser's focus on shared problems is useful for reminding us that when we say that something is public, we typically mean that it is an issue of common concern on which people may disagree, but collectively seek to address.

For Warner (2002), publics are also processes, but they emerge through attention to texts. As texts circulate and respond to one another, the audience that attends to that circulation is participating in a public. Warner particularly emphasizes that publics are in some sense imaginary; members of a public may never meet or interact directly. As Warner describes it: "a public enables reflexivity in the circulation of texts among strangers who become, by virtue of their reflexively circulating discourse, a social entity" (12). For Warner, counterpublics are defined by their tension with a larger public; participants in a counterpublic are in some way distinct from persons or citizens in general. In addition, the rules of discussion within a counterpublic are different. He writes: "being structured by alternative dispositions or protocols, making different assumptions about what can be said or what goes without saying" (56). To the extent that a public is conscious of its subordinate status, for Warner, it is a counterpublic.

Warner (2002) is particularly interested in queer counterpublics, so he emphasizes the way counterpublics participate in a process of world-making in which new forms of gender and sexuality can be lived. Although not drawing on Warner specifically, scholars such as Shardé S.M. Davis (2018) have demonstrated that Black world-making and identity-building also refutes the discursive norms of dominant society. In the case of the 2013 #WhiteGirlsRock vs. #BlackGirlsRock controversy, Black women "were often vulgar, enraged, politically incorrect, and replete with other ratchet conduct that undermined the politics of respectability" (S.M. Davis 2018, 270). While their mutual expressions of disgust and fury would likely have been deemed

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unacceptable in larger society, they were important for establishing connections and solidarity between Black women in this context.

Recently, scholars of the rhetoric of health and medicine have begun to attend to the ways that rhetorical theories of publics and publicity can provide insight into how people organize around biological, medical, and health issues. Lisa Keränen (2014) argues that rhetorical theories of publics can help to refigure the notion of public in "public health." The notion of the public, as it is typically evoked in appeals to public health, is built on Habermasian foundations. As Jennifer Malkowski explains: "public health policy is often conceptualized, mobilized, and addressed in terms of one united mission that positions humanity against disease…however, in practice, this site is often populated by competing health practices, multiple publics, and resistant communication" (2014, 69). Keränen (2014) and Malkowski (2014) both argue that rhetorical theories can help address multiplicity of roles that stakeholders play in health practices, research, and communication, "even as it can reveal the places where public participation is curtailed or prohibited" (Keränen 2014, 105).

Malkowski (2014) explains medical publics are groups of people who are engaged by a particular health issue. Members of a medical public may not necessarily meet in person, but their attention to a health-related issue as an important, action-worthy concern that connects them to larger discourses and institutions. Medical publics may include people who work with medical establishments, and they often involve conflict, both within the medical public and between the medical public and others. Malkowski writes: "a medical public likely consists of complex networks that are comprised of people who individually intersect with medicine, but that, as a collective, can operate independently and unofficially with regard to policies and practices of Western medicine" (57). To Malkowski's definition, I would incorporate some of the diffuse-ness

of Warner's approach. The public that emerges to attend to the problem of maternal mortality, for instance, does not function as a unified collective. As illustrated in the opening of this chapter, the stakeholders addressing this problem have different, and sometimes conflicting, experiences, assumptions, priorities, and visions for the future.

The literature on publics and medical publics is necessary for a project about the processes by which a health issue comes to be considered a public problem. In the case of maternal mortality, the medical public that is forming to attend to this problem includes public health researchers, physicians, birth workers (such as midwives and doulas), social workers, journalists, and public officials. In the next section, I turn our attention to a sub-set of that medical public that has often been overlooked in communication and rhetorical scholarship – reproductive justice activism. Reproductive justice is essential to a project on racial disparities in maternal mortality because its foundational assumptions widen the lens by which we view the problem of maternal mortality, bringing a richer collection of social issues into view.

1.3 Communication and Reproductive Justice

Reproductive justice is one framework for developing assumptions and priorities related to racial disparities in maternal health. Reproductive justice is a framework developed in 1994 by a group that would come to be known as *SisterSong: Women of Color Reproductive Health Project.* In contrast to the movement for reproductive rights, which was led primarily by middle class and wealthy White women, the movement for reproductive justice centers the experiences of women of color, other marginalized women, and trans people. Women of color have long faced oppression surrounding their reproduction, not only including restrictions on their right to have an abortion,

but also infringements on their right to bear children. As a result, the three central tenets of reproductive justice converge around the principle of bodily autonomy: the right to have children, the right not to have children, and the right to parent children in safe and sustainable communities (Ross and Solinger 2017). Due to the third tenet, reproductive justice touches on a wide variety of social justice issues, including food security, incarceration and criminal justice, and environmental justice.

For communication scholars, one of the key take-aways from the reproductive justice framework is that the White movement for reproductive rights has too often rendered the experiences and needs of marginalized women invisible.[1] At the same time, when the reproductive practices of Black women and marginalized people have been made visible, they are often used to blame, demonize, and dehumanize. There is a small, but growing, body of literature on reproductive justice in the fields of rhetoric and communication. Communication and rhetorical scholars are particularly well-equipped to identify the ways that women of color are discursively maligned and to identify and foster rhetorics of resistance.

Amber Johnson and Kesha Morant Williams's (2015) analysis of the anti-abortion *Life Always* campaign identifies the way the campaign's messaging devalues Black women's reproductive capacity. This devaluing is perhaps most clearly demonstrated in the tagline on one of the campaign's billboards, which reads: "The most dangerous place for an African American is in the womb" (A. Johnson and Williams 2015, 154). Johnson and Williams argue that, while the *Life Always* campaign purports to promote Black life, it in fact deepens reproductive health

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[1] Indeed, communication scholars have written extensively (and insightfully) about the subjects of women's health (Dubriwny 2013; Hayden 1997; Sobnosky 2013), pregnancy and childbirth (Dubriwny and Ramadurai 2013; Mack 2016; Pollock 1999; Winderman 2016), and maternal healthcare (Lay 2000; K.H. Owens 2015). However, most of these projects reflect the overall reproductive rights movement in the U.S. in that they center the experiences of middle-class, White women.

disparities. A reproductive justice perspective on abortion, they note, transcends the pro-life, pro-choice dichotomy. The pro-choice framework does not account for the social, political, and economic conditions that constrain people's choices: "Even if abortion were completely legal and accessible, it would not assuage the problems women face, particularly women of color…choice presupposes unbiased information and a variety of entities to choose from" (151). Rather than advancing the agency, voice, and experiential knowledge of Black women, the *Life Always* campaign instead "channels the power of naming to further blame, ostracize, and demonize Black women" (158).

Natalie Fixmer-Oraiz (2019) demonstrates that the demonization of non-normative motherhood is baked into post-9/11 homeland security culture. She uses the term "homeland maternity" to refer to the ways motherhood and reproduction "are imagined to bolster the project of building and securing the nation" (3). In particular, expectant and new mothers are made responsible for managing risk to children and families, and this rhetoric of risk policies the motherhood of marginalized women and birthing people in particular.

In her analysis of the discourse surrounding Nadya Suleman, often referred to in media coverage as "Octomom," Fixmer-Oraiz (2019) demonstrates that there is a fine line between being "at risk" and being "a risk." Suleman gave birth to octuplets in 2009. As a single, bi-racial woman on public assistance, she quickly found herself and her babies in the center of a media firestorm. The discourse surrounding Suleman is an intensified example of a common pattern: Black, brown, low-income, unwed, or queer birthing bodies are positioned as "risky," a rhetoric that draws on the authority of medicine to assert a "differential value of motherhood" (75). The rhetoric of risk easily moved from marking Suleman as "at risk" for various health conditions to being "a threat to her children, the fertility industry, and the nation at large…a perpetrator of risk, a threat to be

contained" (76). Naming or identifying a risk is a powerful act, because it implies a compulsion to act in order to preempt danger, "authorizing any number of preemptive strikes in its wake" (71). In short, rhetorics of risk have stratified effects – in the context of pregnancy and childbirth, a veneer of medical objectivity obscures the role race, class, and family formation in the way rhetorics of risk function.

Mollie Murphy (2017) highlights a potentially productive overlap for resisting rhetorics of risk in the reproductive justice and environmental justice movements. She argues that the rhetoric of biologist Sandra Steingraber functions to resist the expectation that pregnant women manage all possible risks to the fetus they carry. Steingraber uses synecdoche to link the maternal body and the fetus at the same time as she links reproductive and environmental rights. Steingraber's rhetoric reveals that protecting the maternal body and, by extension, the fetus, from environmental toxins necessitates the regulation of toxins in the environment, not the regulation of the maternal body. As Murphy writes: "pregnant women cannot be held responsible for managing toxic threats to the fetus because what's in the world's water, air, and soil is always already in women's bodies" (157). Similarly, Kathleen de Onís (2012) examines the way that metaphor functions in the work of Asian Communities for Reproductive Justice to create an framework for articulating the intersections between climate and reproductive justice. The metaphor "looking both ways," she argues, provides a convincing rationale for cross-movement coalition building, but also has limitations for a comprehensive coalitional perspective.

Leandra Hinojosa Hernández and Sarah de Los Santos Upton (2018) have analyzed the role of mass media in constructing knowledge about reproductive and gendered violence against women in the Americas, demonstrating that White feminists and news media coverage have repeatedly failed women of color in advocating for their specific reproductive health needs. In

particular, they note that news media outlets neglected to cover reproductive justice efforts and the ways that reproductive rights bills in the U.S. impacted women of color, poor women, and disadvantaged women. News coverage of the Zika virus and Lain American health, for instance, was buried in confusing and gendered language that made women responsible for Zika prevention, despite the fact that many of the women in question lived in areas with little access to healthcare.

In light of the kinds of analyses above, Shui-yin Sharon Yam (2020) has called for a reproductive justice-informed model of rhetorical analysis. Notably, she points to its value for scholarship in the rhetoric of health and medicine in particular. With the exception the sources I have noted above, Yam argues that the current body of rhetorical scholarship on reproductive politics is "based on a reproductive rights framework, focusing specifically on abortion access and women's right not to bear children" (20). This orientation, of course, has significant limitations. In contrast, Yam's proposed reproductive-justice model would "actively seek out objects of study that lie outside dominant legal and institutional contexts" (21) in order to more directly critique "oppressive networks of power, and further illuminate possibilities for coalition across different social movements" (21). For Yam, the lack of attention to the rhetorics of marginalized communities is particularly notable in the sub-field of rhetoric of health and medicine. Attention to the experiences of patients and audiences who occupy intersectioning positionalities would be valuable to the study of rhetoric of health and medicine, she argues:

> An RJ-informed framework of analysis prompts scholars to more critically examine how
> interlocking networks of power influence the production, circulation, and effects of
> medical discourse, and also who the relationship among medical institutions, providers,
> and patients is differently based on the patients' identities and sociocultural positions. (21)

Rhetoric of health and medicine scholars themselves have acknowledged that the sub-discipline has not yet thoroughly interrogated the role of race in medical and health discourse (Teston 2018). This project builds on the work of Fixmer-Oraiz (2019), Yam (2020), and others in demonstrating the ways that interlocking networks of power impact the production, circulation, and reception of knowledge about maternal mortality.

1.4 Critical Approach

As a rhetorician, I take seriously the idea that any attempt to make phenomena in the world legible to others involves highlighting some aspects while obscuring others. As Kenneth Burke has long reminded us, while language offers us the opportunity to reflect reality, it is also "by its very nature…a selection of reality; and to this extent it must function as a deflection of reality" (1968, 45). This assumption is at the center of this project, and my own work is no exception. The research in this dissertation, like all rhetorical criticism, is contingent on the perspective I am able to bring as a critic. And as a straight, White, middle-class, cisgender, married mother, my perspective in this context is limited. My life, reproductive choices, and parenting practices are all viewed and valued differently than those of queer folks, people of color, poor women, trans people, and unmarried women.

While I am not able to draw on my own experience to know what it is like to attempt to become a parent as a person of color, I am able to see the stark contrast between the stories Black birthing people share, and my own experiences with prenatal care, labor and delivery, and postpartum care as a White woman. In my view, it would be unethical not to make an attempt – however incomplete – to interrogate and critique the limitations of White spaces in making

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maternal mortality legible as a public problem and shaping public action. Chapters 2 and 5 of this dissertation focus on the experiences of Black women and birthing people in the U.S. – Chapter 2 takes a historical view while Chapter 5 focuses on contemporary work by Black activists. These two chapters form a sort of bookend for two case studies of discourse from dominant institutions – public health surveillance and news media. My hope is that this structure will allow us to see the potentially dire consequences of a story of maternal mortality that centers White motherhood and the possibilities that emerge when the experiences of Black women and birthing people are centered.

There is also an important note to make about the language used in this dissertation. Women are not the only people who get pregnant and give birth to children, and not all women can or do get pregnant and give birth. In order not to re-create the prejudices that make transgender people invisible and vulnerable, I often use terms such as "birthing person" or "person who can pregnant and give birth." At the same time, I also do not wish to erase the experiences of women as the category has been traditionally defined and recognized. As Loretta Ross and Rickie Solinger write, there is the long history of using "the sexuality and fertility of traditionally defined women to achieve specific demographic, political, and cultural goals…in ways that have depended on and guaranteed the subordination of these women to traditionally defined men" (2017, 8) In addition, I am often constrained by the terminology used by public health institutions to describe the phenomenon of death among pregnant and post-partum people. Overall, I strive to use gender-inclusive language and switch between terms like "women/mothers" and "individuals/parents" throughout the project. My hope is to write as inclusively as I can without erasing the experiences and vulnerabilities of any group of people.

This project aims to address the question: How is maternal mortality made legible as an issue for public action? Maternal deaths have long been framed as private, personal tragedies, and it is only recently that their occurrence has been publicly reported as a consistent trend. The reporting team behind the *Lost Mothers Project* became acutely aware of this as they collected stories about maternal death and, over time, they began to see their project as working to reframe the issue of maternal harm, from "a private trauma to a public health issue" (Gallardo 2018b). The ways that maternal mortality is made publicly visible as can illuminate some aspects of the problem while obscuring others, impacting the kinds of public action that are considered. Here, I draw on the work of Olga Kuchinskaya (2015) in her study of how citizens in Belarus come to perceive radiation and its effects, despite the fact that these are imperceptible through their human senses. She writes:

> Our experience of imperceptible hazards is always necessarily mediated by measuring equipment, maps, and other ways to visualize it, but also with narratives. Different ways of representing Chernobyl can make radiation and its effects observable and publicly visible – or they can make them unobservable and publicly nonexistent. (2)

Similarly, our understanding of a problem like maternal mortality emerges as it is mediated through the surveillance tools of epidemiological research, narratives conveyed in the media, and appeals to public and government officials.

Therefore, the question of how maternal mortality becomes publicly legible entails multiple components. For instance, how is it that a diffuse, multi-faceted problem that is distributed across a population becomes recognizable? How is that problem (once recognized) represented and circulated in the media and other reports? How does the lens through which we view the issue of maternal mortality shift when we center the stories of Black women and birthing people? And

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how does all of the above impact the kinds of policies and legislation that are put into place to improve maternal health?

1.5 Outline of Study

In Chapter 2, I draw on Simone Browne's (2015) concept of *dark matter* to address a core tension of this dissertation project: both invisiblility and hypervisiblity serve, in a White supremacist society, to make Black life un-visible. The ongoing national conversation about racial disparities in maternal mortality, for instance, makes Black reproduction highly visible. When researchers, journalists, and activists share the experiences of Black women who have suffered and died in childbirth, they are usually doing so because they are hoping that making such experiences public will lead to improvements for Black women, their families, and their communities. And yet, historically, when Black women's reproduction has become the focus of public attention, it has served to contribute to an increase in oppression and discrimination. In Chapter 2, I argue that race – and particularly the racist legacy of violence – is the dark matter that makes possible key processes of making maternal mortality public. I trace how racist violence undergirds the three interlocking processes of making maternal morality public that I examine in this dissertation: public health research, news media, and activism.

In Chapter 3, I focus on maternal mortality review committees (MMRCs) as key sites for making maternal mortality public. MMRCs are tasked with addressing a great amount of uncertainty about the complex relationships between bodies, environments, and health care institutions. They also produce the information by which state and local governments make decisions about how to improve maternal health in their area. I turn to the work of Christa Teston

(2017), to explain the role of public health infrastructure in making maternal mortality public through the MMRCs. Teston demonstrates that medical evidence is enacted through material-discursive practices. That is, humans engage with technologies, infrastructures, and objects in order to generate *evidenced objects* – the information that is used for deliberation and decision-making. In the case of MMRCs the members of the committee cooperate with the material infrastructure of public health surveillance systems to make evidential cuts that shape knowledge about maternal mortality.

In Chapter 4, I focus on the role of news media in creating, producing, and circulating knowledge about racial disparities in maternal mortality. In particular, NPR and ProPublica's co-published Lost Mothers Project (LMP) serves as the focus of my analysis. LMP was the result of a six-month investigation that aimed to make sure the stories of people who die during pregnancy and childbirth are not lost. I turn to the work of Charles Briggs and Daniel Hallin (2016), Ronald Jackson (2006), and Armond Towns (2020) to examine the way knowledge about maternal mortality and health disparities is mediated by predominantly White news organizations. Briggs and Hallin's notion of biocommunicable cartographies illuminates the ways that health news does not just convey information, but projects ideas about how knowledge is created, who should have access to it, and how audiences should attend to it. In Jackson and Towns, we see that the projection of ideas about knowledge in news media is grounded in an ideal of whiteness that, perhaps unknowingly, treats Black bodies as commodities.

The MMRCs examined in Chapter 3 and the LMP examined in Chapter 4 both begin from a perspective of normative whiteness. That is, the maternal mortality of White women is taken as the norm, and racial disparities are addressed only when they become legible relative to that frame of reference. In Chapter 5, I focus on efforts to make maternal mortality public that begin instead

from the starting point of racial disparities. Reproductive and birth justice activists have for decades argued that the reproductive futures of people of color are uniquely regulated and controlled. Chapter 5 focuses on the work of key birth justice groups associated with the Black Mamas Matter Alliance (BMMA), which formed in 2018. Since its formation, BMMA has been actively working to make the Black birthing experience more publicly visible. This chapter draws on the work of Squires (2002) to examine the counterpublic nature of BMMA, the ways they make Black maternal mortality visible to dominant publics. Their work provides a different picture of maternal mortality than the MMRCs and LMP. In the process, we will examine the possibilities and limitations of advancing reproductive and birth justice by advocating to dominant publics for changes in policy and legislation.

Following the case studies featured in Chapters 3, 4, and 5, a concluding Chapter 6 summarizes study findings, explores theorietical implications, and reflects on limitations and opportunities for future research.

2.0 The Legacy of Maternal Mortality

As maternal mortality rates in the U.S. have become a prominent topic of national discussion, attention has increasingly turned to the drastic racial disparities in maternal health outcomes. For instance, in 2019 Congresswomen Alma Adams (D-NC 12th District) and Lauren Underwood (D-IL 14th District) formed the Congressional Black Maternal Health Caucus, which introduced the Black Maternal Health Momnibus Act (H.R. 959/S. 346), a package of legislation including 12 bills designed to reduce racial disparities in maternal health. On the state and local level, Maternal Mortality Review Committees (MMRCs), responsible for researching maternal mortality cases in their area, have begun to focus attention on key drivers of racial disparities in maternal health outcomes. And news media outlets have highlighted racial disparities in maternal health even more since disparities related to COVID-19 deaths have become more widely recognized (Hopkins 2020; Stone 2020).

Many Americans have historically conceptualized maternal mortality as a problem in the developing world; therefore, the problem of maternal mortality has been "racialized as nonwhite" (Bridges 2020, 1269). As the conversation in the U.S. has increasingly focused on maternal death among Black women, the problem of maternal mortality has been racialized as a Black problem. Indeed, as Khiara Bridges puts it, "the United States is a dangerous place for *black* women to give birth" (2020, 1297). Therefore, public discussion about racial disparities in maternal health puts Black women's reproductive choices and experiences in the spotlight.

Whether they occur in committee meetings, legislative sessions, or online comment sections, conversations about racial disparities in maternal mortality do certain kinds of work. Therefore, as a rhetorical scholar, I am interested in the kind of work discourses about racial

disparities in maternal mortality perform. This chapter draws from history, literature, Black studies, and Black feminism to address the question: What are the consequences of focusing attention on racial disparities in maternal mortality?

For almost everyone who initiates a conversation about racial disparities in maternal mortality, the hope is that public policy changes will improve the lives of Black birthing people and their families. Indeed, commentators and theorists have demonstrated that sharing the lived experiences of Black women in particular can refigure dominant understandings of race and gender. The Combahee River Collective, a Black feminist organization that emerged from both the anti-racist and women's liberation movements, formed in 1974. In their collective statement, the group highlights the importance of sharing their experiences with one another in order to make the personal political:

> Even our Black women's style of talking/testifying in Black language about what we have experienced has a resonance that is both cultural and political. We have spent a great deal of energy delving into the cultural and experiential nature of our oppression out of necessity because none of these matters has ever been looked at before. No one before has ever examined the multilayered texture of Black women's lives. (Combahee River Collective 2019, 29)

For members of the Combahee River Collective, the process of making personal experiences public by sharing them with the rest of the group enhanced their sense of identity and dignity and drove the collective to pursue further political action to struggle against the interlocking systems of race-, gender-, sexuality-, and class-based oppression.

Shardé Davis (2018) describes a similar function for sharing Black women's experiences in a contemporary context. Davis examines the controversy around two hashtags –

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#BlackGirlsRock and #WhiteGirlsRock – ultimately arguing that in the face of an identity-threatening event, Black women explicitly articulated themselves as a counterpublic by rejecting notions of racial and gendered unity and advocating the interests of Black women specifically. Davis argues that the online community she studied functioned as a counterpublic where Black women could be "vulgar, enraged, politically incorrect, and replete with other ratchet conduct that undermined the politics of respectability" (287). Here, politically incorrect, even vulgar language, was used to challenge the structures of whiteness and patriarchy and to reorganize the power and status position of Black women and girls (285). Other scholars have pointed to Black Twitter as a counterpublic that has the potential to function as a space in which Black users are able to perform their racial identities (Florini 2013) and use the platform as a venue for civic activism (Brock 2012).

Megan Morrissey and Karen Kimball (2017) highlight the ways that Black female breastfeeding activists (or Blacktavists) worked on, against, and through the Black breastfeeding body to challenge the exploitation of Black mothers by Medolac – a company that processes human milk into a shelf-stable product. In 2014, Medolac announced an initiative to purchase pumped breast milk from low-income Black women in Detroit. Morrissey & Kimball argue that Blacktavists used three rhetorical strategies of visibility in response: they demonstrated the historicity of Black labor for White interests, established the economic value of that Black labor, and named Whiteness as a racial category (53). Through these strategies, Blacktavists were momentarily able to manage the normative civic discourses about Black motherhood.

For Morrissey and Kimball (2017), though, this disruption was only momentary. Medolac did retire its campaign in Detroit, but in doing so the company drew on the authority of Whiteness to judge the Blacktivsts, labelling them difficult troublemakers:

[E]ven though Medolac retired its campaign in Detroit, the company nevertheless implied

that the good work it could have done was unduly stopped by Blacktavists who never gave

Medolac the opportunity to actualize its efforts. In this way, Medolac rhetorically

constructed a scenario that cast the company's efforts as 'good' and the Blacktavists'

efforts as 'bad,' reproducing Black mothering rhetorics that mark Black women as

troublemakers, aggressive, and/or pathological. (62)

Therefore, the Blacktavists in Morissey & Kimball's case study were able to challenge Medolac's

exploitation of Black mothers in Detroit, but they were not able to "revise harmful Black mothering

rhetorics that continue to inform the positionality of Black women" (63).

Gwendolyn Pough's (2004) study of hip-hop culture and the public sphere discusses a

similar phenomenon. Pough describes the process of Black people fighting to obtain and maintain

a presence in the larger public sphere as "bringing wreck." Here she is drawing on a hip-hop term

that "connotes fighting, recreation, skill, boasting, or violence" (17). Pough highlights two specific

aspects of making Black experiences public that have both potential and liabilities for improving

Black life: spectacle and representation and the public/private split.

Because Black people have been systemically excluded from the public sphere, the first

step in creating a disruption is often to make themselves seen and their voices heard. "When Black

bodies and Black voices lay claim to public spaces previously denied to them," Pough writes,

"that space necessarily changes on some level due to their very presence" (2004, 21-22). At the

same time, there is risk in relying on spectacle and representation to refigure dominant

understandings of race and gender. If spectacle is not tied to political projects, the rappers Pough

studies "risk becoming stuck in forms of publicity that have limited usefulness…As soon as the

spectacle is co-opted, it ceases to be effective" (30). The same principle applies to the case of the

Blacktavists in the Medolac controversy – they succeeded in making their voices heard in order to end Medolac's campaign, which was likely important for Black mothers in Detroit. However, their representation of themselves was co-opted by Medolac in order to frame them as bad, disruptive mothers for resisting exploitation.

Pough also highlights that Black people have often engaged in the public sphere in order to fight for basic rights that public sphere theorists like Habermas assume already exist in the private sphere. Habermas's basic assumptions about the public sphere grow out of the "experiences of the traditional patriarchal conjugal family's private sphere" (2004, 31). However, as will be explored more in section 1.2, the legacy of chattel slavery reveals the extent to which such a conjugal family was impossible for the enslaved person. As Pough notes, "Thus, the private spaces in which subjectivity and the private/individual self is formed do not exist in the same way for American Blacks today" (31). Rather, the dichotomy between public and private has little utility when both spheres are characterized by privation and surveillance.

Therefore, before engaging in a study of the ways racial disparities in maternal mortality are made visible, it is important to acknowledge that historically, when Black women's reproduction becomes the focus of public attention it has contributed to an increase in oppression and discrimination. In order to assess the consequentiality of rhetoric about maternal mortality, rhetorical critics like myself need to be aware of the historical context of representation and be on alert for the tropes that have been used to dehumanize and oppress Black communities.

Scholars working in Black studies have argued that the Trans-Atlantic slave trade and its afterlife has impacted every aspect of life in the U.S. In this chapter, I review work across history, literary studies, sociology, and Black studies to explore the ways in which the conditions for making maternal mortality public are rooted in a legacy of violence and oppression toward Black

birthing people. This dissertation examines three interrelated processes by which maternal mortality and racial disparities become public: research, media, and policy advocacy. This chapter connects each of these three processes with our nation's history of chattel slavery and anti-Black racism.

Simone Browne argues, in the context of contemporary surveillance studies, that blackness is dark matter, the "nonnameable matter that matters the racialized disciplinary society" (2015, 9). Unlike in surveillance studies, the role of race *is* specifically discussed in public conversations about maternal health and racial disparities. However, the formation of blackness in the U.S. on the basis of chattel slavery and its role in determining reproductive futures is typically not discussed. Yet, this violence operates in the background of all these discourses, "unperceived yet producing a productive disruption of that around it" (9). Our nation's oppressive legacy against Black women is the 'dark matter' that makes public action around reproductive health possible. My hope is to complicate the way we understand discourses about racial disparities in maternal health. A reckoning with our nation's history of violence against Black women should impact the way researchers, journalists, and policy-makers understand the contemporary conditions for discussing and addressing maternal mortality.

I start by developing a theory of race and visibility, based on the work of Browne (2015), Ralph Ellison (1952), and Richard Dyer (1997). I then provide a brief overview of the way that gender and reproduction operated in the formation and maintenance of chattel slavery and its impact on Black families. The second half of the chapter revisits how this legacy of violence forms the dark matter that makes possible key processes of making maternal mortality public. Both natural science and social science research have taken advantage of and committed violence against Black people and Black women in particular in order to benefit White society.

Representations of Black women in various forms of media have consistently demonized Black women, casting them as the source of social problems in the U.S. Finally, the advancement of reproductive rights for White women has routinely occurred on the basis of oppressing Black birthing people. The resulting inventory promises to build important historical context for the case studies featured in subsequent chapters.

2.1 Race and Visibility

Most people assume that increased visibility for any problem being faced by a minority group is an inherently good thing. After all, if a problem is invisible to the public, it is difficult to gain support for change. However, history indicates that increased visibility does not necessarily lead to better outcomes for Black communities. Rather, Black scholars have argued that both invisibility and hypervisibility function to make Black life un-visible. In contrast, the invisibility and instability of whiteness further strengthen White supremacy.[2] By using the term dark matter, Browne (2015) highlights that although blackness is often invisible, it "structures the universe of modernity" (9). Blackness is mainly invisible to White culture, but it is sensed, experienced, and lived by Black people. [3] Browne argues that blackness is intimately connected with the experience of being surveilled – overseen, observed, or watched. At the same time, the invisibility of

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[2] I use the term White supremacy broadly to refer to the ways in which the U.S. has been built by and for White people to the detriment of the lives of Black, Brown, and Indigenous people.

[3] In using the term "White culture" I am drawing specifically on Richard Dyer's (1997) work in his book *White*. Other scholars have also written about the ways in which White people in the U.S. see themselves as unraced and as the natural model of what it means to be an American, for instance, Nakayama and Krizek (1995). As Dyer puts it, in white culture, "white people create the dominant images of the world and don't quite see that they thus construct the world in their own image; white people set standards of humanity by which they are bound to succeed and others are bound to fail" (9).

whiteness functions to allow for White people to be in positions of surveillance – overseeing, observing, or watching.

Surveillance makes Black bodies visible in some contexts and invisible in others but both function to render Black life un-visible, or "outside the category of the human" (Browne 2015, 68). In the Preface to *Invisible Man*, Ellison reflects on the "high visibility" of Black bodies: "While the darker brother was clearly 'checked and balanced' – and kept far more checked than balanced – on the basis of his darkness he glowed, nevertheless, within the American conscience with such intensity that most whites feigned moral blindness toward his predicament" (1952, xv). Here Ellison notes that the intense visibility of the Black body did not translate to increased awareness of the predicament of the Black person. Rather, the racialized White gaze was completely blind to the experience of Black life. Ellison continues: "Thus despite the bland assertions of sociologists, 'high visibility' actually rendered one un-visible – whether at high noon in Macy's window or illuminated by flaming torches and flashbulbs while undergoing the ritual sacrifice that was dedicated to the idea of white supremacy" (1952, xv). Thus, the high visibility, or hypervisibility, of Black bodies can dehumanize Black persons. This can occur, for instance, by calling attention to physical attributes alone. This kind of framing reflects commonly held but racist notions that Black people are physically superior to Whites but intellectually inferior.

In White culture, Black bodies are often only visible through a racializing gaze that that sees and codes blackness through a limiting framework of stereotypes and abnormalization (Browne 2015). In *Invisible Man*, the unnamed protagonist reflects on being invisible in the south and being seen as a racial caricature in the north. The protagonist emphasizes that the change was not in his personality or physical characteristics, but "occurs because of a peculiar disposition of the eyes of those whom I come in contact" (Ellison 1952, 3). Browne emphasizes that this

racialized gaze is grounded in whiteness: "Where public spaces are shaped for and by whiteness, some acts in public are abnormalized by way of racializing surveillance and then coded for disciplinary measures that are punitive in their effects" (Browne 2015, 17). It is this White gaze that has the potential to make visibility problematic, even dangerous, for Black individuals.

Whiteness too is invisible to White culture. Even when it is physically present to the eye, it is unmarked and assumed to have no content. Thomas Nakayama and Robert Krizek write that participants in their study on whiteness identified themselves as White because "they lacked any other racial or ethnic features; hence, they must be white by default" (1995, 299). The invisibility of whiteness, however, functions to make White people seem to transcend their bodies. To be White is to identify with the common belief that White people are not raced, they are "just people," while other races need to be specified. As one participant in Nakayama and Krizek's study put it, "we were just white, not black or brown" (299). Dyer emphasizes that this assumption is insidious, as it "is not far off saying that whites are people whereas other colours are something else" (2) When White culture finds the need to note the race of Black people and not White people, this reduces Black and Brown people to their bodies. In contrast, "white people are something else that is realized in and yet is not reducible to the corporeal" (14). Where Black bodies[4] are thought to be "prey to the promptings and fallibilities of the body," White people are able to aspire to the "highest reaches of intellectual comprehension and aesthetic refinement" (23). Therefore, where the invisibility of Black people functions to make them un-visible and to dehumanize, the invisibility of whiteness reinforces the notion that White humans are something transcendent of their bodies.

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[4] Throughout this chapter, I use the words "Black body" or "Black bodies" with intention, to highlight the ways in which White culture reduces black life to the physical body. I do my best not to reproduce this tendency in White culture by using terms like "Black people" when I am not explicitly attempting to make this point.

If blackness is surveilled, whiteness is surveillance. Dyer (1997) points out that whiteness consists of a paradox: in a visual culture visibility and representability are necessary for communication and power; however, the power of whiteness resides in its invisibility, as positions of control require an unseen watchfulness. He writes that the choice of the "color" white to describe White people captures this paradox:

> The paradox and dynamic of this are expressed in the very choice of white to characterize us. White is both a colour and, at once, not a colour and the sign of that which is colourless because it cannot be seen: the soul, the mind, and also emptiness, non-existence and death, all of which form part of what makes white people socially white. Whiteness is the sign that makes white people visible as white, while simultaneously signifying the true character of white people, which is invisible. (45)

Thus, the power of whiteness resides in its invisibility. Where the invisibility of Blackness functions to dehumanize, the invisibility of whiteness functions to create and maintain systems of White supremacy. In the next section, I will discuss ways that both the hypervisibility of Black bodies and the invisibility of White bodies (i.e. the notion that White bodies are the norm) served to justify and legitimate the enslavement of African people. Given the focus of this project on maternal harm, I focus specifically on the Black female body, but related arguments about Black male bodies can be found in scholarship by Armond Towns (2018) and Gabby Yearwood (2018).

2.2 Reproduction and the Trans-Atlantic Slave Trade

The hypervisibility of the Black female has been used to justify the regulation and control of Black women's reproduction since European travelers first encountered African people.

Jennifer Morgan (2004) describes travel narratives written by Europeans visiting Africa starting in the 1600s. She argues that these encounters and their consumption in Europe "constituted an essential component of the ideological arsenal that European settlers brought to bear against African laborers" (22). That is, the portrayal of African people in these narratives justified their captivity and forced labor.

While some early travelers remarked on the beauty of African women, more often the Black body was seen as a monstrosity. The following description by Englishman Richard Ligon is representative of the travel narratives' focus on the size of African women's breasts and genitals. He wrote: their breasts "hang down below their Navels, so that when they stoop at their common work of weeding, they hang almost to the ground, that at a distance you would think they had six legs" (Morgan 2004, 23). In addition, travelers often focused on the nakedness and immodesty of African people. As Morgan writes, "Nakedness was an essential part of most descriptions of native peoples in this period and became the precursor to discussions of women's physical and reproductive anomalies" (37).

Dutch traveler Pieter de Marees, for instance, castigated West Africans for the shameless manner in which they gave birth openly, surrounded by men, women, and children (Morgan 2004, 38). Indeed, the spread of erroneous beliefs about Africans' ability to give birth and breastfeed easily and without pain served multiple purposes: it othered African people in the eyes of European readers, and it reinforced a belief that African people were uniquely equipped for hard labor in the American colonies.

> By the time the English made their way to the West Indies, decades of ideas and information about brown and black women predated the actual encounter. In many ways, the encounter had already taken place in parlors and reading rooms on English soil,

assuring that colonists would arrive with a batter of assumptions and predispositions about

race, femininity, sexuality, and civilization. (49)

The descriptions of African women's purported reproductive anomalies, lack of modesty, and effortless childbirth made the African birthing body hypervisible to many European and American readers long before they ever encountered an African.

The bodies of African women continued to be put on display when they were brought to the European continent. The story of Saartjie ('little Sarah' in Afrikaans) Baartman is an illustrative example. Baartman was born in South Africa in 1790 and was publicly exhibited, nearly nude, in both London and Paris in the early 1800s (Guy-Sheftall 2002; Young 1997). She was perversely called The Hottentot Venus, Hottentot being a derogatory term for Baartman's Khoi people, "who had long been classified as the 'lowest Africans, the closets to animals'" (Kendi 2016, 137). Venus, of course, referred to the Greek goddess of love and fertility. Baartman became a main attraction and generated a thriving business for the men in London who exhibited her (Young 1997, 699). She drew large crowds because of her irregularly large buttocks and genitalia, referred to at the time as *steatopygia*. Baartman's physical appearance was unique both among her fellow Khoi women and across the African continent, yet she was displayed as though she were a representative example of the authentically African female (Kendi 2016, 137). One of Baartman's exhibitors described Baartman's body as "the kind of shape which is most admired among her countrymen" (Altick 1978, 269), implying that her body type was normal among Africans and that African sexuality was pathological (Young 1997, 701).

After a difficult life and early death, scientific examination and writing further secured her status as a representative example of all African women. While in Paris, Baartman was taken to meet famed comparative anatomist Georges Cuvier. After Baartman's death at the young age of

twenty-six, Cuvier received official permission to dissect her body for the sake of knowledge and curiosity (Kendi 2016, 139). After the dissection, Baartman's preserved buttocks and genitalia remained on display at the Musee de L'homme in Paris until they were finally repatriated and buried in South Africa in 2002.

Because Cuvier was widely known and respected, his report on Baartman came to be "regarded in scientific circles as an authentic description of the African woman more generally" (Guy-Sheftall 2002, 18). The report further reinforced two insidious notions about the Khoi people specifically and African people more generally: 1) that they were closely related to animals and 2) that their sexuality was pathological. Cuvier specifically wrote in his report that "he had 'never seen a human head more resembling a monkey's than her' and that she moved like a monkey as well" (Guy-Sheftall 2002, 18). In addition, his continued emphasis on her genitalia reinforced a belief that African women were highly sexual, almost animal-like in their lust and passion.

As Beverly Guy-Sheftall goes on to elaborate, Baartman's experience is characteristic of the way Black female bodies are treated: "Being Black and female is characterized by the private being made public, which subverts conventional notions about the need to hide and render invisible women's sexuality and private parts. There is nothing sacred about Black women's bodies, in other words. They are not off-limits, untouchable, or unseeable" (2002, 18). When Black women's bodies are made hypervisible, they are made available for use by White culture. That use might include the quest for knowledge that motivated Cuvier, or the justification of oppressive systems on which White culture develops, as will be discussed throughout this chapter.

The hypervisibility of African women's bodies also set the stage for their unique position as enslaved people who were capable of producing more enslaved people. As early as 1662, slaveowners in America codified the principle that the children borne by enslaved women were

legally born as slaves. Morgan describes slavery as a "coercive labor system predicated upon a fictive biological marker conveyed by the mother" (2004, 3-4). It is telling that such a law was deemed necessary, since the fathers of said children may well have been White men, even White slave owners. This system of matrilineal lineage was in direct contradiction to typical European patterns of lineage and inheritance, which typically granted rights and inheritance to children based on their paternity. This system, however, ensured that enslaved women had a dual utility for slaveowners "the ability to produce both crops and other laborers" (14). As a result, reproductive experiences would have been central to enslaved women's interactions with their work, their slaveowners, and their fellow slaves.

Because their children would automatically be considered slaves, Black birthing bodies were viewed as a source of profit not only for the labor they could perform, but also for their reproductive potential. Morgan argues that for slaveowners facing bleak prospects, enslaved women presented a opportunity: "Though clearly there was no guarantee, a planter could imagine that a handful of fertile African women might turn his modest holdings into a substantial legacy. Black women's bodies became the vessels in which slaveowners manifested their hopes for the future; they were, in effect, conduits of stability and wealth to the white community" (2004, 87). Morgan points out that slaveowners often "coupled" male and female slaves together, even making these pairings explicit in their wills when they passed slaves on to their own children – "indeed, a third of those slaveowners who transferred enslaved women in their wills or sales explicitly referred to the potential for enslaved women to have children by utilizing the term 'increase.'" (140).

Saidiya Hartman (1997) emphasizes that multiple mechanisms of sexual domination worked together to constitute the slave as sub-human. Although enslaved people were routinely

and compulsorily coupled for the purposes of procreation, slave marriages were not legally recognized. That is, slaves could not have legitimate heirs. This allowed for men, women, and children to be transferred as property. Furthermore, the actual or attempted rape of an enslaved person was neither recognized nor punished by the law. The rape of an enslaved women was unimaginable partially because of the purported sexual excesses of Black women. However, it was also unimaginable as a crime because it did not violate her status or abilities as a slave. As Hartman explains, "the ravished body, unlike a broken arm or leg…did not decrease productivity or diminish value – on the contrary, it might actually increase the captive's magnitude of value" (95). As Hartman implies here, the enslaved Black woman's reproduction was, without exception, the reproduction of property for her master.

Together, the unrecognizability of rape and the disillusion of Black family relationships worked together to render the slave sub-human. As Hartman explains, "In this instance, sexuality is a central dimension of the power exercised over and against the slave population and entails everything from compulsory couplings to the right to manage life" (1997, 84). Morgan also emphasizes that in order to understand how slaves were treated as chattel we must account for reproductive practices: "Childbirth, then, needs to stand alongside the more ubiquitously evoked scene of violence and brutality at the end of a slaveowner's lash or branding iron" (2004, 109). During chattel slavery, female sexuality and fertility were linked to encourage reproduction for the profit and benefit of White slaveowners.

Once we attend to the way Black women's sexuality and reproduction have been controlled, we are pushed to reconfigure our understanding of familial and gender relations. The relationship between enslaved women's reproduction and the profit their children represented for their White slaveowners was a major factor shaping enslaved women's senses of family, parenting,

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and community – in essence, their very sense of humanity: "Each time a slaveowner's will was made public, or an enslaved woman overheard reference to a white child's ultimate interest in her own swelling belly or suckling infant, she responded by repositioning her self in relation to her child, her lover, and her reproductive capacity" (Morgan 2004, 110). As Morgan emphasizes here, awareness of the role their reproduction played in the maintenance of the slave system had an impact on enslaved women's experience of all of their most significant relationships.

As an example, Morgan (2004) relates the story of an enslaved woman named Bessie, whose owner in Barbados died in 1654. Bessie and her children faced a precarious situation following her owners' death, a situation that highlights two implications of the ways that reproduction was tied to the female line. First was the "invisibility of the father of Bessie's children – whether he was enslaved on another plantation, had died, or was the slaveowner himself" (112). The invisibility of the father is central to Hortense Spillers (1987) argument in her essay *Mama's Baby, Papa's Maybe*. The title emphasizes the way that the enslaved child inherits the mother's line, while the identity of the father is unclear or obstructed. Second, Bessie had an "inability to predict where she and her children might find themselves after her owner's will cleared probate" (Morgan 2004, 112). Although children were legally connected to their mothers in the sense that they inherited their slave status, they could also be permanently separated at the whims of slaveowners. As Spillers describes, "the offspring of the female does not 'belong' to the Mother, nor is s/he 'related' to the 'owner'" (1987, 74). She goes on to write that in these circumstances "'kinship' loses meaning, since it can be invaded at any given and arbitrary moment by the property relations" (74). That is, the relationships between enslaved parents and children were more like the relationships between two pieces of property than between family members who are able to claim one another.

Spillers (1987) highlights that this is the essence of Black family relationships, such as they were, that were constituted in captivity. For Spillers, this lack of kinship is the condition of possibility sustaining the White family's apparent coherence. Of course, such coherence was an illusion given the oft invisible White father of enslaved children. As a result, we need other ways of thinking about the possibilities for family and relationality in the Black community. Later, this chapter will discuss the way that White, heteronormative standards for the nuclear family, developed in the U.S. in the mid-twentieth century, were used in social scientific research to label the Black family and Black mothers as pathological.

At the same time, the mechanisms of sexual and reproductive domination that constituted slavery require that we reconsider the fundamental concept of gender. In a context where human beings are being treated as chattel, what does gender mean? Both Hartman (1997) and Spillers (1987) point out that historically, our notions of female gender are often fundamentally domestic – related to women's roles in relation to their husbands and children. As Spillers writes, the domestic is "an essential metaphor that then spreads its tentacles for male and female subject over a wider ground of human and social purposes" (72) This approach to gender is reductive and ultimately functions only to describe the arrangements of the dominant, White patriarchal family (Hartman 1997, 97).

If we are to make any sense of gender within the context of slavery, Hartman argues we must examine "gender formation in relation to property relations, the sexual economy of slavery, and the calculation of injury" (1997, 97). That is, we must examine how the female gender in the context of slavery is defined on the basis of the mechanisms of sexual and reproductive domination described above. The gender of the enslaved woman was fundamentally defined based on her ability to bear children, yet the relationships between herself and her children were considered to

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be relationships between property rather than living beings. Maintaining this definition of the "female" then, ultimately reduces Black women to their reproductive function.

The White, middle-class female who "norms the category" (Hartman 1997, 100) of female, however, seems to occupy a fundamentally different subject position than the enslaved woman. As Spillers puts it, "we might guess that the 'reproduction of mothering' in this historic instance carries few of the benefits of a *patriarchilized* female gender, which, from one point of view, is the only female gender there is" (1987, 73). As we will see in the next section, natural and social sciences research have historically been unwilling to reconfigure notions of gender, solidifying their role in reproducing violence against the Black family.

In her influential book, *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*, Dana-Ain Davis (2019) argues that ideas about Black women and birthing people that circulate in the medical field must be understood as an extension of what Hartman calls the afterlife of slavery. Hartman describes the afterlife of slavery as follows:

> If slavery persists as an issue in the political life of black America, it is not because of an antiquarian obsession with bygone days or the burden of a too-long memory, but because black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery – skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment. I, too, am the afterlife of slavery. (2007, 6)

Crucially, for both Hartman and Davis, Black life in the U.S. is still devalued by a series of tropes, practices, beliefs, and policies that were used to justify and maintain the practice of chattel slavery. Davis (2019) argues that we need the afterlife of slavery as a framework if we are going to make sense of ongoing racism in maternal and infant healthcare. As she puts it, "Both racism and slavery

in the United States have facilitated a reproductive dystopia in which almost all aspects of reproduction idealize whiteness. From breastfeeding to the fragility of uteruses, the pretense of perfection and importance has been legitimated through white womanhood" (14). In the context of maternal healthcare, Davis is pointing out, White reproduction is praised and encouraged, while Black birthing people are often left fighting the system.

This section has provided a brief overview of the way that gender and reproduction operated in the formation and maintenance of chattel slavery and its impact on the Black family. Early European travelers to the African continent wrote narratives that portrayed African women as monstrous, immodest, and extraordinarily strong. These narratives set the stage for the continued display of Black female bodies on the European continent, reinforcing arguments that Africans were built for hard, forced labor. Slaveowners in the U.S. intentionally developed a legal scheme ensuring that Black women would maintain the slave system by reproducing more enslaved people, and multiple mechanisms of sexual and reproductive oppression worked together to constitute the slave as sub-human. Because enslaved children inherited their mother's slave status, the father of enslaved children was rendered invisible. In addition, in a system in which any slave could be bought, sold, and separated from their family members, familial relationships were delegitimized. These same systems of sexual and reproductive domination put the enslaved woman in a fundamentally different subject position than White women.

The second half of the chapter describes how this legacy of violence forms the dark matter that makes possible key processes of making maternal mortality public. Both natural science and social science research have taken advantage of and committed violence against Black people, and Black women in particular, in order to benefit White society. Representations of Black women in various forms of media have consistently demonized them, casting Black women and birthing

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people as the source of social problems in the U.S. Finally, the advancement of reproductive rights for White women has routinely occurred on the basis of oppressing Black women and birthing people.

2.3 The Violent Legacy of Research

Public health and social science research are key processes by which maternal mortality is made public. Researchers collect and analyze data, report it to the public, and make recommendations about the best ways to address maternal harm. Research intended to improve public health covers a wide-range of concerns and uses a variety of research methods. Researchers working in human genetics or infectious diseases might rely primarily on laboratory research of specific bacteria, viruses, molecules etc. Epidemiologists, for example, focus on the incidence, distribution, and control of disease and typically rely primarily on large-scale clinical studies, such as randomized controlled trials or case-control studies. Scholars working in health management or behavioral/community health might use social science research methods, such as surveys or ethnographies, to study the impact of various behaviors, interventions, and policies on the health and well-being of the public. Natural science, medical, and social science research have all been implicated in justifying the exploitation and oppression of Black people. Below, I will briefly discuss how the natural sciences played a role in the formation of racial categories generally before moving to medical racism in the field of gynecology and obstetrics.

Following the period of the Enlightenment, European scientists and philosophers spent a great deal of time and energy debating about whether the members of various races were in fact part of the same species (Keel 2013; Knapman 2016; E. West 2003). As Ibram X. Kendi notes,

polygenists argued that: "The principal fact was that the 'anatomical structure' of the European was 'superior' to that of the other races. As different species, Blacks and Whites had been 'placed at the opposite extremes of the scale'" (2016, 133). Ultimately, both polygenesists and monogenesists sought to use comparative anatomy to prove that the anatomical structure of Europeans was superior to that of other races.

Over the course of the eighteenth century, the study of human anatomy gained greater authority. By the end of the century, Andrew Curran writes that biology and behavior were understood to be intimately linked: "the springs and pulleys of anatomy were increasingly understood to reflect human destiny…anatomists had arrogated to themselves the right not only to identify black African's corporeal 'liabilities,' but to explain why this particular category of human was fundamentally inferior to the highest expression of humankind, the European" (2011, 6).This belief in biological, anatomical differentiation between members of different races came to suffuse every aspect of the human body and was easily used to further justify slavery. Popularity of this type of study continued into the 19th century as well. John Hoberman notes that Black people's bodies were found to be more "hardy," which presumes "a more primitive (and less complex) human type that is biologically different from the civilized white man" (2012, 59). He writes about the anthropologist, James Hunt:

> Hunt's original and borrowed observations included physiognomy ('absence of expression in the features'), muscularity ('the shoulders are less powerful'), the skeleton ('the bones larger and thicker'), the calf ('usually weak'), the skull ('very hard and unusually thick'), the nerves ('larger than in the European'), the skin ('much thicker'), the voice ('peculiar'), precocity, cranial capacity, convolutions of the brain ('less numerous and more massive'), eyes, teeth, and pain threshold ('physical pain never provokes them'). (61)

Comparative anatomists like Hunt argued that these differences indicated that Black people were, on the whole, more physically hardy and less intelligent.

Dr. Samuel Morton's *Crania Americana*, and his accompanying collection of human skulls at Philadelphia's Academy of Natural Sciences, is an infamous example of the use of comparative anatomy to make arguments about Black people's inferior intelligence. As Stephen Jay Gould (1996) explains, craniotomy, measuring and comparing human skulls, was a practice used to generate data about human intelligence. For many scientists at the time, worth could be assigned to various groups based on intelligence measurements.

Morton's hope was that comparative mathematical anatomy would provide anatomists with an objective tool for distinguishing between racial categories. Kendi writes: "[Morton] had made painstaking measurements of the 'mean internal capacity' of nearly one hundred skulls in cubic inches. Finding that the skulls from the 'Caucasian Race' measured out the largest in that tiny sample, Morton concluded that Whites 'had the highest intellectual endowments' of all the races" (2016, 180). However, Morton's assumption—the bigger the skull, the bigger the intellect of the person—was fundamentally incorrect. Nevertheless, many White scientists used this faulty work to support the claim that White people were superior in intelligence and were more biologically complex than "primitive" Black groups. In the process, the life sciences reduced Black people to their materiality, or flesh, in order to further the interests of White supremacy.

Relevant to this project, medical racism played a crucial role in the advent of modern gynecology as well. Slaveowners were highly invested in reproductive medicine for their own benefit. Following the ban on importing enslaved people in 1808, reproductive medicine became essential to the maintenance of chattel slavery. Since enslaved people could still be sold and transported within the U.S., women of childbearing age were essential to maintaining the slave

system. Scholars have documented the extent to which modern gynecology was made possible by experimentation on enslaved women (D.C. Owens 2017; Washington 2006). These experiments were often performed by force, without any anesthetic.

Southern doctors conducted experiments on enslaved women to create medical techniques that would ultimately aid elite, White women. Perhaps most notable among these doctors was the renowned father of gynecology J. Marion Simms. Thus, Deidre Cooper D.C. Owens (2017) points out, the development of modern gynecology depended on a paradox: Black women were considered biologically inferior to White women; yet their bodies were exploited to develop techniques that would later be used on White women who were considered more fragile but intellectually superior.

It is not only the natural sciences of the 1800s, however, that have been implicated in the oppression of Black people. Since empirical social science research was popularized in the early 19th century, it too has consistently functioned to make Black life un-visible – to situate Black people and Black families outside the category of the human. In particular, social science research has routinely blamed Black reproduction and maternity for social ills in the Black community and, as a result, in the nation at large. The overall thesis of much of this research is that Black women are the cause of the Black family's instability because they perpetuate "the slave legacy of unwed motherhood" (Roberts 1997, 24). Black matriarchs are thought to damage their families through a dual pathway: demoralizing and alienating Black men while simultaneously passing a pathological lifestyle (poverty and antisocial behavior) to their children (25). Thus, gender relations – relationships between Black men and women – are often implicitly used as a measure of Black cultural disadvantage (Collins 2000, 77).

While this line of argument was popularized as early as the 1920s and 30s, it was revived with the 1965 publication of Daniel Patrick Moynihan's report "The Negro Family: The Case for National Action." At the time, Moynihan was serving as Assistant Secretary of Labor and Director of the Office of Policy Planning under President Lyndon Johnson. Moynihan believed that reforming the Black family was vital to President Johnson's War on Poverty (Roberts 1997, 25). For Moynihan, "The family is the basic social unit of American life" (1965, 5). While the White family has become increasingly stable, Moynihan argues, the Black family has become increasingly unstable. As he puts it, "the family structure of lower class Negroes is highly unstable, and in many urban centers is approaching complete breakdown" (5).

The matriarchal family structure – i.e. the prevalence of families headed by single Black women – caused what Moynihan calls a "tangle of pathology" in Black culture (1965, 29). Black children, especially young men, do not know how to work, have low academic achievement, are likely to engage in criminal activity, and are generally alienated from society. Furthermore, the matriarchal pattern in which the traditional roles of husband and wife are reversed, "reinforces itself over the generations" (31). While the report itself spends much more space describing the disadvantages and alienation faced by Black men and children, the "matriarchal structure" described in the report is the implicit problem throughout.

Spillers notes that the Moynihan report creates a "constant opposition of binary meanings" between the White, human family, and the 'Negro Family' (1987, 66). King explains that for Moynihan "the disorganized Black family is a lesser form of family and works primarily as a unit of comparison to help mark whiteness and white families as normal" (2018, 4). In legal terms, family structures are based on series of rights secured through the courts and the market (e.g. tax filing statuses, legal guardianship, inheritors, and consumers of healthcare coverage). King argues

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that these structures are designed to deny Black people the rights that would make them human in order to perpetuate White power. As she puts it: "Survival under this order of civil society must cohere through structures and orders of family life that sustain themselves through Black death" (3). That is, the legal structures of family exist to maintain White supremacy, and, as a result, are a site of violence for Black families.

As a result, members of Black communities have developed alternative, resistive patterns of relationship. Spillers notes that, during slavery, enslaved persons developed a "horizontal relatedness of language groups, discourse formations, bloodlines, names, and properties by the legal arrangements of enslavement" (1987, 75). However, Spillers questions whether it is even worth calling these arrangements "family," and whether there is really a possibility for familial relationships outside of White supremacy. She writes: "We might choose to call this connectedness 'family' or 'support structures,' but that is a rather different case from the moves of a dominant symbolic order, pledged to maintain the supremacy of race. It is that order that forces 'family' to modify itself when it does not mean family of the 'master,' or dominant enclave" (75). That is, the legal version of family upheld by the dominant social order exists to maintain White supremacy. Thus, Black relationships designed to resist White supremacy might not fit into the category of family at all.

Social science research makes such Black relationships un-visible by highlighting them as deviant and marking them as objects for knowledge production (King 2018, 4). In addition to using scientific empiricism to measure Black deviance, such research also functions to legitimize state-sanctioned surveillance and intervention. This includes "a diffuse network of welfare case managers, monthly reporting and documentation of sexual behavior, children, income and daily activity" (5). In addition, King points out, family structure purportedly functions for White families

to protect them from the excesses of state power. She writes: "However, black matriarchal households in the *The [Moynihan] Report* are porous spaces that the state enters obliterating any possibility of private space. In this way, Black households in *The Report* fall outside of liberal humanist discourses that posit humans (and human families) as self contained and inviolable, particularly from state abuses" (6). In the same way that Black parents and children during chattel slavery did not have the privilege of claiming one another as family, Black households under the surveillance of social science research do not have the privilege of claiming their relationships as private and unbreakable.

This section has highlighted how research in the natural and social sciences is implicated in a legacy of violence and oppression toward Black people, and Black women in particular. Studies of biology and anatomy in the 18th century sought to prove that Black people were inferior to White people. Southern doctors forcibly performed painful and humiliating experiments on enslaved women in order to create medical techniques that would ultimately aid elite, White women. Social science research has also perpetuated the belief that the Black matriarch is the source of social problems in the Black community. In so doing, social science research marks the Black family as deviant and treats Black people as objects for knowledge production. The next section will discuss recurring representations of Black women that also function to frame Black women and their families as deviant and justify the regulation and control of their reproduction.

2.4 Demonization of Black Maternity in the Media

The images and vocabulary that justify the mistreatment of Black women are embedded in our discursive economy in ways we do not always realize. Spillers opens her essay with the following words:

> Let's face it. I am a marked woman, but not everybody knows my name. 'Peaches' and 'Brown Sugar,' 'Sapphire' and 'Earth Mother,' 'Aunty,' 'Granny,' God's 'Holy Fool,' a 'Miss Ebony First, or 'Black Woman at the Podium': I describe a locus of confounded identities, a meeting ground of investments and privations in the national treasury of rhetorical wealth. My country needs me, and if I were not here, I would have to be invented. (1987, 65)

Here, Spillers is highlighting the way that tropes about Black women function as rhetorical resources. By trope, I mean a recurring image or representation that functions as a shorthand for a whole set of assumptions about a person or group of people. In this instance, Americans – wittingly or unwittingly – rely on a set of tropes about Black women to make sense of the state of our country. King makes a similar point when she writes, "the Black Matriarch has embedded itself in the US imaginary in an almost archetypal fashion…it has become the primary discourse used to both imagine and speak about the 'Black Family' specifically as a problem and thus a source of disquiet" (2018, 1). In talking about and addressing social problems in the U.S., tropes about Black womanhood always lurk just beneath the surface.

The tropes associated with representations of Black women function specifically to position Black women as bad mothers. Black women are thought to corrupt the process of reproduction at every stage: passing on inferior traits, engaging in bad habits during pregnancy, and setting a bad example for their children (Roberts 1997, 18). The recurring images described

below make it easy for the public to believe that "this damaging behavior on the part of Black mothers – not arrangements of power – explains the persistence of Black poverty and marginality" (18). Scholars have identified four major tropes that function to position Black women as bad mothers: the hypersexual Jezebel; the angry, hostile Sapphire; the Welfare Queen; and the asexual Mammy.

The recurring representation of Black women as "Jezebels" invites construction and perception of them as immoral, hypersexual, and promiscuous mothers. Carolyn writes that manifestations of the Jezebel image tend to closely resemble White standards of beauty: "Physically, Jezebel was often portrayed as a mixed-race woman with more European features, such as thin lips, straight hair, and a slender nose" (1995, 462). She is lascivious, seductive, and her sexual prowess leads men to "wanton passion" (Roberts 1997, 20). The purported sexual promiscuity of Black women provided "a powerful rationale for the widespread sexual assaults by White men typically reported by Black slave women" (Collins 2000, 81). At the same time, the alleged propensity of Black men toward sexual violence was also blamed on Black women, the charge being that "Black men lacked any understanding of sexual violation because their women were always eager to engage in sex" (Roberts 1997, 20). Not only did the image of the Jezebel authorize sexual violence against Black women, but her hypersexual nature is also tied to "excessive" procreation that warrants additional governmental control. As Roberts writes, "Lacking the inclination to control their own fertility, it is thought, Black women require government regulation" (1997, 21).

The common trope of Black women as "Mammys" evokes the image of a domestic servant who faithfully cares for her White charges under the supervision of a mistress, but is unable to care for her own children. The Mammy image is especially compelling because many Black women

were required to stay on as domestic servants for White slave owners post-Emancipation (Mowatt, French, and Malebranche 2013, 651). Physically, the Mammy is depicted "as a bandanna clad, obese, dark complexioned woman with African features" (C.M. West 1995, 459). As an asexual, nurturing woman, the Mammy figure stands in opposition to the Jezebel. As Collins argues, "the mammy image buttresses the ideology of the cult of true womanhood, one in which sexuality and fertility are severed" (2000, 74).

Roberts, however, emphasizes that although the Mammy figure was devoted to the White family she served, "the ideology of Mammy placed no value on Black women as mothers of their own children" (1997, 22). Rather, while Mammy cared for White children, she remained under the constant supervision of her White mistress, and was thought to be careless, neglectful, and unable to care for her own children. Collins notes that the image of a faithful, obedient servant persists, under a modern guise, in contemporary media representations of professional Black women: "These women are tough, independent, smart, and asexual. But they are also devoted to their organizations, their jobs, and, upon occasion, their White male bosses. They are team players and their participation on the team is predicated upon their willingness to lack ambition for running the team and never to put family ahead of the team" (2004, 141). That is, the expectations of subordination, nurturance, and constant self-sacrifice perpetuated by the Mammy image persist, even if the specific job duties have changed.

The recurring representation of Black women as 'Sapphires' portrays a Black woman who is unfit for motherhood because she is angry, hostile, and abusive. In many ways, the Sapphire image functions as the antithesis of the Mammy. "Her primary role," writes West "was to emasculate Black men with frequent verbal assaults, which she conducted in a loud, animated, verbose fashion" (1995, 461). Presumably, these men then either deserted or refused to marry the

mothers of their children. Thus, the Sapphire is "a failed mammy, a negative stigma to be applied to African-American women who dared reject the image of the submissive, hardworking servant" (Collins 2000, 75).

Furthermore, the Sapphire fails to model appropriate gender behavior: "[L]abeling Black women unfeminine and too strong works to undercut U.S. Black women's assertiveness" (Collins 2000, 77). This labelling can be clearly seen in the comedy routines of Black male comedians in the 1990s, argues Patricia Hill Collins, particularly in the common practice of Black male comedians dressing as black women: "Through this act of cross-dressing, Black women can be depicted as ugly women who too closely resemble men (big, Black, and short hair) and because they are aggressive like men, become stigmatized as 'bitches'" (2004, 125). By refusing to adhere to the cult of true womanhood, the Sapphire bears the blame for the downfall of the Black family.

The final trope of Black women as "Welfare Queens" presents the image of a lazy mother who deliberately breeds children in order to benefit from public assistance at the expense of taxpayers (Roberts 1997, 26). The Welfare Queen functions as a contemporary update to images of immoral, neglectful, and domineering Black mothers. This trope emerged as Black women gained more access to U.S. welfare state entitlements and became especially prevalent after the Reagan's election in 1980. The Welfare Queen functions as a "class-specific controlling image developed for poor, working-class Black women who make use of social welfare benefits to which they are entitled by law" (Collins 2000, 78). The emphasis on Black women's fertility provides an ideological justification for both reproductive control for Black women and policies that shrink social welfare benefits. As Collins writes, "The image of the welfare mother fulfills this function by labeling as unnecessary and even dangerous to the values of the country the fertility of women who are not White and middle class" (79). The perception that Black women are hypersexual,

careless, and overly aggressive merge in this final trope to make clear White America's investment in overseeing and controlling the reproduction of Black women.

Gender and sexuality are crucial aspects of the 'incurable immorality' that purportedly makes Black women failures as mothers. The Jezebel, Mammy, Sapphire, and Welfare Queen tropes all position Black women as inappropriately conforming to gender and sexuality expectations, which necessitated control and oversight of their reproductive decisions. The Jezebel trope, of course, figures Black women as sexually aggressive. Not only is her hypersexuality evidence of her immorality, but it also implies that "increased fertility should be the expected outcome" (Collins 2000, 81). Both the Sapphire and Welfare Queen figures are also sexual beings in ways that are distinctly linked to their fertility. In fact, the link between sexuality and fertility is "one fundamental reason they are negative images" (84).

The Sapphire figure does not adhere to the gentle, passive gender roles upheld by the cult of true womanhood. Rather, she "emasculates Black men because she will not permit them to assume roles as Black patriarchs" (Collins 2000, 84). For the welfare mother, her uncontrolled sexuality and low morals are identified as the cause of her impoverished state. In contrast to the other three images, the Mammy is an asexual image, which leaves her "free to become a surrogate mother to the children she acquired not through her own sexuality" (84). As Collins notes: "Each image transmits distinctive messages about the proper links among female sexuality, desired levels of fertility for working-class and middle-class Black women, and U.S. Black women's placement in social class and citizenship hierarchies" (84).

2.5 Oppression in Reproductive Rights Advocacy

The afterlife of slavery also impacts advocacy and policy decisions. In particular, reproductive rights for White women have routinely advanced in light of oppressive actions toward Black women and girls. The racist tropes about Black women described above provide a backdrop for regulation of Black reproduction. Roberts puts it succinctly when she writes, "America has always viewed unregulated Black reproduction as dangerous" (1997, 17). Black women are encouraged to reproduce freely, however, when doing so is tied to free/cheap labor and profits for White men. Collins argues that during chattel slavery and Jim Crow segregation, there was a need for cheap, unskilled labor in the South that "fostered population policies that encouraged Black women to have many children" (2004, 132). In the post-civil-rights era, however, poor Black children became more expensive to hire as workers, so Black children and youth became expendable. At the same time, Black children became eligible for social welfare benefits. "In this political and economic context, poor and working class African American women were encouraged to have fewer children, often through punitive population control policies" (133). Therefore, over time, policies that encourage Black women to produce more children *and* policies aimed to discourage their reproduction serve to further the interests of White supremacy.

Women of color generally, and Black women in particular, have long been aware that their reproductive destinies are shaped by racism and capitalism. Over the last three decades, the reproductive justice movement has formed in response. The term reproductive justice was coined in 1994, when a group of Black women gathered in Chicago, Illinois, prior to attending the International Conference on Population and Development in Cairo, Egypt. The discussion at the conference in Cairo would focus heavily on the individual right to choose when and how to start a family, but the group gathered in Chicago preemptively "recognized that the women's rights

movement, led by and representing middle class and wealthy white women, could not defend the needs of women of color and other marginalized women and trans people" (SisterSong). This group named themselves Women of African Descent for Reproductive Justice, a group that later expanded in into a collective known as SisterSong: Women of Color Reproductive Health Project. Today, SisterSong's mission is "to build an effective network of individuals and organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities" (SisterSong).

When SisterSong was formalized as a collective in 1998, it included sixteen women of color organizations from across the U.S., each of which was already involved in either providing direct reproductive health services or advocating around reproductive health issues, including "midwifery, AIDS services, abortion and contraceptive services, clinical research, health rights advocacy, sexually transmitted diseases, and reproductive tract infections" (Ross et al. 2001, 81). The sixteen organizations also equally represented four marginalized racial groups in the U.S.: Black/African-American; Latina/Hispanic; Native American/Indigenous; and Asian/Pacific Islander (81).

SisterSong combined the notion of reproductive rights with social justice to form the concept of reproductive justice. The group defines reproductive justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong). As implied in this definition, the group draws on international human rights movements, arguing that the U.S. should be held accountable to the same standards of human rights that are recognized around the world, and that the U.S. plays a key role in enforcing in other countries. Members of the collective write:

The United States lacks a sufficient legal framework that guarantees women of color safe and reliable access to health care; emphasis on individual civil and political rights neglects economic, social and cultural human rights that address group or collective needs. In order to ensure appropriate treatment and access to health care, and to address the intersectional oppression matrix (class, race, gender) that affects women of color, a comprehensive human rights-based approach is necessary. (Ross et al. 2001, 85)

The group seeks to challenge "the United States' denial of the applicability of human rights treaty norms, standards and mechanisms when developing or implementing domestic policies that negatively affect women of color" (Ross et al. 2001, 85). Today, members of the SisterSong collective are involved in training reproductive justice advocates across the country, educating mainstream groups about how to incorporate reproductive justice into their work, and mobilizing Black women to access political power.

Reproductive justice broadens the lens we use to look at issues of reproductive health and rights. In particular, it moves away from the concept of reproductive choice. As Ross writes:

Reproductive Justice says that the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community – and these conditions are not just a matter of individual choice and access. Reproductive justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny. (2006, 14)

As such, reproductive justice functions as a critique of the pro-choice movement. While reproductive justice activists strongly support improving access to abortion services, they also emphasize that any individual's freedom of choice is restricted by their social, political, and economic conditions.

As Rickie Solinger writes in her foundational book on race and reproductive politics, *Pregnancy and Power*, "the reproductive experiences of different groups of women in the United States have been distinct *and dynamic*" (2005, 24, emaphsis in original). By this, Solinger means that the experiences of White women and the experiences of women of color are different, yet they are also interrelated. She argues that the racial difference in the U.S. is dependent on race-based reproductive laws and experiences. White women's reproductive experiences are structured by "certain laws and policies that helped define and qualify certain women as white" (24). At the same time, Black women "have had their reproductive lives structured to various degrees by laws and policies devised to define the nonwhite status of these women and their children" (24). Thus, the advancement of reproductive rights for White women is ultimately built on the racialization and exclusion of women of color.

Whereas the mainstream reproductive rights movement focuses primarily on securing women's right to have an abortion, reproductive justice advocates have argued that the pro-choice framework neglects the economic, political, and social conditions that put women in situations where they have unwanted pregnancies. As Amber Johnson and Kesha Morant Williams put it: "Reproductive justice requires an undoing of all the conditions surrounding 'choice'" (2015, 151). Andrea Smith (2005) argues that both pro-life and pro-choice agendas are predicated on structures of White supremacy and capitalism that function to constrain the available choices for marginalized women. She also distinguishes between the "freedom to make choices" as advocated by the pro-choice framework and the assumption that women "possess inherent rights to their bodies regardless of their class standing" (134). Because it is hyper-focused on protecting women's ability to choose not to give birth to a child, Smith writes, "the pro-choice position often supports

population control policies and the development of dangerous contraceptives that are generally targeted toward communities of color" (134).

The invention of contraceptive pills in 1950s and its popularization in the 1960s was heralded as a life-changing innovation for women, because it allowed them to more easily make decisions about their when and how to have children. In the Black community, however, the invention and widespread use of contraceptives like the Pill has been highly controversial. While many Black women have benefitted from the use of hormonal contraceptives like the Pill, its popularization also hinged on an appeal to eugenicists who saw it as a means of negative eugenics (i.e. limiting birthrates among 'unfit' populations). Margaret Sanger, the most famous proponent of the birth control pill in the U.S., found that her feminist agenda – focused on women's rights to enjoy sex and choose when to have children – was not appealing enough to spur widespread popularity of the birth control pill. Instead, she appealed to a eugenics-based argument, which allowed her to appear to have scientific backing and argue that the availability of birth control would be a "national good." Roberts argues that while we cannot determine Sanger's personal beliefs about race/racism, we can say for sure that she perpetuated two harmful ideas: 1) "that social problems are caused by reproduction of the socially disadvantaged"; and 2) that "child-bearing [by socially disadvantaged people] should therefore be deterred" (1997, 90).

In 1939, Sanger worked with the Birth Control Federation of America (BCFA) to implement The Negro Project, "which 'was established for the benefit of the colored people,' specifically Black women who were being denied access to city health services" (Washington 2006, 197). This project attempted to address Black social ills via negative eugenics by offering free contraceptives specifically in largely Black areas. Although the Negro Project only functioned for a few years, Harriet Washington argues that the experiment was so successful that it persists in

various forms today. For instance, in the 1970s, The Pill was regularly made freely or cheaply available to poor Black women via government-sponsored Planned Parenthood clinics in central urban areas. These clinics also fitted far more Black women than White women with intrauterine devices (IUDs). As Washington writes:

> [A] history of forcible sterilization fed suspicions that the federally financed birth-control clinics in their neighborhoods were attempts to discover the best way to limit or even to erase the black presence in America…These genocidal fears were dismissed as paranoia, but prominent white physicians had long advocated a reduction in black births as a means of pinching off the race. (198)

While providing access to birth control is not inherently a eugenicist project, when women of color are specifically targeted to receive new birth control methods, it does raise the specter of the nation's troubled history with eugenics.

In some cases, the goal of regulating Black reproduction is more overt. Norplant, for instance, is a hormonal contraceptive that is inserted into the arm. "Planned Parenthood notes that 90 percent of Norplant implantations are paid through Medicaid in forty-three states. A higher proportion of African American women than white women receive these implants, chiefly in public and low-income clinics" (Washington 2006, 207). When Norplant was introduced in the U.S. in 1991-1992, large numbers of the fifty thousand devices implanted were for "black teenagers between thirteen to nineteen years old in the overwhelmingly African American Baltimore public schools" (207). In addition, in the 1990s, Norplant was used as an incentive for welfare recipients and as a form of mandated birth control in criminal cases. As Roberts points out, it is ideal for both these uses: "Once the device is inserted, a defendant cannot remove it on

her own, and it is easy for a probation officer or other official to cheek whether the capsules remain in place just by looking at the woman's arm" (1997, 203).

In addition, contraceptive methods are not always proven safe before they are targeted for use by poor, Black populations. The IUDs that were primarily dispensed in inner-city clinics to Black women in the 1970s, for instance, were taken off the market because they were associated with "deadly infections that hampered or destroyed users' fertility" (Washington 2006, 201). A variety of hormonal birth control methods – such as The Pill, Norplant, and the Depo-Provera shot – were first tested on women and girls in the global south (including Mexico, Africa, Brazil, Puerto Rico, and India). During the immediate post approval stage – when many serious effects of a drug often emerge for the first time – these hormonal birth control methods were distributed via Planned Parenthood clinics, school-based clinics, and urban health clinics to large numbers of Black and Hispanic women and girls:

> At this stage, serious health complications emerged with methods such as the IUD, Norplant, and the shot before they ever gained popularity with middle- or upper-class white women who are cared for by private physicians. In patterns too consistent to be accidental, reproductive drug testing makes poor women of color, at home and abroad, bear the brunt of any health risks that emerge. (202)

That is, in order for middle- and upper-class White women to have access to safe hormonal birth control, poor women of color are put at risk. Roberts captures the problem succinctly when she writes: "It is amazing how effective governments--especially our own--are at making sterilization and contraceptives available to women of color, despite their inability to reach these women with prenatal care, drug treatment, and other health services" (1997, 104). The demonization of Black

women as bad mothers naturalizes attempts to limit the number of children they give birth to while limiting or denying them access to other forms of reproductive health care.

Reproductive rights advocacy in the U.S. generally ignores this racial background and focuses primarily on the benefits of access to birth control for women and a woman's constitutional right to obtain an abortion. As Roberts argues, a focus on abortion rights is not enough to ensure reproductive freedom for all people:

> Reproductive liberty must encompass more than the protection of an individual woman's choice to end her pregnancy. It must encompass the full range of procreative activities, including the ability to bear a child, and it must acknowledge that we make reproductive decisions within a social context, including inequalities of wealth and power. Reproductive freedom is a matter of social justice, not individual choice. (1997, 15)

Therefore, reproductive justice touches on a wide variety of issues, including food security, incarceration and criminal justice, environmental issues, and immigration *as well as* access to abortions (Fortuna et al. 2019; Hayes, Sufrin, and Perritt 2020; Murphy 2017).

It is important to recognize that the reproductive justice movement is necessary because the reproductive rights movement actively participated in the regulation of Black women's reproduction. Hormonal birth control methods, including the Pill, IUDs, and hormonal implants, have all been targeted for use in poor, Black communities. Often, communities of color were targeted for early use of these products, before dangerous side effects have been discovered. In some cases, this has had detrimental effects on the fertility of Black women and birthing people. The reproductive justice movement has focused on a White, middle-class norm, which has both ignored the voices and needs of Black women and birthing people and perpetuated their oppression.

2.6 Conclusions

Discourses about racial disparities have consequences for Black birthing people and their communities. We began this chapter by noting possible positive outcomes for making Black women's experiences public. In some cases, it provides Black women with a space to affirm their identity and dignity and to organize for political action (S.M. Davis 2018; Morrissey and Kimball 2017). We then turned to the history of violence toward and oppression of Black women in the U.S. in order to grasp that history has dark matter that asserts agency in deliberations about racial disparities in troublesome ways. Natural science, medical, and social science research have all been implicated in justifying the exploitation and oppression of Black people, and related beliefs and assumptions still linger in public health research. Images and vocabulary that justify mistreatment are embedded deeply in our representations of Black women, often in ways White culture might not realize. Black women's reproduction has been and continues to be regulated in ways that White women's reproduction is not. As a result, the advancement of reproductive rights for White women has consistently interlocked with oppressive actions toward Black women and girls.

Therefore, researchers, journalists, policy-makers, and activists cannot assume that making Black women's reproduction more visible will result in improvements in their lives and experiences. This is due to the fact that when Black women's reproduction becomes the focus of public attention it has historically contributed to an increase in violence, oppression, and discrimination. This dissertation examines three interrelated processes by which maternal mortality and racial disparities become public: medical review, investigative journalism, and birth justice activism. This chapter connects each of these three processes with our nation's oppressive

legacy against Black women. This violent legacy is the 'dark matter' that makes public action around reproductive health possible.

Discourses about racial disparities in maternal health that do not address this historical context have potential to reproduce the same kinds of violence, discrimination, and oppression. Without context, the association between race and poor health reifies the notion that Black people are somehow inferior to White people. Although it has come under criticism, the biological-genetic model still undergirds many assumptions for some public health researchers (Mendez and Spriggs 2008; Risch et al. 2002). Furthermore, the health-behavior model of accounting for racial health disparities comes into play when the fact that Black people experience more complications during pregnancy and childbirth is used to indicate that they engage in unhealthy behaviors prior to and during their pregnancies (Dressler, Oths, and Gravlee 2005).

Because the images and vocabulary that demonize Black women as bad mothers are embedded in our discursive economy in ways we do not always realize, it is easy for journalists and reporters to reproduce them in their work. In fact, it is possible to be invoking or relying on such tropes without ever stating them explicitly. Wahneema Lubiano writes of the welfare queen image: "[she] is omnipresent in the media – even (and perhaps especially when) she is not explicitly named" (1992, 332). This is possible because the welfare queen (and, I would argue, the other tropes for Black women) stand in as a "single (albeit complicated) sign for and of everything wrong with the United States" (334). Thus, it is almost impossible for journalists to tell the stories of Black maternal mortality without either explicitly or implicitly invoking the tropes of the Jezebel, Mammy, Sapphire, or Welfare Queen.

Having addressed this dark matter, we are now in a better position to pursue three case studies about processes that make maternal mortality public. The context from this chapter should

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allow us to better identify both the possibilities and limitations of medical review, investigative journalism, and birth justice activism. The next chapter examines the role of public health infrastructure in making maternal mortality public through MMRCs. Members of MMRCs cooperate with the material infrastructure of public health surveillance systems to make evidential cuts that shape and produce knowledge about maternal mortality.

3.0 Evidencing Maternal Mortality

On December 21, 2018, U.S. President Donald Trump signed the "Preventing Maternal Deaths Act," which authorizes $12 million a year in new funds for states to establish or improve their maternal mortality review committees (MMRCs). The bipartisan bill was championed in the U.S. House of Representatives by Jaime Herrera Beutler (R-WA 3rd District) and Diana DeGette (D-CO 1st District), and in the U.S. Senate by Heidi Heitkamp (D-ND) and Shelley Moore Capito (R-WV). Unlike national forms of surveillance run by the Centers for Disease Control (CDC), the MMRCs funded by this legislation are expected to identify factors that contributed to individual deaths and develop recommendations for prevention (Creanga and Callaghan 2017; St. Pierre et al. 2018). Despite widespread acknowledgement that rates of maternal mortality are increasing and that the drastic racial disparities in maternal health require action, uncertainty remains as to the causes of increasing maternal mortality and widening racial disparities.[5] Therefore, production of knowledge about maternal mortality requires a process for making sense of the complex relationships between bodies, environments, and health care institutions. MMRCs are tasked with addressing that uncertainty.

MMRCs are state- and locally-based review committees that identify maternal deaths in their area and assess cases to suggest opportunities for prevention. Most MMRCs are coordinated and supported by their state or local health departments, and health department officials are responsible for recruiting and appointing committee members. Committee members include

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[5] Studies have suggested a wide range of factors, including: increases in chronic diseases, rising maternal age, disparate provision of and access to care, and social factors like income, housing, and education (Abe et al. 2019; Creanga et al. 2015; Dehlendorf et al. 2010; Smedley, Stith, and Nelson 2003). Some scholars have also argued that the spike in maternal mortality rates is in fact due to improvements in surveillance, indicating that rates of maternal death were underestimated in the past (Joseph et al. 2017; MacDorman et al. 2016).

medical doctors who specialize in maternal health, but many states also incorporate certified nurse-midwives, psychiatrists, social services providers, health statisticians, epidemiologists, and addiction medicine specialists. The committees review specific cases of maternal death and identify root causes, contributing factors, likelihood of preventability, and quality improvement opportunities.

In sum, MMRCs identify maternal deaths that have already occurred, evaluate the circumstances surrounding specific deaths, and use that information to create recommendations for future action. In doing so, members of MMRCs carry out both surveillance, research, and intervention activities. Public health surveillance is defined as: "the ongoing, systematic collection, analysis and interpretation of health-related data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know. The final link in the surveillance chain is the application of these data to prevention and control" (Thacker 2010, 2). Although early practitioners of public health surveillance believed it was distinct from prevention and control efforts, in practice, the results of surveillance are tightly linked to public health action (Birkhead and Maylahn 2010, 12). Public health surveillance involves many processes, including: data collection, data quality monitoring, data management, data analysis, interpretation of analytical results, information dissemination, and application of the information to public health programs (Groseclose and Buckeridge 2017, 58). Surveillance data are used to generate objectives for public health research, evaluate control and preventative measures, plan public health interventions, and appropriate and allocate resources (Thacker 2010, 13).

Khiara Bridges (2020), however, emphasizes that public health surveillance is not an ideologically neutral process. As she notes, the Preventing Maternal Deaths Act does not require

that the state- and locally-based MMRCs who receive federal funds investigate structural and institutional forces. She writes: "commissions can just as easily identify the problem of maternal mortality be structural in nature (i.e., due to low Medicaid reimbursement rates) as they can identify it to be individual in nature (i.e., due to a woman's obesity)" (1237). In this chapter, I emphasize that it is not only the individuals who are members of MMRCs who will make these kinds of determinations; the infrastructure of the public health surveillance systems those individuals utilize also will shape and direct their attention in particular ways.

This chapter explores how members of MMRCs cooperate with the material infrastructure of public health surveillance systems to co-produce evidence used to make important decisions about people's health at a population level. In the last chapter I argued that because efforts to make maternal mortality public are built on a legacy of violence and oppression, any attempt to address maternal mortality in general will center White women. Thus, it is unlikely that the results will address Black birthing people's experiences with the maternal healthcare system. The analysis in this chapter will observe the infrastructural elements of the public health surveillance system that obscure issues of race and racism, with detrimental consequences.

In this analysis, I argue that as committee members collaborate with public health infrastructures they make evidential cuts that shape knowledge about maternal mortality. Infrastructural objects like death certificates, standard case definitions, and testing for accuracy all narrow MMRC's view of what can be classified as a pregnancy-related death. Data collection tools and contributing factors used to determine preventability frame racial disparities in maternal health as fundamentally rooted in individual, racialized bodies.

Below, I review literature in rhetoric and science and technology studies on the role of non-human objects in producing medical evidence, focusing in particular on how these theories apply

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to public health research. I then introduce the artifacts and methods I use to identify key infrastructural objects that collaborate in producing evidence about maternal death. This chapter focuses on two methodological assessment conundrums faced by the committees: 1. How do we determine which deaths are pregnancy-related? and 2. How do we determine which deaths are preventable? The analysis stands to shed light on the public health dimension of maternal mortality, an especially important aim because the findings and recommendations produced by the MMRCs are taken up in media stories and reporting about this issue and can play a key role in shaping popular perceptions, clinical strategies, and legislative actions going forward.

3.1 Enacting Evidential Objects

In this chapter, I follow Christa Teston's (2017) call for rhetorical scholars to interrogate critically the ways that medical evidence is enacted through material-discursive practices. In her case study on biomedical decision-making about cancer care, physicians navigate uncertainty about the course of cancer in a particular patient's body. Physicians rely on medical evidence – including biopsies, PET scans, systematic reviews, and statistics – to make decisions about treatment plans. Medical evidences are rendered visible and actionable, Teston argues, by "backstage, behind-the-scenes biomedical practices" (1). That is, evidence is created through processes, practices, and performances that take place in conjunction with objects. These objects – microscopes, CT scan machines, X-ray machines, etc. – do *work* in the context of medical practice. This work is often invisible, but it should be examined. In order to understand the associations between human and nonhuman agents, Teston writes, scholars must recognize that "*things* in medical practice *do work*, and medical professionals do work with them" (19).

Scholars like Annemarie Mol (2002) and Karen Barad (2007) also argue that epistemological approaches to science have focused too much attention on whether or to what extent science represents reality. Rather, they argue that reality is enacted through material-discursive practices. That is, non-human objects also act, and as humans engage in practices and performances with technologies, infrastructures, and objects, humans themselves are remade. Mol (2002) also emphasizes that all phenomena have multiple ontologies based on the series of material-discursive interactions that have constituted that phenomena; certain ontologies come into being more easily and are thus more likely to intervene in and shape our world.[6] In Teston's (2017) terms evidenced objects come into being through specific practices. If the human being is one element of an assemblage that forms the world, she argues, the physical body and the cancer cells exist, but the *evidenced* object – the one that will be used for medical decision-making, "emerges through a series of material, spatial, and temporal performances" (57).

This process of co-production lays the groundwork for deliberation and decision-making about how to move forward. Teston terms these co-productions "evidential technologies"— "more than mere tools used by humans to find answers; evidential technologies such as these exert suasive force when possibilities for cancer care are made to matter" (2017, 21). Evidential technologies concern the ways that data are made to mean and encompass a wide range of scientific norms that determine what is counted and valued as evidence. Many scholars, for instance, have critiqued medicine's over-reliance on randomized clinical trials (RCTs) (Derkatch 2016; Solomon 2015). Scientists and statisticians have also been engaged in debate over the use and value of statistical tests of reliability (Chavalarias et al. 2016; Greenland et al. 2016; Wasserstein and Lazar 2016). The critique of RCTs and statistical tests are examples of scholars reflecting on the ways individual

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[6] For a detailed case study on how interdisciplinary medical professionals rhetorically navigate the multiple ontologies of pain, see Graham (2015).

points of data are made meaningful and persuasive through processes of evidential co-production. Therefore, evidential technologies are at the heart of rhetoric's perennial concern with both invention and judgment. A key challenge for rhetorical scholars is to examine the methods by which evidence is "visualized, assessed, synthesized, and computed prior to the deliberative decision-making moment" (Teston 2017, 6).

3.2 Infrastructural Practices and Performances

The practices and performances through which evidence is made persuasive are worthy of attention. For example, Teston (2017) outlines the ways that cancer-care professionals negotiate, map, and trace the constant change of cancer cells through imaging techniques, such as MRI scans, X-rays, biopsies, FISH tests, and pathological staining. Images used as evidence in cancer care are co-produced with nonhuman objects, including dyes, electrons, and microscopes. Mol argues that "*ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day sociomaterial practices" (2002, 6). What is involved in these practices? "Words participate, too. Paperwork. Rooms, buildings. The insurance system. An endless list of heterogeneous elements that can either be highlighted or left in the background, depending on the character and purpose of the description" (26).

In the context of public health research, objects like records, forms, checklists, and other standards and classification systems tend to figure prominently. Geoffrey Bowker and Susan Leigh Star emphasize that these infrastructures should also be understood as material. As they write, "classifications are means of spatially, temporally, or spatio-temporally segmenting the world " (2000, 10). Standards are the flip-side of classifications, in that they impose classification systems,

setting "agreed-upon rules for the production of (textual or material) objects" (13). Star and Lampland further argue, "such standardization is always a process of screening out unlimited diversity" (2009, 8). That is, standards and classifications function to constrain, build, and preserve knowledge.

Bowker and Star suggest that scholars practice what they call infrastructural inversion, foregrounding the practices that are ordinarily considered mere background to the legitimate processes of knowledge production (1998, 234). As they write, "This inversion is a struggle against the tendency of infrastructure to disappear (except when breaking down). It means learning to look closely at technologies and arrangement that, by design and by habit, tend to fade into the woodwork" (34). Thus, infrastructural inversion aims to move infrastructures from the invisible background to the foreground where they can be examined. To do so reveals the ways in which infrastructures of standardization "stabilize knowledge, freeze action, delete ourliers [sic] and facilitate use" (13).

Practicing infrastructural inversion is important, these scholars argue, because standards and classifications function as "objects for cooperation across social worlds" (Bowker and Star 2000, 15). At the same time, these infrastructural components have social ramifications that can be used to maintain hegemonic status quos: "Where they are used to make decisions, or to represent decision-making processes, such technologies also act to embed and reify those decisions" (135). In the analysis below, I aim to invert the infrastructures behind MMRCs, in order to call attention to the role infrastructures play in the performances that enact evidence about maternal mortality.

These infrastructural practices can also be understood as a means of attuning to the material world around us. The process of recording and reporting the events that occur to and within bodies in death certificates, toxicology reports, medical records, case report forms, and statistical analyses

is a process of attunement. Like the attunement Teston (2017) discusses in the context of cancer care, infrastructural attunement is not neutral. Kuchinskaya (2015) points out that infrastructural conditions define the limitations of our ability to articulate health dangers. That is, our ability to identify the scope and character of environmental dangers and make them observable or apparent is dependent on the available tools, standards, categories, and thresholds (8).

Mitigating uncertainty around maternal mortality requires attuning to the nature of racial disparities in maternal health. Explanations for racial health disparities in the public health literature vary widely, including individual-level biological and lifestyle issues, social determinants of health, psychosocial responses to social conditions, and political and economic determinants of health and disease (Dressler, Oths, and Gravlee 2005; Geronimus 1992; Krieger 2011; Prussing 2014; Shim and Thomson 2010). However, funding for epidemiologic research often focuses on the biomedical questions of surveillance and etiologic research (Carter-Pokras et al. 2012). Given vast racial disparities in the rates of maternal mortality, infant mortality, and other life-threatening diseases (Creanga et al. 2015; Joseph et al. 2017), it is important to attend to the ways that MMRCs aim to resolve uncertainty about racial disparities.

3.3 Artifacts and Critical Approach

This chapter addresses how the infrastructure MMRCs use for data collection and assessment shapes the public health framework for addressing maternal mortality. I trace ways that committee members and infrastructure collaborate to make evidential cuts that resolve key methodological assessment conundrums. Methodological assessment conundrums emerge from discrepancies about how to assess the weight of evidence (Teston 2017). Karen Barad (2007) coins

the term *agential cut* to refer to the ways that material practices enact boundaries, properties, and meanings within an otherwise inseparably entangled universe. Teston uses the term *evidential cut* to describe the choices researchers make about "which evidences will or will not count in their final arguments" (2017, 95). Evidential cuts are unavoidable responses to methodological assessment conundrums, as answering such questions inevitably involves decisions about enacting boundaries, properties, and meanings out of massive amounts of data.

To identify the infrastructural objects involved, I examine the data collection and research processes for MMRCs in two of the largest states in the country (California and Texas), as well as for two smaller jurisdictions (Delaware and Philadelphia). California and Texas are the two states with the most live births in country and have fairly active MMRCs. However, the two states differ in their population, politics, and the approaches of their MMRCs. While neither California nor Texas include family interviews in their data collection processes, some smaller MMRCs do. My study accounts for this by including materials from Delaware and Philadelphia's MMRCs, enabling analysis of how qualitative data from family interviews might be incorporated into the infrastructure for enacting maternal mortality. Basic information about the MMRCs is included in Table 1.

Table 1. MMRCs Included in Analysis

MMRC	Committee Size	First Convened	Live Births	Deaths Reviewed	Data Used for Review
California	30	2007	503,788 in 2012	159 in 2012	Medical and Public Health Records
Texas	17	2014	382,438 in 2012	89 in 2012	Medical and Public Health Records
Delaware	26	2011	10,855 in 2017	5 in 2018	Medical and Public Health Records, Family Interviews
Philadelphia	28	2012	23,000 in 2016	55 from 2010 to 2012	Medical and Public Health Records, Family Interviews

The analysis in this chapter is based on a total of 58 workflow documents and reports. Some documents, such as policies, forms, data dictionaries, and interview protocols, are materials that guide MMRC action. Others, such as reports, articles, and briefings, are produced by MMRCs and are useful for the descriptions they provide of the process by which the MMRCs identify maternal deaths, review cases, and make recommendations. Since my aim is to identify the ways the material infrastructure MMRCs use for data collection and assessment shape the public health framework, I begin by coding any passages that describe infrastructural elements or public health recommendations from the committee. This process identifies four broad practices enabled by infrastructural objects: data collection, data abstraction, policies and procedures for case review, and translation into quality improvement opportunities and recommendations. Across all of these four practices, two primary points of tension emerge about how to collect and evaluate information: 1. How do we determine which deaths are pregnancy-related? and 2. How do we determine which deaths are preventable? Below, I provide an overview of the MMRC process and then focus on how infrastructural objects play a role in answering each of the above questions. The ensuing analysis shows how MMRCs tune evidence to medicalized, individualized bodies.

This has important implications for grasping how public health contributions shape emergent understanding of racial disparities in maternal mortality as a public concern.

3.4 Overview of Maternal Mortality Review

The maternal mortality review process is a vast classification system that enacts the evidence used to create strategies for preventing maternal death. While the process differs slightly from state-to-state, large states like California and Texas follow four major steps, as shown in Table 2. First, there must be a process for identifying maternal deaths and determining which deaths will be reviewed by the committee. Not all MMRCs are able to undertake an extensive review process for all the maternal deaths that occur each year in their jurisdiction. Some states, like California, follow a specific set of procedures to sort deaths that are likely to be pregnancy-related from deaths that are pregnancy-associated but not related.

According to the CDC's definitions, all deaths that occur during pregnancy or within one year of the end of pregnancy, regardless of their cause are referred to as *pregnancy-associated deaths.* Pregnancy-associated deaths can be divided into two possible categories. First, if a woman dies while pregnant or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy, her death is referred to as a *pregnancy-related death*. If a woman dies during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy, this is referred to as a *pregnancy-associated but not-related death*. Most MMRCs only focus on pregnancy-related deaths in identifying opportunities for improvement and prevention.

Table 2. Maternal Mortality Review Committee Process

Step	Identify Potential Pregnancy-Related Deaths	Collect and Abstract Medical Records	Committee Review	Developing Recommendations for Prevention
Description	Maternal deaths are identified by linking birth certificates, maternal and fetal death certificates, and hospital discharge data.	Available information about each potentially pregnancy-related case is abstracted onto a standardized committee review form	Cases are reviewed by a multi-disciplinary committee	Published report includes recommendations for preventing maternal deaths
Process	Identify all pregnancy-associated deaths in a given year Some MMRCs (like California's) also take an extra step of identifying cases that are most likely to be pregnancy-related for committee review	Medical records are requested for potentially pregnancy-related cases Trained abstractors review records and record information on standardized, de-identified forms Abstractors transcribe all relevant medical records information into a chronological narrative summary Information packets are assembled for committee review.	During the review, the committee answers the following key questions: Was the death pregnancy related? What was the cause of death? What was the risk level at time of prenatal and intrapartum care? What are the patient, health care professional, and health care facility factors that may have contributed to the woman's death? Were there opportunities for improvement identified in the course of care the woman received?	Recommendations are developed based on quality improvement opportunities identified for specific cases and the broader deliberations during case review

Once a group of cases for review have been identified, medical records are collected and standardized for committee review. Ideally, state and local health departments hire staff to handle

the process of identifying cases, collecting records, and abstracting information prior to committee review. The medical records that are collected include prenatal records, hospitalization records, outpatient and emergency department visits, and medical transport documentation. In addition, if they are available, health departments collect coroner/medical examiner autopsy and toxicology reports from coroners or medical examiners. Some MMRCs, including Delaware and Philadelphia, also interview family members of the deceased, if possible. Information from these medical records is recorded onto standardized, de-identified abstraction forms. In addition, the abstractors create a chronological case narrative summary for each case. The case summaries, abstraction forms, and key pieces of the medical record are assembled for the committee to review.

It is only after the cases have been sorted and abstracted that they are reviewed by the committee. MMRCs are intentionally interdisciplinary, and include healthcare professionals, public health officers, epidemiologists, social services providers, and medical examiners. However, it is important to note that the committees are heavily weighted toward the perspective of medical clinicians. During the review process, the committee answers a series of key questions about pregnancy-relatedness, risk level, contributing factors, and quality improvement opportunities. After the committee has identified quality improvement opportunities for each case, these are generalized into recommendations for improving maternal health that are applicable at the state or local level.

3.5 Classifying Pregnancy-Related Deaths

One of the central tasks for MMRCs as they address uncertainty around maternal death is distinguishing between pregnancy-associated deaths and pregnancy-related deaths. Identifying

pregnancy-related deaths is a key move for the MMRCs, as it is the first step in the process toward identifying opportunities for prevention. The infrastructure the MMRCs rely on is developed to facilitate this particular classification. MMRCs in small jurisdictions, like Delaware or Philadelphia, are able to review all maternal deaths that occur in one year, and Texas's Health Department directed the MMRC to review all cases of maternal death in the legislation that formed the MMRC. California, however, has developed a standardized set of procedures designed to "identify the likeliest yield of pregnancy-related cases among each cohort" (Mitchell et al. 2014, 519). The committee describes these protocols as an algorithm that can be used to determine which cases are sent to the full committee for review, at which time they will officially be classified as either pregnancy-related or pregnancy-associated but not related.

The MMRC's case selection algorithm is a series of material, spatial, and temporal classification practices that contributes to producing the evidenced object of maternal mortality. Bowker and Star describe a classification system as "a set of boxes (metaphorical or literal) into which things can be put to then do some kind of work – bureaucratic or knowledge production" (2000, 10). Here, MMRCs classify the circumstances surrounding the deaths of people who are pregnant or have recently given birth in order to produce knowledge about possibilities for preventing maternal mortality. Furthermore, "Each standard and each category valorizes some point of view and silences others" (5). For instance, the cause of death codes used by the MMRCs are standardized by the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Bowker and Star write of the medical classifications in the ICD-10: "They do not describe the world as it is in any simple sense. They necessarily model it. This modeling within classification systems of all sorts is where the rubber hits the road in terms of the enfolding of social, political, and organizational agendas into the scientific work of describing nature" (102).

In the same way, the case selection algorithm used by California's MMRC cannot fully account for the role that pregnancy and childbirth played in the deaths of the individuals involved. Rather, it enacts a picture of maternal death using performances that are oriented around a medicalized view of the reproductive body. Below, I trace the ways that three infrastructural objects – death certificates, standard case definitions, and standards for assessing accuracy – play a role in the evidential attunement necessary for MMRCs to define and classify pregnancy-related deaths.

3.5.1 Death Certification

Much of the work of the MMRCs is structured around death certificates, but this is not to say that MMRCs rely solely on death certificate information to determine pregnancy-relatedness. Rather, the MMRCs gain legitimacy to the extent that they can demonstrate that their review process is more accurate than national forms of pregnancy surveillance that rely primarily on death certificate data. Therefore, death certificates function as pivotal objects that shape the structure of the review process in two ways. First, initial evidential cuts about which deaths might be pregnancy-related are made on the basis of causal and temporal information recorded on death certificates. Second, death certificates consistently function as a point of comparison for the MMRCs.

Death certificates should be viewed as infrastructural objects. The production of death certificates is a form of shadow work – or invisible, ambient labor (Lampland and Star 2009). If a person dies in a hospital, under the care of healthcare professionals, their death certificates are completed by physicians. Bowker and Star note that for most physicians, death certification is an unappealing aspect of the profession, since it is boring, low-status, and is regarded as clinically

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unimportant (2000, 24). Physicians in hospitals may have other priorities and incentives and "seldom understand that their diagnoses guide national health priorities" (Rampatige et al. 2014, 3). In cases where a person dies in sudden, violent, or suspicious circumstances, the death is reported to medical examiners[7] or coroners[8] who are responsible for completing an investigation and death certification.

In the case of California's case selection algorithm, all pregnancy-associated deaths are identified by linking death certificates for all female California residents with birth and fetal death certificates. Death certificates are central to the review process because, as Steven Timmerman notes, "The words on the death certificate form the final link in a chain of transformation from life into death" (2006, 66). Death certificates are our society's means of legally and institutionally recording a narrative about the events leading up to a person's death. As such, they also function as what Bowker and Star (2000) refer to as a boundary objects, which function across multiple communities of practice because they are plastic enough to be useful in a variety of different contexts, but also robust enough to maintain informational utility. Death certificates function as boundary objects as they offer a means of communication "between the state bureaucracy, legal institutions, and medicine" (Timmerman 2006, 71).

Once pregnancy-associated deaths are identified, their data are merged with hospital discharge data and available public health records, including death certificates, coroner, medical examiner, autopsy, and toxicology reports. Next, the cases are sorted into two categories – those that are identified on the death certificate as having a cause of death related to pregnancy or

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[7] Timmerman (2006) in-depth study of a medical examiner's office traces the pathological, social, legal, and moral work performed by medical investigations, highlighting the medico-legal and cultural authority afforded to medical examiners.

[8] In some U.S. counties coroner is an elected position and may require little or no medical training. As of 2004 (the latest available data), 14 states had a county coroner system, and 13 had a mixed county medical examiner and coroner system (Hickman et al. 2004).

childbirth, and those that are not. The cause of death section of a death certificate has three sections: cause of death, approximate interval between onset and death, and other contributing factors or significant conditions. The underlying cause of death is "the disease or condition that initiated the train of morbid events leading directly to death." Timmerman notes that, read from bottom to top, the death certificate provides a chronological and etiological narrative of the death, ordering cause of death from the most remote to most immediate cause and from underlying condition to subsequent complications (2006, 58). In the case of maternal mortality review, a key cause of death in question is obstetric death. The ICD-10 includes a set of codes specifically designed to identify deaths due to obstetric issues – Codes O00-95 and O98-O99, often referred to as "O-codes." For example, the ICD-10 codes associated with preeclampsia/eclampsia are O11 and O13-16.

All O-code deaths are then further sub-divided into early deaths and late deaths. Death certificates also provide a means for MMRCs to classify maternal deaths temporally. Beginning in 2003, many states began to implement a pregnancy check-box on the death certificate. This check-box asks the certifier to indicate the pregnancy status of the deceased, with five options: 1) Pregnant at time of death; 2) Not pregnant at time of death, but pregnant 0-42 days before deaths; 3) Not pregnant at time of death, but pregnant 43 days – 1 year before death; 4) Not pregnant within the year before death; and 5) Unknown. The committee can use this checkbox to identify all early O-code cases (during pregnancy or within 42 days postpartum), which are automatically included in the cases that are sent to the committee for review.[9]

The medical and public health records associated with all late O-code deaths (occurring 43-365 days postpartum) are screened for language related to pregnancy or death related to

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[9] It is important to note that deaths from ectopic pregnancies or abortion-related deaths are often not captured, since fetal death certificates are unavailable for deaths occurring before 20-weeks gestation (Mitchell et al. 2014).

pregnancy. In cases where such language is found, those cases are included in the cases that are sent to the committee for review, and all others are excluded. Finally, non-O-code deaths are evaluated. All motor vehicle accidents, homicides, and suicides are automatically excluded from the review. The remaining non-O-code deaths are also screened for inclusion based on language related to pregnancy or death related to pregnancy, and in cases where such language is found, those cases are also included, along with the identified O-code cases, for review.

California, for instance, reported that if they had relied solely on death certificate O-codes when reviewing deaths that occurred from 2002 to 2007, they would have missed a total of 78 pregnancy-related deaths. In particular, cardiovascular deaths were often not identified by an obstetric code. This was a significant finding, since over a third of cardiovascular deaths among African-Americans were miscoded. Many of the significant findings reported by MMRCs reflect this kind of comparison with the results of death certificate data alone. As a result, attention is drawn toward new findings the MMRCs produce by comparing their results with the data available on death certificates. In fact, in California, members of the MMRC took the time to further examine 64 cardiovascular pregnancy-related deaths to learn more about racial disparities, risk factors, signs and symptoms of death, birth outcomes, and contributing factors (Hameed et al. 2015). This demonstrates that the findings produced by comparing the results of MMRC review and death certificate data direct knowledge production along a particular path. In this case, the path pointed toward a deeper understanding of the nature of pregnancy-related cardiovascular deaths, as well as the nature of racial disparities in maternal mortality.

Certain ICD-10 codes, however, function much more definitively in the MMRC process than O-codes do. All of the MMRCs included in my study exclude violent deaths due to homicide (ICD-10 Group number 338-346) and suicide (ICD-10 Group number 331-337) from their analysis

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of pregnancy-related deaths. As described in more detail below, the MMRCs articulate a variety of reasons for excluding violent deaths from review. While California excludes homicides and suicides as a component of their case selection algorithm, other states, like Texas, exclude them by clearly defining them as not-pregnancy-related deaths. However, discrepancies in committee's explanations for excluding homicides and suicides from analysis of pregnancy-related deaths reveal violent deaths as a significant point of tension/methodological conundrum. Below, I argue that the exclusion of violent deaths from MMRC review is an evidential cut made in collaboration with standard case definitions and standards for assessing accuracy.

3.5.2 Standard Case Definition

Formation of standard case definitions is a foundational step in public health surveillance. The standard case definition is the criterion by which a public health researcher decides whether an individual illness or disorder is included as a case in their investigation. In the case of MMRC review, the standard case definition determines whether or not a particular case is identified as pregnancy-related and thus included in the cases assessed for preventability. More restrictive case definitions may minimize false positive cases, but they can also exclude true cases, and "are most useful when investigating a newly recognized condition, in which the ability to determine etiology, pathogenesis, or risk factors is decreased by inclusion of non-cases in the study population" (McNamara and Martin 2018, 1). Given that MMRCs represent some of the first thorough investigations into maternal mortality as a public health issue, they may be relying on a more restrictive standard case definition for their reviews.

However, it also appears that states are relying on differing interpretations of the standard case definition for pregnancy-related death. The CDC defines a pregnancy-related death as "the

death of a woman while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Centers for Disease Control 2019). Texas's MMRC elaborates that causes of death related to the pregnancy could include "(a) a pregnancy complication; (b) a chain of events initiated by pregnancy; or (c) the aggravation of an unrelated condition by the physiologic effects of pregnancy" (Texas Maternal Mortality and Morbidity Task Force 2016, 3-4). California uses the same definition of pregnancy-relatedness, elaborating, "If a woman dies while pregnant or within one year of termination of a pregnancy from causes unrelated to pregnancy or its management (e.g., injuries or complications of other conditions) then the death is defined as not-pregnancy-related" (The California Pregnancy-Associated Mortality Review 2017, 12).

In the case of both suicide and homicide, MMRCs from Philadelphia and California point out that violent deaths could, in fact, be pregnancy-related. For instance, Philadelphia's MMRC states, if "a woman committed suicide because she was devastated from suffering yet another miscarriage" or "was killed by her partner because he was upset with her for being pregnant" (Buehler et al. 2015, 9), these would be considered pregnancy-related deaths. In contrast, however, Texas's MMRC excludes suicide cases by default, describing them as "non-natural, non-obstetric causes" that are not classified as pregnancy-related (Texas Maternal Mortality and Morbidity Task Force 2016, 19). Delaware and Texas both explicitly exclude homicides by default, based on the definition of pregnancy-relatedness. Texas lists homicide as a non-natural, non-obstetric case of death (Texas Maternal Mortality and Morbidity Task Force 2016, 19) and Delaware automatically classifies homicides under non-pregnancy-related deaths, describing pregnancy-related deaths as

those due to "medical complications of pregnancy" (Delaware Child Death Review Commission 2018, 20).

Thus, Delaware and Texas use the standard case definition to make an evidential cut that excludes homicide deaths. Based on their application of the definition, the relationship between the pregnancy and the death should be physiological, or medical. The key tension here focuses around the clause "from any cause related to or aggravated by the pregnancy or its management" referred to in the CDC's definition. If it is assumed that the relationship between the pregnancy and the cause of death must be purely physiological, then the definition would appear to exclude homicide deaths (though it would less definitively exclude suicide deaths). However, if there is room in this clause to interpret the relationship between the pregnancy and the cause of death as having social or interpersonal causes, the range of deaths that could be included in the category of pregnancy-relatedness would be expanded.

When used to track diseases, standard case definitions are intended to be simple, clear, concise definitions that can be easily applied to everyone in the population of interest. The case definition for pregnancy-related death, however, reveals the complexities of a surveillance effort designed not to track individual diseases, but to track the relationships between pregnancy and various health outcomes. Rhetorical scholars have demonstrated that definitions are not objective reflections of the world around us. Rather, they should be viewed as strategies, responses to situations that posit attitudes, or agendas toward those situations (Chesebro 1985; Walton 2001; Schiappa 2003). When definitions move from flexible social use to being objectified as standard case definitions, however, they become solidified as a component of the infrastructure for tracking maternal mortality.

The discrepancies between the MMRCs' interpretations of the definition of pregnancy-related death exemplifies what Edward Schipappa calls a definitional rupture. A definitional rupture reveals the instability of our natural attitude toward definitions, that is, it disrupts the "often unspoken and unexamined belief that definitions unproblematically refer both to the nature of X and to how the word X is used" (Schiappa 2003, 7). In this case, the discrepancy in interpreting the definition of pregnancy-related death reveals the extent to which the definition cannot unproblematically capture all deaths related to pregnancy. For states like Texas and Delaware, it seems unproblematic to assume that the true nature of pregnancy-related deaths is that they are physiological, whereas California and Philadelphia are wrestling with the discrepancy between the potential "reality" of what pregnancy-related deaths are and the way we define the term in surveillance infrastructures.

In some parts of the U.S., homicides are actually among the leading causes of death for pregnant and new mothers.[10] In California, for instance, homicide accounted for about 8% of the non-obstetric maternal deaths between 2002 and 2007, a total of 58 murders. The only medical cause of death with a higher number of total deaths in California during that time period was cardiovascular disease (The California Pregnancy-Associated Mortality Review 2017, 17). Texas's Task Force found that between 2012 and 2015, 12% of maternal deaths were homicides (Texas Maternal Mortality and Morbidity Task Force 2018, D-1). Diana Cheng and Isabelle Horon found that homicide was the leading cause of pregnancy-associated death in Maryland, accounting for a total of 17% of deaths between 1993 and 2008 (2010, 1182).

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[10] This is partially because homicide is among the leading causes of death for young females in the U.S., along with cancer, heart disease, suicide, and unintentional injuries (Centers for Disease Control and Prevention, 2019b).

The MMRCs exclude homicides from their analyses because they do not have a physiologic relationship to pregnancy, and the infrastructure of the MMRC only allows for the study of the physiological body. However, researchers and scholars have argued that there are likely some homicides that would not have occurred if the victim had not been pregnant. In a study of death certificates in U.S. states between 2005 and 2010, Maeve Wallace and her colleagues found that pregnant women were more likely than non-pregnant women to be murdered: "the risk of homicide among pregnant/postpartum women was 1.84 times that of nonpregnant/nonpostpartum women" (2016, 364.e4).

Many of these homicides may well have been the result of intimate partner violence (IPV). While studies have found that IPV does not normally begin for the first time during pregnancy, it can often increase in frequency or intensity when a woman becomes pregnant (Alhusen, Frohman, and Purcell 2015; Mogos et al. 2014). Because IPV is often related to an abusive partner's desire for control, an unwanted pregnancy can be a "precursor for violence or a factor that leads to greater frequency and intensity if IPV" (Hampton 2015b, 12). In addition, such coercive, controlling violence can be triggered by significant relationship changes, such as pregnancy (Hampton 2015a, 5).

The erasure of homicides from maternal mortality also erases the experiences of those who are most vulnerable to violence. Studies have repeatedly found that younger women, Black women, and unmarried women are far more likely to be victims of both intimate-partner homicide and non-partner homicides (Cheng and Horon 2010; Wallace et al. 2016). Horon and Cheng (2005) found that, when comparing the rate of homicides in pregnant White and Black women, Black women under 20 years old were five times more likely to be murdered, and Black women between 25-29 were eleven times more likely to be murdered.

In their 2002-03 report, members of California's MMRC write that because the committee does not automatically review homicide and suicide cases, "estimates of pregnancy-related deaths are likely underestimates as they will not include some violent deaths that were triggered by the pregnant status and condition of some women" (The California Pregnancy-Associated Mortality Review 2011, 16). These lines from the California MMRC highlight that that the MMRC process enacts only one possible version or picture of maternal mortality, and that others could come into existence through different practices, different data, different infrastructures.

3.5.3 Testing for Accuracy

The MMRCs that have not made the evidential cut to exclude violent deaths on the basis of standard case definitions do so based on the standards for accuracy in epidemiological research. Assessments of sensitivity, specificity, and predictive values are used to legitimate the results of medical and epidemiological tests that involve a binary classification process (in this case, classifying maternal deaths as either pregnancy-related or pregnancy-associated but not-related). Sensitivity and specificity calculations are used to assess how accurate tests are in discriminating between positive and negative cases.

Sensitivity identifies the proportion of individuals who do have a disease or illness and are given a positive test result (the true positive rate). Specificity measures the test's ability to correctly identify individuals who do not have a given disease or illness (the true negative rate). For MMRCs, sensitivity would refer to the proportion of deaths deemed pregnancy-related that are indeed pregnancy-related, while specificity would refer to the proportion of deaths deemed not to be pregnancy-related that are in fact not pregnancy-related. Therefore, the sensitivity and specificity of a test are often inversely related: "Generally, a screening test should be highly

sensitive, whereas a follow-up confirmatory test should be highly specific" (McNamara and Martin 2018, 1).

Sensitivity and specificity also depend mathematically on the prevalence of a condition, which is measured by predictive values. The positive predictive value (PPV) measures the proportion of correctly identified positive cases in a population. The negative predictive value (NPV) measures the proportion of correctly identify negative cases in a population. Therefore, predictive values will depend on both test sensitivity and specificity as well on the prevalence of the disease or disorder in the population. Positive and negative predictive values are important measures in evaluating the success of any screening or surveillance program.

Members of the Texas MMRC focus in on sensitivity, specificity, and PPV in assessing the accuracy of the standard method for identifying maternal deaths (Baeva et al. 2018). Compared to their enhanced method, the standard method had high sensitivity and specificity (83 and 99% respectively). However, only 32% of the maternal deaths identified by the standard method were confirmed using the committee's enhanced method, meaning that it had a low PPV and is likely to over-identify maternal deaths. Other documents by the committees do not make explicit statements about sensitivity, specificity, or PPV, likely because there is not currently a more thorough, nation-wide method for identifying pregnancy-related deaths that their results could be tested against. However, the concern about inaccurately identifying some deaths as pregnancy-related that may, in fact, not be pregnancy-related reflects a concern about measures of specificity and PPV.

MMRCs, like those in California and Texas, that acknowledge that violent deaths could be pregnancy-related, argue that they cannot include violent deaths in their review of pregnancy-related deaths because they will have difficulty establishing a fact pattern that is strong enough to demonstrate that the death was in fact pregnancy-related. For instance, members of the California

MMRC published an earlier article in the *Maternal and Child Health Journal*, reviewing deaths from 2002-2004. Connie Mitchell and her colleagues state that homicides and suicides specifically are excluded because, in the pilot review process, the committee found that without mental health or law enforcement records, it was difficult for the committee to determine whether or not to classify the death as pregnancy-related (Mitchell et al. 2014). Thus, the California MMRC acknowledges that such deaths could be related to pregnancy and childbirth, either directly or indirectly, but that the committee has not collected the data necessary to make such a judgement. Here, the committee is reflecting a concern about the sensitivity, specificity, and PPV of their work.

Therefore, these standards for assessing the accuracy of a medical review function as infrastructural objects that attune the committee members to see certain kinds and forms of evidence in particular ways. By defining the boundaries of what will and will not be included in the analysis, sensitivity, specificity, and PPV function to distill "data from noise" (Teston 2017, 77) and render order from biological, environmental, and social chaos. In doing so, however, these standards narrow the horizon of possibilities for categorizing pregnancy-related deaths and identifying opportunities for prevention.

This section has focused on the role infrastructural objects play in classifying deaths as pregnancy- and non-pregnancy-related. Since pregnancy-related deaths are the ones that are examined by MMRCs in order to identify opportunities for prevention, this distinction is a crucial one. Each MMRC utilizes a case selection algorithm, a series of material, spatial, and temporal classification practices that ultimately produces the evidenced object of pregnancy-related death. Death certificates provide an initial means for committees to classify deaths by cause and timing. Standard case definitions and standards for assessing accuracy in epidemiological research further

serve to make evidential cuts in the classification process, for example by excluding violent deaths from review. These evidential objects function to focus the committee's attention to physiological relationships between pregnancy and death. While this may be a justifiable focus for MMRC purposes, the point of the preceding analysis is to highlight the contingency of the MMRC process, which enacts only one possible version or picture of pregnancy-related death, and that others could come into practice through the use of different infrastructural objects.

3.6 Classifying Preventability

After the selection algorithm identifies deaths that are likely to be pregnancy-related, members of MMRCs are faced with a second methodological assessment conundrum: How do we determine which of these deaths were preventable? MMRCs aim not only to identify cases of morbidity and mortality, but also to provide recommendations for improving maternal health in their communities. The policy implementing Delaware's MMRC, for instance, states:

> The ultimate purpose of these reviews is to describe and track factors associated with maternal deaths, identify systems-wide issues that may have contributed to the deaths, develop recommendations for change, disseminate information and assist in the implementation of recommendations that will improve the health of mothers and infants in Delaware. (Delaware Child Death Review Commission 2016, 1)

In order to develop recommendations, committees distinguish between cases where death was preventable (i.e. where there was a chance to alter the outcome), and cases where there was little or no possibility of altering the circumstances that led to the death. Partially mirroring the process used for classifying deaths that are likely to be pregnancy-related, members of MMRCs collaborate

with infrastructural objects to make evidential cuts about preventability. Data collection tools and contributing factors function as key infrastructural objects that collaborate in generating and shaping evidence committees use to make judgements about preventability.

3.6.1 Data Collection Tools

In order to address the question of preventability, committee members need more data about each case. Once cases to be reviewed are identified, additional data about each case are collected and synthesized for members to inspect. The types of data collected and the means of collecting that data shapes the form of evidence committee members use to determine factors contributing to each death and the likelihood of preventability. The MMRCs in this study collaborate with two specific data collection tools – medical record abstraction forms and family interview questionnaires – to generate evidence about specific deaths.

Medical record abstraction forms provide a means of structuring the variety of information available on medical records. The MMRCs included in this study collect information from death certificates, vital statistics records, hospital discharge data, medical records, and death investigation reports (Baeva et al. 2018; Buehler et al. 2015; Delaware Child Death Review Commission 2018; The California Pregnancy-Associated Mortality Review 2011). Data from these documents are transcribed onto standardized, de-identified abstraction forms to protect confidentiality and improve the efficiency of the review process. For analysis in this study, I relied on the data abstraction forms used by California's MMRC, which include individual forms to collect the following: demographic information, medical history, prenatal care, transport, labor and delivery and immediate postpartum, terminal event/autopsy, and additional outpatient, ER, or

postpartum visits.[11] Altogether, completion of the medical abstraction forms results in at least 20 pages of documentation for each case.

As an infrastructural object, the abstraction forms shape and direct attention to certain types of information. Rhetorical scholars have noted that medical forms are not merely blank slates for recording information. Rather, the structure of the forms shapes the medical practice and discourse that surrounds it. Lisa Keränen (2007), for instance, demonstrates that conversations about end-of-life decision making are fundamentally shaped by hospitals' "Patient Preferences Worksheets." Roger Munger argues that arrangement of run reports generated by emergency medical technicians impact EMTs immediate and future medical practices (1999, 119). Similarly, the use and arrangement of check boxes, short answer blanks, and narrative space on the abstraction forms structure the deliberation that take place during the MMRC's review process. Committee members rely on the evidence as it is presented in these forms to make judgements about pregnancy-relatedness, cause of death, risk-level, contributing factors, and preventability.

California's MMRC repeatedly notes that, while medical records are necessary for the review process, reliance on them alone has significant limitations. First, the committee's judgement is constrained by the documented information, which "seldom fully captures the dynamic nature of the medical decision-making" (The California Pregnancy-Associated Mortality Review 2011, 16). This is particularly true in cases where there are gaps or missing information in the medical records. Significantly, not all information about a provider's perspective on medical care and treatment is evident in medical records.

In addition, medical records provide limited information about social determinants of health (SDHs), which are "factors apart from medical care that can be influenced by social policies

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[11] The forms used by California's MMRC are adaptations of sample forms used by Florida's MMRC and published in the CDC's *Strategies to Reduce Pregnancy-Related Deaths* (2001).

and shape health in powerful ways" (Braveman and Gottlieb 2014, 19). Reliance on medical records alone leads to a bias toward the clinical perspective, obscuring factors related to the delivery of healthcare or patient barriers to care (The California Pregnancy-Associated Mortality Review 2011, 50). Because medical records are written by medical professionals for use by medical professionals, they necessarily do not include a patient's perspective on their own care and treatment.

While medical records do include some information about what might be called "social risk factors," (such as smoking, diet, and drug and alcohol use) these are what Braveman, Egerter, and Williams (2011) call downstream determinants of health. Focusing on social risk factors centers medical care and traditional health promotion/education as appropriate solutions. Frank Baum, however, emphasizes that a thorough understanding of SDHs requires acceptance that medical therapies are limited in their ability to make significant improvements to population health (2007, 92). Braveman, Egerter, and Williams (2011) argue that we need to turn our attention to the upstream determinants, or "causes of causes" (Braveman and Gottlieb 2014) of health, such as income, wealth, and education. Other scholars have also argued that there is a need to expand our view of social determinants of health in order to account for racial disparities in health. Amy Schulz and her colleagues, for instance, argue that macrosocial factors, such as historical conditions, legal codes, economic structures, and ideologies influence downstream determinants of health in important ways (Schulz et al. 2002, 690). Therefore, the extent to which SDHs are accounted for in reviews of maternal death will play a major role in shaping the evidence and recommendations committees make regarding racial health disparities.

In order to account for gaps in medical records, the patient's lived experience, and the role of social determinants of health, some MMRCs include interviews with surviving friends and family as a component of their data collection prior to review. Philadelphia's MMRC explains:

> While hospital records contain a social history section, the information is often incomplete or inaccurate. One of the Philadelphia MMR team's evolving strategies to fill in these missing details is incorporating a family interview into its case review, where a social worker trained in bereavement counseling gathers a social history from someone who knew the decedent very well (e.g. sibling, partner, close friend, parent). (Buehler et al. 2015, 13)

Similarly, Delaware's MMRC completes a family interview "to learn more about the context of the woman's life and the events surrounding her death" (Delaware Child Death Review Commission 2016, 2). According to Delaware's policy, family interviews are scheduled with a spouse/partner, next of kin, or the emergency contact listed in the patient's medical records. Interviewees receive a letter or phone call, and the interviews are conducted by a Senior Medical Social Worker (Delaware Child Death Review Commission 2016, 3).

Family interview questionnaires shape the evidence that is collected during these interviews. As described by the Philadelphia and Delaware MMRCs, as the interviewer and the interviewee collaborate with the questionnaire, they can generate robust information that is not available in medical records or on the abstraction forms. This includes information about medical care and treatment that may be missing from the medical records, as well insights into the upstream social determinants of health.

Below, I follow the California MMRC's suggestion that a focus on medical records alone may obscure the role of SDHs in contributing to maternal death, examining the way these two data collection tools generate evidence about three key SDHs: socioeconomic status, living

environment, and stress. A comparison of the abstraction forms and the family interview questionnaires reveals differences in the evidence available to committees as they make judgements about contributing factors and preventability. This analysis is not exhaustive. For example, there are also differences in how the two infrastructural objects generate and shape information about specific medical conditions and healthcare decision-making. However, because of the prominent role SDHs play in accounts of racial disparities and the California's MMRCs own suggestion that their analysis underplays SDHs, I focus on those here.

3.6.1.1 Socioeconomic Status

Socioeconomic status (SES) is a widely cited, but difficult to operationalize, social determinant of health. Many studies have investigated the relationship between SES and various health outcomes (Avendaño et al. 2005; Backlund, Sorlie, and Johnson 1996; Lawlor et al. 2006; Marmot et al. 1978). Assuming that SES impacts health through diverse pathways, including educational attainment, sense of control, social standing/support, and economic resources, it is difficult to know whether to gauge SES by education-level, occupation, income, or some other measure. As a result, "The terms 'socio-economic status,' 'socioeconomic position,' and 'social class' (collective SES) are widely used in health research, but are not operationalized in a consistent manner across studies" (Braveman et al. 2005, 2879). Whether researchers use education, occupation, income, or wealth as indicators of SES, these variables measure different aspects of social life and therefore cannot be used interchangeably (Braveman et al. 2005; Daly et al. 2002).

Occupational status is a commonly used indicator of SES in European studies. Occupation does provide information about the physical and psychosocial aspects of the working environment, as well as "a range of expected earnings and social capital in the form of relative standing or

prestige" (Daly et al. 2002, 1151). In practice, however, occupations are classified into categories, as seen in California's data abstraction forms (Table 3).

In cases where such categories "include workers with diverse prestige, skills, power, and/or earnings" (Braveman et al. 2005, 2883-4), they do not meaningfully produce knowledge about SES. The occupational categories on California's data abstraction form appear to be loosely based on the International Standard Classification of Occupations (ISCO-08). While the ISCO is designed to provide meaningful information about SES, the categories on the data abstraction form collapse a number of categories from the ISCO's classification. For example, Managers and Professionals are two separate categories in the ISCO. The data abstraction forms also collapse Craft/Trades and Plant/Machine Operators into one occupational category. The more categories are collapsed together on the data abstraction form, the less useful the information is for producing knowledge about the role of the patient's occupation in their health. The family interview questionnaire, as an open-ended question, allows for more specific explanations of the type of work the patient was engaged in before their death.

Table 3. Data Collection about Socioeconomic Status

California Department of Public Health Data Abstraction Form	Delaware's Family Interview Questionnaire

Occupation
☐ Unemployed
☐ Managerial & Professional
☐ Technical, Sales, Administrative Support
☐ Farming, Forestry, Fishing
☐ Student
☐ Housewife
☐ No Occupation or None
☐ Precision Production, Crafts & Repairs, Operators, Fabricators, Laborers
☐ Other (specify) _____
☐ Unknown
 	
Education (# yrs at time of death)
  Elementary/Secondary
      ☐ 0
      ☐ 1
      ☐ 2
      ☐ 3
      ☐ 4
      ☐ 5
      ☐ 6
      ☐ 7
      ☐ 8
      ☐ 9
      ☐ 10
      ☐ 11
      ☐ 12
 	
  College
      ☐ 1 year
      ☐ 2 years
      ☐ 3 years
      ☐ 4 years
      ☐ ≥ 5 years
      ☐ Other
Economic Risk Factors
      ☐ No financial support from FOB
      ☐ Insufficient food supplies
      ☐ Needs WIC referral
	21. What was the highest grade or degree that ____ completed?
	
	25. In the year before she died, did _____ have a job?
	
	26. What type of work was she doing?
	
	27. I am going to list a number of ways that people support themselves. Please tell me if you know if _____ received money from any of the following sources to support herself in the last year of her life?
	    a. Wages or pay from a job;
	    b. Benefits such as AFDC, Welfare, General Assistance, Food Stamps, or SSI;
	    c. Unemployment benefits;
	    d. Child support or alimony;
	    e. social security, worker's compensation, veteran's benefits or pensions;
	    f. family;
	    g. friends;
	    h. Other _____
	
	28. Would you be willing to share with me an estimate of _____'s household (combined) annual income in the year prior to her death?
	___Yes ___No (If no, go to question 31).
	
	29. What was her total household income for the last 12 months of her life before taxes?
	
	30. Was that similar to her income in the previous 12 months?

Education is an easily obtained indicator that is often treated as a proxy for income or for SES overall (Braveman et al. 2005, 2881). While education is an important factor in one's working life and economic circumstances, measuring education does not account for "the differential on-the-job training and other career investments made by individuals with similar levels of formal schooling nor the volatility in economic status during adulthood" (Daly et al. 2002, 1151). Both the data abstraction forms and the interview questionnaire collect limited information about education, asking for number of years completed or highest grade/degree completed. This may be useful supplementary information, but on its own does not contribute to a significant production of knowledge about the patient's socioeconomic life circumstances.

Income is a commonly used measure of economic resources in developed countries, and household income is likely to be indicative of the "standard of living and of life chances household members experience through sharing goods and services" (Daly et al. 2002, 1152). However, income does not function as a proxy for wealth, "the accumulated stock of assets or economic reserves at a given point in time" (1152). As Braveman et al. note, "wealth can buffer the effects of temporarily low income due to unemployment or illness and can reflect power or influence over others. Furthermore, wealth can vary dramatically across different social groups with similar incomes" (2005, 2883).

The data abstraction forms provide extremely limited information about income, only highlighting economic issues if the patient was struggling with food insecurity or qualified for the federal Women, Infants, and Children (WIC) program.[12] On the other hand, the family interview questionnaire explicitly asks about household income, and can potentially co-produce a specific

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[12] The income limit for the WIC program is 185% of the federal poverty guidelines.

estimate. Other items in the questionnaire (not included in Table 2) also ask about the number of children living in the household, which, combined with average income provide a sense of the economic resources devoted to supporting a family. The questionnaire also asks for information about sources of income other than wages, such as government benefit programs or loans/gifts from friends and family. While it does not completely replace an estimate of wealth, an indication that the patient was receiving support from family or friends may provide some information about the socioeconomic situation of the people in the social support system.

3.6.1.2 Living Environment

Researchers have noted that the physical and social environments of a neighborhood contribute to residents' health. For example, air and water quality, access to basic resources, educational opportunities, built environment, and the nature of social relationships can all vary by neighborhood in ways that impact health (Acevedo-Garcia et al. 2008; de Sa and Ardern 2014; Gordon-Larsen et al. 2006). These health pathways are also interconnected and mutually reinforcing. As Ana Diez Roux and Christina Mair (2010) note, residential segregation leads to an inequality of resources, which in turn further reinforces residential segregation. The nature of the built environment of the neighborhood (i.e. the quality of public spaces) impacts social interactions between residents, which in turn, impacts their ability to improve public spaces in their neighborhood. Finally, "stress can result in the adoption of unhealthy eating behaviors as coping mechanisms, and some behaviors (such as physical activity) can buffer the adverse effects of stress" (Diez Roux and Mair 2010, 125). Thus, the pathways through which neighborhood conditions impact health are complex and interact with racism and SES at multiple points.

Table 4 outlines how two infrastructural objects used by MMRCs – medical record abstraction forms and family interview questionnaires – generate evidence about the patient's

living environment. The medical abstraction forms only account for individual-level factors about the specific patient's physical home. The family interview questionnaire provides limited opportunities to discuss other aspects of the patient's neighborhood. However, the questionnaire initially only asks about city/town, which can include a diverse range of neighborhoods with varying social and physical conditions. The final question, which asks the interviewee to rate the safety of the neighborhood, can be interpreted to include both physical and social aspects of the neighborhood's condition. Without a qualitative follow-up question, however, there is no data to indicate why the surrogate believed the neighborhood to be unsafe.

Table 4. Data Collection about Living Environment

California Department of Public Health Data Abstraction Form	Delaware's Family Interview Questionnaire
☐ Housing ☐ Transient housing ☐ Substandard housing ☐ No phone/message phone ☐ Weapons in home	22. What city or town did _____ live in for the last year of her life? 23. What type of housing did _____ live in for all or part of the last year of her life? (check all that apply) Private house Apartment building or complex Housing project Homeless shelter Residential program for drug or alcohol treatment Institution Homeless 24. On a scale of 1 to 5, how would you rate the safety of the neighborhood she lived in, with 1 being very dangerous and 5 being very safe?

Some scholars have argued that race-based residential segregation is a fundamental determinant of racial inequities in health. Schulz et al. (2002), for instance, argue that the macro-level historical conditions, legal codes, racist ideologies, and economic conditions that result in race-based segregation also lead residents in primarily Black neighborhoods to have less political power, and therefore less control over their physical environment. Acevedo-Garcia et al. (2008)

concur, noting that race-based residential segregation is not purely a result of racial differences in socioeconomic status. Rather, Black people also have limited neighborhood choices "because of persistent housing discrimination and whites' avoidance of integrated neighborhoods" (Acevedo-Garcia et al. 2008, 322). Residential segregation leads to racial inequities in health through three pathways: First, "segregation constrains the socioeconomic advancement of minorities by limiting educational quality and employment, as well as by diminishing the returns to home ownership because school quality, job opportunities, property values are lower in disadvantaged neighborhoods" (Acevedo-Garcia et al. 2008, 322). Second, it increases Black people's exposure to unfavorable conditions like crime, environmental hazards, and food deserts. Finally, residential segregation also leads to segregation in healthcare settings, which are associated with disparities in quality of care and treatment" (Acevedo-Garcia et al. 2008). Both lack of political power and lack of access to resources are intermediate factors that influence "more proximate factors related to health, including physical activities, dietary patterns, and social relationships" (Schulz et al. 2002, 696). Therefore, information about neighborhood distribution could yield important data about how segregation contributes to health inequities.

3.6.1.3 Stress

Researchers have been studying the ways that stress impacts the physical body, contributing to higher rates of morbidity and mortality. In the last two decades, the concept of allostatic load has emerged as a central theory for explaining, predicting, and preventing the effects of stress on the body. Allostatic load refers to the strain produced on the body by repeated physiological responses to stress that predispose an organism to disease. The body's adaptation to stress is not inherently a damaging process, but chronic stress can cause a wear and tear on the body that promotes ill health (McEwen and Gianaros 2010). Research indicates that chronic

exposure to physical and behavioral stressors "contributes to physiological dysregulation, poor mental and physical health, chronic disease, and diminished longevity, particularly in vulnerable or disadvantaged individuals" (Beckie 2012, 311).

One primary difference in the ways the two data collection tools generate evidence about stress is that all the questions relating to stress on the medical abstraction forms are structured by checkboxes. These checkboxes segment the conditions of the patients' life into distinct categories. Any types of stress that do not fall into the categories accounted for in the checkbox do not become part of the evidence that is assessed by the committee. The "experiencing significant life stressors" category functions as what Bowker and Star (2000) call a "garbage category," a category used to classify things we do not know what to do with, things that do not fit in any other category. In contrast to the classification provided by checkboxes, the family interview questionnaires focus on a number of common sources of stress among pregnant people. While many of the questions are yes-no or Likert scale questions, some – like question 103 – do provide space for open-ended answers about stressors that may not be captured by other items.

Stress associated with racial discrimination has also been linked with poor mental and physical health. Studies have found, for instance, that high levels of self-reported experiences of racial discrimination were associated with poor self-reported physical health in both men and women, with stronger associations among women than among men. Gender differences persisted after adjusting for education, income, and skin color (Borrell et al. 2006, 1422). The authors note, "women could be experiencing a double-load of discrimination because of their race and their

Table 5. Data Collection about Stress

California Department of Public Health Data Abstraction Form	Delaware's Family Interview Questionnaire
Pregnancy Care ☐ Ambivalent about pregnancy ☐ Unwanted/unplanned pregnancy ☐ Using natural remedies ☐ Hx pregnancy/child losses ☐ Hx STI self/partner ☐ Needs referral for discomforts Coping Skills ☐ Experiencing significant life stressors ☐ Hx domestic violence ☐ Victim of violence/sexual abuse: self/children/parents ☐ Hx suicidal ideation/attempt ☐ Depression ☐ Inadequate support system	56. How many times all together was _____ pregnant? 58. How many children did she have altogether? 60. Were all of her children living with her at the time of her death? ____Yes (skip to question 62) ____No 62. Did the children receive any special services, such as social services, behavioral therapy, physical therapy? 63. Have any of _____'s children been very sick or badly injured? ____Yes ____No (skip to question 66) 65. Have any of _____'s children died? ____Yes – how old were they when they died? ____ ____ No 70. Would you say that ____ planned to get pregnant? ____Yes, planned pregnancy ____No, unplanned pregnancy 81. Did ___consider having an abortion or putting the child up for adoption? ___Yes _____No 82. If she considered abortion, what kept her from doing that? 83. On a scale of 1 to 5, with 1 being strongly negative and 5 being strongly positive, what was ____'s reaction when she learned she was pregnant? 103. Did _____ have any particular worries during her pregnancy (about her health, the baby, other stressors)? ___Yes (explain) _____ ___ No 116. The next set of questions is about events that may have happened to _____ in the last year of her life. I will read you a list of items and for each tell me whether or not it happened during this time in her life. Did she move apartments or houses?If yes, how many times did she move? ___ Was she ever homeless? Did a close friend or family member become very sick or die? Did anyone hit, punch, or kick her? If yes, who? _____ Was she the victim of a crime? If yes, what type of crime? _____ Was she arrested? If yes, for what? _____ Was she involved in a gang? If she experienced a fetal or infant death, did she receive bereavement support services? Did any other difficult event take place? ___Yes (specify) _____ No _____

gender and the health consequences of discrimination may be enhanced by sex discrimination"
(1423). In addition, African-American participants in the study who reported experiencing racial
discrimination were more likely to be highly educated than those who reported no experience of
discrimination (1419), indicating that while high levels of education may improve health through
improved earning opportunities and social mobility, it may also contribute damage to health for
some minorities who are exposed to racial discrimination due to spending more time in majority
White populations.

The preceding analysis has shown that interviews with surviving family members have
potential to collect meaningful information about social determinants of health like socioeconomic
status, living environment, and stress levels. Whereas the checkbox system utilized in the medical
records abstraction forms limits categories available for generating evidence about social
determinants of health, interviewers have the opportunity to ask multiple, open-ended questions
about the social and environmental conditions of each woman's pregnancy. However, my study
design necessarily leaves open the question of how information about social determinants of health
is incorporated into the MMRC's reporting and results. The next section discusses challenges
associated with integrating interview data with information from medical records and considers
factors necessary for meaningfully incorporating interview data about social determinants of health
into the MMRC review process.

3.6.1.4 Incorporating Social Determinants of Health

Despite evidence that surrogate interviews can provide robust data about the social
conditions of people's lives, it is not guaranteed that simply collecting such information will lead
it to be meaningfully incorporated into the MMRC review process. Neither Philadelphia nor

Delaware's MMRCs provide explicit information in their reports or documentation about how interview data is shared with the committee or incorporated into the review process.

Teston (2017) highlights a similar problem in her case study of the Food and Drug Administration's (FDA) 2011 Avastin hearing. The hearing concerned the use of Avastin as a treatment for breast cancer, which had been granted accelerated approval by the FDA. Genentech, the pharmaceutical company that manufactures Avastin, needed to present randomized clinical trial data that confirmed Avastin had a clinically meaningful benefit for breast cancer patients in order to maintain the breast cancer indication on the drug. As Teston observes, determination about clinical benefit "hinges on a trial's ability to achieve endpoints that are defined by the FDA as 'clinically meaningful'" (62).

A number of breast cancer patients testified at the hearing about their experience with the drug, specifically explaining that it had slowed or halted the progression of their breast cancer. However, Teston (2017) notes that these patient testimonies were ultimately irrelevant to the FDA's decision because they speak to an endpoint of progression-free survival, as opposed to the FDA's defined "clinically meaningful endpoint," overall survival. As Teston points out, the FDA commissioner at the time of the hearing "acknowledged the evidential value of quality-of-life measures and progression-free survival data" but "argued that these endpoints were simply not meaningful enough to warrant approval for a drug that, while it benefited some, posed grave health risks…to others" (62). Despite the commissioner's acknowledgement, evidence from the patient testimonies ultimately held little weight in the FDA's decision-making. Teston (2017) argues that the Avastin trial demonstrates the need to invent methods of assessment that are attuned to many kinds and forms of evidence without losing their methodological, disciplining ethos. That is, we need ways to incorporate a variety of types of evidence – including both medical records and

patient/family testimony – in ways that are rigorous and will contribute to sound judgement and decision-making.

The maternal mortality review process is already somewhat removed from high levels of reliance on randomized clinical trials and inferential statistics. Therefore, it has potential to develop the kind of appropriate evidential attunement Teston (2017) describes. However, incorporating qualitative data from surrogate interviews into the work of larger MMRCs, such as those in Texas and California, will require additional resources and procedures for collecting, recording, synthesizing and reviewing interview data. Furthermore, in the same way that the Avastin authorization renewal hearing hinged on the FDA's definition of clinically meaningful endpoints, the results of MMRC reviews hinge on the definition and procedures for determining preventability. The section below argues that these procedures could function to make the social conditions of pregnant, laboring, and post-partum people irrelevant factors in the review process.

3.6.2 Contributing Factors

As part of the process of determining preventability, most committees begin by identifying contributing factors.[13] A contributing factor is "any behavior or systems issue, or the deficiency thereof, which increases the severity of morbidity or the likelihood of mortality" (The California Pregnancy-Associated Mortality Review 2017, 38). Contributing factors do not necessarily cause death, but "may be one of a number of factors occurring in the chain of events leading to the maternal death" (The California Pregnancy-Associated Mortality Review 2017, 38). While the exact terminology for the categories varies slightly, all MMRCs include contributing factors

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[13] Philadelphia's MMRC is the only one included in this study that does not specify this procedure for determining preventability.

related to: 1) the patient and their family; 2) healthcare providers; and 3) healthcare facilities. Some

MMRCs also include an additional category for systems/community-level factors. Table 6 displays

the specific contributing factors outlined in the data dictionary used by members of California's

MMRC to guide their completion of a contributing factors form.

Table 6. Contributing Factors Defined

Healthcare Provider Factors
- Inadequate response to or management or triggers; delay in or lack of diagnosis and treatment (i.e. response by OB, ER, or other providers, specify)
- Ineffective/inappropriate treatment (can include procedures, BLS/ACLS, inductions, cesareans, or pharmaceuticals)
- Misdiagnosis
- Failure to refer or seek consultation
- Lack of continuity of care (i.e., between providers, prenatal)
- Early discharge/inadequate post-discharge follow-up
- Poor communications among team and/or lack of leadership, (including nursing to MDs, etc.)
- Complications from current cesarean section
- Complication from labor induction or augmentation
- Other

Patient Factors
- Underlying significant medical condition(s)
- Obesity
- Excessive gestational weight gain
- Complications from prior cesarean section
- Delay in or failure to seek care, treatment, or follow-up
- Refusal of medical advice
- Lack of knowledge regarding the importance of event
- Substance abuse
- Lack of social support (i.e., from family, partner, friends)
- Financial barriers
- Cultural/language barriers
- Other

Facility Factors
- Inadequate knowledge, judgment, or performance by facility personnel
- Inadequate or unavailable equipment
- Inadequate or unavailable services or consultations within facility
- Facility systems contributed to delay or inadequate treatment
- Lack of continuity of care (i.e., fragmentation among facilities/between units)
- Off hours/inadequate number of personnel
- Inter-facility transfer issues
- Unavailable/inadequate laboratory/blood bank services
- Other

Healthcare provider factors cover elements introduced by healthcare providers responsible for the care of the woman, and which contributed to the maternal death. In California's review of maternal deaths from 2002-2007, provider factors were the most commonly identified contributor to maternal death, present in 81% of cases (an average of 2.5 factors per case) (The California Pregnancy-Associated Mortality Review 2017, 39). While this finding is not surprising, given the role of healthcare providers in treating pregnant people, it may also reflect a bias in the type of data MMRC members have access to (i.e. medical records), as well as a bias in the types of people who are members of MMRCs. For instance, all of the members of California's MMRC have either medical or nursing degrees. The provider contributing factors identified by Texas's MMRC are similar to those identified on California's Contributing Factors Form. Notably, however, Texas highlights that "prioritization of the pregnancy outcome over the maternal condition in some cases of pregnancy-related death led to emergent delivery despite declining maternal health status" (Texas Maternal Mortality and Morbidity Task Force 2018, B-5).

Patient or individual-level factors are "conditions or circumstances introduced by the woman that contribute to the cause of maternal death" (California Department of Public Health 2011, 7). In California's review of maternal deaths from 2002-2007, the committee identified patient-related factors in 75% of deaths (an average of 1.9 patient-related factors per woman) (The California Pregnancy-Associated Mortality Review 2017, 39). Texas's MMRC notes that deaths related to cardiovascular disease are highly likely to have associated individual and family-level factors (Texas Maternal Mortality and Morbidity Task Force 2018).

Healthcare facility factors are "factors such as staffing, facility infrastructure or system-level processes that are introduced by the health care facility and which contributed to the cause of maternal death" (California Department of Public Health 2011). Factors related to nursing care

are included in facility factors rather than provider factors, because nurses are "staff of the facility and subject to the rules governing the facility" (California Department of Public Health 2011). In California's review of maternal deaths from 2002-2007, facility-related contributing factors were far less commonly identified than provider or patient factors, being identified in 44% of the cases (an average of 0.8 factors per case). However, preeclampsia and hemorrhage related deaths were mostly commonly associated with facility contributing factors (The California Pregnancy-Associated Mortality Review 2017, 39). Texas's review found that inadequate knowledge, judgment, or performance by facility personnel, lack of recognition of high-risk status, and lack of continuity of care were the mostly commonly identified contributing factors to death (Texas Maternal Mortality and Morbidity Task Force 2018).

Contributing factors, then, function as key infrastructural objects in the process of defining and determining preventability. Committees first identify contributing factors and then assess the contributing factors they have identified to determine the chances that a death could have been prevented. SDHs emerge prominently in the patient factors and facility factors. Financial barriers, for instance, are directly related to SES. Lack of social support is a factor that has been liked to both SES and neighborhood (Diez Roux and Mair 2010; Schulz et al. 2002), and can lead to stress. Obesity also is linked, in some cases, to factors such as neighborhood and living environment, especially considering the role of access to nutrient-dense foods and available areas for exercise (de Sa and Ardern 2014; Gordon-Larsen et al. 2006). Some contributing factors – such as delay in or failure to seek care – are not necessarily the result of SDHs. However, issues such as cost of care, lack of access to transportation, or lack of access to childcare are all likely reasons why someone would delay or "fail" to get medical attention.

Here, the strength of contributing factors as an infrastructural object becomes especially clear. Data collection through family interview questionnaires would allow MMRCs to find out why someone missed prenatal appointments or declined to seek treatment for a medical issue. However, there is no room within the current structure of the contributing factors to attribute "delay in or failure to seek care" to anything other than the patient. In fact, Delaware's MMRC (one of the two MMRCs in this study who conduct surrogate interviews) reported a dramatically higher number of patient-related factors as compared to other contributing factors in their 2018 report. While they reported three instances of each for provider, facility, and systems of care factors, the MMRC identified a total of 25 patient/family factors. Patient/family factors in the Delaware report included: chronic disease, substance use disorder, tobacco use, lack of social support/isolation, lack of adherence to medical recommendations, mental health issues, delay in seeking care, lack of knowledge, childhood trauma, unstable housing, intimate partner violence, and incarceration. This discrepancy raises the question of why the number of patient contributing factors is so high in the Delaware MMRC's report. One possible explanation is a difference in the committee's process for categorizing contributing factors. Another, however, is that the Delaware MMRC had much more information about the social conditions of patient's lives based on surrogate interviews, and that such information was mostly translated into patient-level contributing factors.

3.6.2.1 The Motivated Vocabulary of Contributing Factors

Embedded in the infrastructural object of contributing factors is a vocabulary that reveals implicit assumptions, and as rhetorical theorist Kenneth Burke suggests, this vocabulary motivates actions. Burke argues that in developing a vocabulary to describe a person or thing, we are also developing a set of motives toward that person or thing, motives that provide us with an attitude or program of action. For Burke, all terms exist within an implicit family or network of terms. His

dramatistic pentad provides resources for analyzing the way those terms work together to reveal motives. He writes that in any vocabulary or terminology: "You must have some word that names the *act* (names what took place, in thought or deed), and another that names the *scene* (the background of the act, the situation in which it occurred); also, you must indicate what person or kind of person (*agent*) performed the act, what means or instruments he used (*agency*), and the *purpose*" (Burke 1969, xv). Once the pentadic elements are identified, it is possible to identify the source of motives for action demonstrated in a particular vocabulary. For instance, if the terminology being used situates the agent as the source of motives, it inclines the reader to attribute that person's behavior to some trait integral to their personality or being. Furthermore, Burke argues that the critical significance of the pentad is in the "internal relationships which the five terms bear to one another" (1969, xvi). He refers to the relationships between pentadic elements as "ratios." For example, in the scene-act ratio, the act will be consistent with the scene in which it takes place, and the act and the scene will also result in a change in the quality of the act.

A pentadic analysis of the contributing factors in Table 6 reveals different pentadic ratios for healthcare provider, patient, and facility factors. The framing of the healthcare provider factors contains an agent-act ratio. The healthcare providers are cast as the agents who carry out (or fail to carry out) the acts of responding, diagnosing, treating, referring, and communicating. The descriptions of facility factors reveal a scene-act ratio, in which the physical and interpersonal aspects of the environment shape the kinds of actions that are possible within the organization. It is significant to note that nurses and other staff members are reduced to an element of the scene, since California's Data Dictionary specifically notes that "Nursing factors are included under Healthcare Facility Factors since they are staff of the facility and subject to the rules governing the facility" (California Department of Public Health 2011, 9).

Most of the factors listed under patient factors are also elements of the scene. For example, underlying medical conditions, obesity, or complications from previous cesareans are not acts that the patient has carried out, they are elements of the background conditions in which the patient's pregnancy occurred. Unlike in the facility-related factors, however, in the terminology for patient-centered factors, the patient is cast as an agent, who acts by bringing these conditions into the pregnancy with them. The vocabulary for patient factors, then, contains an agent-act ratio that functions to linguistically obscure the role of the scene while simultaneously making the agent responsible for elements of the scene. That is, by describing factors such as "complications from a previous cesarean section" as a "condition or circumstance introduced by the woman" that contributed to her death (California Department of Public Health 2011, 7) the contributing factors dictionary focuses attention on the woman's responsibility for her medical condition. While the vocabulary used by the committee may, at first glance, seem expected, it is possible to imagine alternatives. For instance, an alternative scene-agent ratio might focus on the way high rates of cesarean section in a particular hospital function as an element of the scene, or background, in which a pregnancy and delivery occur.

Rather, embedded in the infrastructural object of 'contributing factors' is a framing that attributes responsibility for health to individuals. In fact, the data dictionary written to guide members of California's MMRC in the review process specifically notes, "Patient factors may be exacerbated by interaction with the healthcare system, but they are factors that are brought to the pregnancy by the patient" (California Department of Public Health 2011, 7). While individual members of MMRCs may recognize the role of SDHs and other contextual features, within the protocols for MMRC review, SDHs are situated in the scene-act and agent-act ratios of the facility and patient contributing factors. The framing of contributing factors as an agent-act ratio, in

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particular, casts patients as responsible for their obesity, chronic conditions, lack of medical knowledge, or lack of social support. Alternatively, a scene-agent ratio would bring into focus the public health conditions that lead to high rates of obesity, heart disease, and other chronic health issues.

If individuals are responsible for their poor health, then the agent-act ratio used for healthcare provider contributing factors also indicates that the task of taking action to improve health belongs to the medical profession. This is particularly evident in the definitions used for preventability by various MMRCs. California designates a death to be preventable if "specific and feasible actions had been implemented that might have changed the course of the woman's disease trajectory and potentially prevented the death" (Main et al. 2015, 939; The California Pregnancy-Associated Mortality Review 2017). Philadelphia outlines criteria for preventability less thoroughly, simply noting that healthcare provider members of the committee were specifically concerned with the question of "whether or not the medical or health care systems could have prevented some of these deaths" (Buehler et al. 2015, 12). This definition articulates an explicitly clinical focus on preventability, which is implicit in other MMRCs definitions. Texas, for instance, writes, "A death is considered preventable if the Task Force finds that there was at least some chance of the death being avoided by one or more reasonable chances to the circumstances of the patient, provider, facility, systems, or community factors" (Texas Maternal Mortality and Morbidity Task Force 2018, 6). Here we see how the pentadic ratios embedded in the vocabulary of contributing factors shapes subsequent definitions of preventability.

The assumption that better medical care will improve population health is contested by some public health researchers, who point out that individual health behaviors and receipt of recommended medical care do not occur in a vacuum. Rather, "these factors are shaped by more

upstream determinants related to living and working conditions that can influence health both directly…and indirectly" (Braveman, Egerter, and Williams 2011, 383-4). Biomedical advancements and interventions are unlikely to have a significant impact on health inequities across a population because they are used on relatively few individuals (specifically, high risk or diseased individuals, usually at the end of their lives). Furthermore, such "interventions tend to reach more advantaged groups before, if ever trickling down" (Baum et al. 2009, 1968). In contrast, slight alterations in risk factors across a whole population "can have a great impact on the incidence of a disease or problem in the community" (Baum 2007, 91).

Scholars like Baum and Braveman are critical of biomedicine's ability to make a huge impact on health inequities across populations. Rather, they suggest that healthcare sectors collaborate with other public agencies to create environments that are supportive of health. As Adler, Glymour, and Fielding argue, "Promoting healthy behaviors involves making healthy behavioral choices easier, less expensive, and more socially normative" (2016, 1641). Creating supportive environments for health, however, would require action in a variety of sectors, including trade, taxation, education, agrictulture, urban development, and food and pharmaceutial production.

Sara Glasgow and Ted Schrecker note that many policy initiatives around SDHs and health equity begin by recognizing "the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on indiviudal lifestyle factors" (2016, 205). They argue that the unreflective adoption of individualized or risk factor oriented approaches to disease prevention may fit destructively with broader current of an ideologically neoliberal focus on personal resonsbility. Brenda Cossman and Judy Fudge describe this connection to a neoliberal focus on individualization: "Health care and poverty are treated as individual shortcomings,

products of poor individual choices, to be remedied by emphasizing individual responsibility…Social and structural analyses are displaced in favor of individual solutions to individual problems valorizing individual choice and markets" (2002, 21-22). As Glasgow and Schrecker emphasize, researchers and policy makers may not intentionally be seeking to reinforce such broader ideologies, but an emphasis on individual risk, choice, and responsibility may indeed "superimpos[e] on the socio-economic gradient in (ill) health an additional burden of ascribed responsbility that weighs most heavily on those who have least control over their conditions of life and worth" (2016, 207).

Race and racism play a central role in discourses around social determinants of health. Although race is often cited as a social determinant of health, Tiffany Green and William Darity (2010) argue that it is important to reject race as a measure of intrinsic risk in population health research. To treat it as such is to reify the existence of race as a stable genetic category. Because race as a social category is perpetuated by economic, political, and cultural inequality, *racism* may be a SDH that manifests itself in intersection with various other SDHs (including, but not limited to, the ones I discuss below).

Davi Johnson Thornton's (2010) analysis of the "Depression is Real" campaign demonstrates how problematic it can be when racism as a social determinant of health is not directly addressed. Although the campaign is positioned as an anti-stigma, pro-recovery intervention in the name of racial empowerment, Thornton argues that it articulates racial and cultural difference as risks that individuals are responsible for eradicating. Specific practices in the Black community, such as reliance on spiritual beliefs or teaching Black girls to be independent, are framed "risks" or "cultural barriers" to obtaining biopsychiatric treatment for depression. In order to be truly healthy, the campaign implies, women need the "trapping of traditional (White)

femininity – a husband, children, and the various elements of the American dream, down to the white picket fence" (322). The campaign does not deny the existence of racism; in fact, it describes racism as a risk factor that contributes to psychological distress among Black Americans. However, it frames the health risks of racism as immutable, and proposes an individual remedy – biopsychiatric treatment. As Thornton writes:

> By reducing African American's failure to seek psychiatric treatment to pathological 'cultural mores,' the campaign not only evades any examination of structural inequalities by locating the source of this 'problem' within African American individuals and communities: it also amounts to massive historical erasure in its failure to account for a deeply troubling legacy of racist and colonialist practices in psychiatry and medicine. (230)

In the case of the racial disparities of concern for MMRCs, the focus on patient-factors and clinical interventions also, perhaps inadvertently, implies that the solutions for racial disparities are fundamentally the individual's responsibility and that medicine can provide the answers.

3.7 Conclusions

This chapter has examined the ways that maternal mortality review committees (MMRCs) address uncertainty around the issue of maternal mortality by collaborating with the material infrastructure of public health surveillance systems. The four MMRCs included in the study faced two methodological assessment conundrums: 1. How do we determine which deaths are pregnancy-related? and 2. How do we determine which deaths are preventable? The preceding analysis focused on how infrastructural objects used by MMRCs answer these questions, focusing

on their active role in framing and constructing knowledge about maternal mortality, at this critical time when the issue is in the process of being made legible for public action.

In the process of classifying pregnancy-related deaths, I found that death certificates, standard case definitions, and standards for accuracy assert considerable agency in the process of knowledge production. All three of these elements attune committee members to pregnancy-related death as a physiological or medical phenomenon. One result of this evidential cut is to exclude violent deaths (i.e. deaths due to suicide or homicide) from the purview of review. I then moved on to examine the data collection process used by the committees. An analysis of the medical record abstraction forms and the family interview questionnaires revealed that interviews have potential to provide more robust data about the social conditions of people's lives, conditions that directly impact their pregnancy, labor, and delivery. However, it is not guaranteed that collecting such information will lead it to be incorporated into the MMRC review process in a way that emphasizes those factors. In assessing the process for determining which deaths are preventable, I focused on the vocabulary of contributing factors – the categories the committee uses to attribute factors related to death in each case they examine. Using Burke's pentadic frames, we can see that the vocabulary of the contributing factors attributes responsibility for health to individuals, obscuring the role of background conditions. Social determinants of health emerge in the contributing factors vocabulary primarily as conditions that are brought to the pregnancy by the patient, not as systemic or institutional factors. Furthermore, the framing of the contributing factors vocabulary assumes that solutions to maternal mortality should be centered within the medical profession, with healthcare providers being primary actors.

In Chapter 2, I argued that a legacy of violence and oppression undergirds all of our processes for making maternal mortality public. Discourses that attempt to address maternal

mortality in general tend to construct White maternity as the norm and are unlikely to address the needs of Black women and birthing people. The MMRCs studied in this chapter note that racial disparities exist but neglect to center race and racism as an issue. As a result, there are few substantive recommendations for reducing racial disparities flowing from MMRC work.

Some of the most robust recommendations made by MMRCs include toolkits for hospitals to use in improving training around specific cases of maternal death. California's Department of Public Health, for instance, developed detailed training kits on: cardiovascular disease, obstetric hemorrhage, preeclampsia, and venous thromboembolism. This recommendation by the MMRC, and its relatively swift uptake by the Department of Health, is reflective of the overall framing built into the infrastructural object of the MMRC process – that solutions to maternal mortality should begin in the medical system. Furthermore, such efforts have not been found to reduce racial disparities in maternal deaths. California's overall maternal mortality rate has dropped drastically since it's MMRC was implemented, from 13.1 per 100,000 in 2005 to 7.0 in 100,000 in 2013. However, Stark racial disparities persist; Black birthing people remain 2-3 times more likely than their White counterparts to die as result of complications from pregnancy or childbirth.

Specific recommendations from the MMRCs to address racial disparities are much more vague. California's MMRC, for instance, recommends that the MMRC "Collaborate with other public health and health care strategies aimed at reducing health disparities, so that disparities in maternal health outcomes are included in long-term health promotion efforts" (California Report, 2002-2003, iv). The Texas MMRC included a recommendation in their 2016 report to "Increase provider and community awareness of health disparities and implement programs that increase the ability of women to self-advocate" (17). This recommendation reflects the framing that Black women be held responsible for advocating for their own health, and that providers have more

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training to recognize enhanced risk among Black women. In fact, California's MMRC emphasizes that "clinicians caring for African-American women need to have a heightened sense of awareness of risk factors among this group, such as potential cardiovascular symptoms or obesity" (California, 2002-07, 8). While this is likely true, it still focuses the recommendations for addressing racial disparities at the level of the healthcare provider, rather than at institutional- or systems-levels.

The focus on patient-factors and clinical interventions inadvertendly implies that racial disparties in health are fundamentally rooted in individual, racialized bodies. As discussed in Section 2.6.2, the framing of the contributing factors dictionary attributes responsibility for poor health conditions to individuals. Given the widely cited evidence that there are racial disparities in many health conditions, including conditions explicitly named on the contributing factors form (National Center for Health Statistics 2015), such a framing implies that Black individuals are responsible for their poor health and should turn to medical professionals for advice and improvement. This is not to say that all members of MMRCs actively believe this to be the case. However, it is an assumption embedded in the infrastructural object they use to make decisions about preventable deaths and recommendations for action.

In addition, racial disparities in maternal mortality are likely even higher than currently reported. As the MMRCs structure their analysis around comparisons with death certificate data, they reveal important areas of miscoding. As the members of California's MMRC note: "Racial disparities persist. CA-PAMR confirmed that African-American women continue to die at three-to-four times the maternal mortality rate of women of other racial/ethnicities groups, and as high as eight times the rate when deaths from pregnancy-related cardiovascular disease is considered" (The California Pregnancy-Associated Mortality Review 2017, 7). Furthermore, if homicide and

suicide deaths are included in the standard case definition of pregnancy-related deaths, racial disparities would continue to widen.

Finally, this chapter brings to light a major dilemma for MMRCs and other institutions interested in investigating social determinants of health (SDHs). The family interview questionnaires used by the Delaware MMRC introduce crucial qualitative data about individuals' lived experiences into the MMRC analysis. However, it remains challenging to integrate those data into other aspects of the infrastructural object of the MMRC process. As Section 2.6.2 described, contributing factors function as key infrastructural objects in defining and determining preventability. Because the vocabulary embedded in that infrastructural object situates many social determinants of health as "patient factors," it is not possible for the MMRCs to fully recognize the ways SDHs might be functioning at facility or system-levels, and thus to make recommendations for prevention at these levels. Therefore, it may be important to include qualitative data about how social determinants of health function in people's lives at a prior step – for instance, in developing the review process itself. As Teston (2017) notes in her study of the FDA's 2011 Avastin hearing, including patient voices as data can be rendered meaningless if the methods of assessing the evidence and making decisions are attuned only to another kind of data. The next chapter examines a process for making maternal mortality public that does center qualitative data in the form of narratives. The Lost Mothers Project is the result of a six-month investigative reporting project by a team of reporters and journalists from ProPublica and NPR. The project is based on the assumption that the stories and experiences of people who die during pregnancy and childbirth should be shared publicly so that public health experts, medical professionals, legislators, and others can learn from them.

4.0 Mediating Maternal Mortality

"When a new or expectant mother dies, her obituary rarely mentions the circumstances. Her identity is shrouded by medical institutions, regulators and state maternal mortality review committees. Her loved ones mourn her loss in private. The lessons to be learned from her death are often lost as well" (Martin, Cillekens, and Freitas 2017). So begins the Lost Mothers Project (LMP), the result of a six-month investigation by a team of reporters and journalists from ProPublica and National Public Radio (NPR).[14] The stated goal of the project is to make sure that the stories of people who die during pregnancy and childbirth are not lost.

The previous chapter explored how maternal mortality is made public through knowledge produced by Maternal Mortality Review Committees (MMRCs). We saw that the public health infrastructure of the maternal mortality review process centers patient-level factors and clinical interventions. In turn, this attributes responsibility for poor health to individuals and in the case of racial disparities, to Black and Brown individuals. In addition, analysis showed that there is crucial qualitative data about patient experiences available to MMRCs, but there are significant questions about how to integrate that data into the MMRC infrastructure.

This chapter focuses on an effort to make maternal mortality public that centers qualitative data in the form of stories of people who have died during pregnancy and childbirth, as well as experiences of women who suffered severe complications during their pregnancies and deliveries. According to LMP's rationale if these stories are shared publicly, public health experts, medical

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[14] This team was led by NPR special correspondent Renee Montagne and ProPublica reporter Nina Martin, joined by additional reporters from ProPublica, as well as freelance journalists and journalism graduate students. Throughout the chapter, I refer to the group as a whole as "the reporting team" in order to recognize the collaborative effort behind such a massive project.

professionals, legislators, and others may be able to learn from them. The result of NPR and ProPublica's investigation has been creation of dozens of articles, radio stories, podcast appearances, community engagement materials, and a unique collection of images and narratives highlighting people who died due to complications from pregnancy and childbirth.

News media, like ProPublica and NPR, play a key role in highlighting, defining, and contesting health issues (Zhang et al. 2016). At the same time, Western media in general, and health news reporting in particular, have consistently centered whiteness and the expectations for health, wellness, and fitness have become associated with White bodies (Briggs and Hallin 2016; Roberts 2010; Daniels and Schulz 2006). Charles Briggs and Daniel Hallin point out that health news reporting is overtly deracialized, practicing "the non-representation of race and ethnicity," unless a focus on race is justified by what they call a triggering frame (2016, 167). When Black bodies are invoked, Ronald Jackson (2006) argues that the media are reliant on particular scripts, fitting bodies to preconceived grand narratives.[15] The script for Black bodies, he emphasizes, is based on deviation from whiteness: "the Black body is discursively bound to an ideological matrix propagated by a socially preponderate whiteness" (2).

Armond Towns asks media scholars to consider "*whose* form of mediation is the ground for comprehending *whose* knowing and being?" (2020, 852). In this chapter's case study, his question might be translated: how does mediation of discourses about racial disparities in maternal mortality by media outlets whose audience is predominantly White impact comprehension of the knowledge and lived experience of Black birthing people? My critical approach foregrounds the kind of work discourses about racial disparities in maternal mortality perform – whether they work

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[15] Throughout this chapter, I use the words "Black body" or "Black bodies" with intention, to highlight the ways in which White culture reduces black life to the physical body. I do my best not to reproduce this tendency in White culture by using terms like "Black people" when I am not explicitly attempting to make this point.

to refigure or reinforce dominant understandings of race and gender. Therefore, in this chapter I ask: what are the limitations and possibilities of creating, producing, and circulating knowledge about racial disparities in maternal health through LMP?

The chapter begins by bringing together media theories to demonstrate how health news stories map an understanding of knowledge production. I then use Briggs and Hallin's (2016) concept of biocommunicable cartographies to plot knowledge production, circulation, and reception in the LMP, focusing on how it works as a consciousness-raising tool to make maternal mortality public and actionable. Processes of consciousness-raising, however, do not unfold in a vacuum, and media theorists like Jackson (2006) and Towns (2020) highlight the ways that anti-Black racism provides important context that may change our reading of LMP's map of knowledge production. When attention is focused on places where the gravitational pull of anti-Black racism is at work, we also see that LMP relies on the figure of the unhealthy/irresponsible black body to anchor their news frame, which functions to reproduce White motherhood.

4.1 News Media and Public Health Communication

News media are an important site for making health issues visible and relevant to a general audience (Arney and Bergen 1984; Ding 2009; Weathers and Kendall 2016). Zhang et al. describe the news media as a public space where social problems can be discussed and causes and solutions can be negotiated. Health problems, they point out, "are particularly likely to be mediated due to their inherent medical complexities" (2016, 119). However, there are challenges to communicating about public health issues and sustaining public attention. As Olga Kuchinskaya (2015) points out, there are often multiple, competing narratives in the scientific community regarding any one

scientific or medical finding. Even once a narrative is selected for use in the new media, making a health issue observable requires explaining scientific theories and methods, which is a difficult topic on which to hold the public's attention (Kuchinskaya 2015, 67).

It is important to critically examine such news stories because the selective presentation of information in media can "promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation" (Entman 1993, 52). Scholars have explored the ways that depression (Major 2018; Zhang et al. 2016), social determinants of health (Knight, Benjamin, and Yanich 2016), and climate change (Weathers and Kendall 2016) are framed as public health issues. In general, news frames about public health issues tend to emphasize individual-level causes and solutions, such as genetics, individual health condition, and health behaviors. In their study about public health coverage of social determinants of health, Knight, Benjamin, and Yanich (2016) found that although social and environmental factors were often cited as the causes of health disparities, improved medical care remained the most cited solution. The ensuing analysis demonstrates that LMP also struggles with this tension, identifying broad social causes for racial health disparities, but advocating individual patient and provider level solutions.

4.2 Biocommunicable Cartographies

Health news stories map and project a process of knowledge production, circulation, and reception. Briggs and Hallin (2016) refer to this process as a biocommunicable cartography. They use the term biocommunicable to indicate that news stories to not just convey existing information about biomedical phenomena. Rather, the process of reporting health information involves

projecting "how knowledge about the phenomenon emerges and circulates and who should attend to it and how" (8). That is, health news stories also report on the processes by which both scientists, medical experts, and laypeople come to know about an issue. Furthermore, the framing of a news story contains a message about what kind of audience the story is intended for and how audience members are intended to engage with the information.

For example, the biomedical authority model is one of the most common models of biocommunicable cartography. In the biomedical authority model, biomedicine (i.e. medical doctors and researchers) are the authoritative voice on an issue. Laypeople, or members of the audience, are intended to engage with these health new stories by passively receiving information (Briggs and Hallin 2016, 25). On the other hand, in patient-consumer models, audience members are assumed to be involved in an information-seeking, decision-making process about their health. Journalists, then, position themselves as advisors to their patient-consumer audience (34). While both biomedical authority and patient-consumer models of biocommunicable cartography both position biomedical authorities the primary source of information, public sphere models do not.

Briggs and Hallin argue that a wide variety of health news stories can fit into the public sphere model, including stories that refer what they call the social movement model (2016, 34). These stories tend to problematize biocommunicable failures, i.e. a block in the process of knowledge production, circulation, or reception. In response to such blockages, "reporters collaborate (implicitly) with activists and researchers in providing alternative circuits for disseminating health information…Since government officials have failed, journalists must intervene to re-situate issues in public sphere" (43). It is important to note that this collaboration is implicit – Briggs and Hallin are not suggesting that reporters who write stories in the social movement model have abandoned their journalistic objectivity in favor of supporting a social

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movement. Rather, they may be implicitly participating in an active social movement by either generating or circulating information that has not previously been shared by official sources.

When covering a story in the social movement model, reporters implicitly take on three roles: 1) they decide which knowledge should be made public; 2) they find information that has been withheld or improperly channeled; and 3) they construct the boundaries of public discourse about health (Briggs and Hallin 2016, 43). Because they are written in response to failures in the process of knowledge production and circulation, social movement model stories are designed to open up an alternative biocommunicable space in which knowledge flows in alternative directions. Often, this means that laypeople are viewed as a *source* of biomedical information rather than receivers or consumers of information.

Briggs and Hallin are quick, however, to bracket the role of laypeople even in public sphere reporting. They write: "Public sphere reporting is often marked by ambivalence or qualification, particularly when involving laypersons stepping outside of the roles assigned to them by biomedical authority and patient-consumer models and asserting rights to produce or to shape health knowledge" (Briggs and Hallin 2016, 44). They go on to explain that the assumption, even in public sphere stories, is that "Eventually scientists – not activists – will fill these 'blank spaces'" (45).

4.3 Artifacts and Critical Approach

The Lost Mothers Project is a significant site for examining the way that media institutions intervene in the process of identifying and inflecting emergent public health challenges because the reporting team explicitly set out to reframe private trauma into a public health issue. The series

consists of over 30 articles. In order to narrow the scope of my investigation, I focused on the following: 1) early articles (those published in the first four months), as these served to generate initial visibility for the series; 2) The LMP photo gallery, as it is a unique form of knowledge collection and representation; 3) articles that focus on the methods by which the reporting team researched maternal mortality; and 4) articles that focus on racial disparities. In total, this results in 16 articles for analysis. For most of the articles, I focus primarily on the written content rather than images, but in the case of the LMP photo gallery, I also attend to the web design of the page since it is so unique. In addition, for each of these 16 articles, comments posted on the ProPublica/NPR webpage, as well as comments from the NPR and ProPublica Facebook pages provide some insight about reader responses to the series.

This chapter follows Briggs and Hallin's (2016) recommendation that scholars identify and describe the maps of knowledge production, circulation, and reception that are embedded in health news reporting. In addition, a large series with multiple components, like LMP, is likely to rely on multiple maps of knowledge production. In this chapter, I identify two biocommunicable cartographies at work in LMP. First, the social movement map that achieves the reporting team's goal of transforming maternal mortality from private tragedy to public health issue. The second map becomes apparent only after layering in the context of race as dark matter (Browne 2015) that structures Western modernity reveals that the collective consciousness generated by LMP purports to be universal, but is actually based on the exclusion of Black life.

In the same way that a map of a bounded physical place is transformed once the surrounding context is added, the biocommunicable cartography of the LMP is altered once we account for the legacy of maternal harm toward Black people in the U.S. as described in Chapter 1. Timothy Barney highlights that cartography is not a neutral process that simply represents what

is there. "Maps communicate volumes," he writes, "not just in what they include but also in…the 'silences' or what maps choose to omit and obscure from view" (2015, 3). While I celebrate the goal of improving maternal care for all birthing people, one of the goals of this project is to highlight the dangers and limitations of attempting to address the issue of racial health disparities in predominantly White spaces.

Before discussing such limitations, in the next section I explain how LMP responds to major gaps in existing knowledge about maternal mortality. The team makes an explicit effort to build their series around the expertise of laypeople – stories collected from readers and others who have experienced severe complications or lost a loved one during pregnancy, labor, or postpartum. I describe how such stories are collected to form the LMP photo gallery, and then argue that the LMP overall functions as a consciousness-raising tool, fulfilling the reporting team's stated goal of reframing private trauma as a public health issue.

4.4 Lost Mothers Project's Response to Biocommunicable Failure

LMP is an example of investigative journalism in response to biocommunicable failure. The project is intended to fill in major gaps – the team argues that information about maternal death is not being produced appropriately, circulated effectively, or received by the audiences that need it. The reporting team critiques the process of maternal mortality review in the U.S., citing major gaps in the knowledge and information available to publics. In response, the team collects stories from their readers and other members of the general public, stories that form the core of the LMP. The reliance on sharing stories of readers' lived experiences creates a form of consciousness-raising or collective rhetoric that encourages readers to identify with the stories, recognizing that

they or someone they love could die or experience a major complication during pregnancy, childbirth, or the postpartum period.

First, the team emphasizes flaws in the way information about maternal death in the U.S. is produced. As discussed in Chapter 3, the task of identifying and reviewing maternal deaths falls to state- and locally-based maternal mortality review committees (MMRCs). The ProPublica team argues that there are serious gaps in this system, calling the "inability, or unwillingness, of states and federal government to track maternal deaths" an "international embarrassment" (Martin, Cillekens, and Freitas 2017). Here, the team is highlighting a biocommunicable failure on the part of governments in the U.S. There is a blockage in what we are able to know about maternal death in the first place because basic data about the phenomenon is not being collected systematically.

Critique of the maternal death review process is also the focus of the aptly titled article "How Many American Women Die From Causes Related to Pregnancy or Childbirth? No One Knows" (Fields and Sexton 2017). In this article the team emphasizes that, in contrast to countries like the U.K., there is no national maternal death review in the U.S.: "Four million women give birth in the U.S. each year, roughly six times as many as in the U.K. Yet the U.S. has no national review of maternal deaths" (Fields and Sexton 2017). Leaving the process of maternal death review to poorly funded state- and locally-based committees leaves significant gaps in our ability to produce information about this problem. "Slightly more than half the states have maternal mortality review committees…that have been operating for at least a year," point out Fields and Sexton (2017), "Many receive little or no funding and rely on volunteers to take on time-consuming case analyses. They publish reports irregularly and, in some cases, do not address the issue of preventability at all." In fact, the article argues, the U.S. federal government has enough

doubts about their data on maternal death that it has not published an official maternal mortality rate in years.[16]

The series argues that this biocommunicable failure indicates a lack of concern and care for birthing people. Review committees are not an expensive proposition compared to many other government expenditures, the team argues (Fields and Sexton 2017). However, the national Maternal Mortality Review Information Application (MMRIA) – which is designed to collect and analyze standardized information from state- and locally-based MMRCs, "receives not one penny of public money" and is instead paid for by an initiative by the pharmaceutical company Merck.[17]

The reporting team contrasts the lack of funding for maternal death review with the nationwide commitment to reviewing child deaths. Fields and Sexton (2017) quote Stacie Geller, an epidemiologist who has been a member of the Illinois Maternal Mortality Review Board for over 15 years: "There's a considerably stronger record of sustaining review processes related to child deaths, which all 50 states and the District of Columbia have." They also cite a high level official at the CDC: "'It's a reflection that for decades, it's really the infant child that has been the focus and priority, and much less so the mother,' said David Goodman, who oversees maternal health efforts at the CDC's maternal and infant health branch." Here, the ProPublica reporting team relies on biomedical authorities to confirm that inconsistent maternal death review in the U.S. is indeed a biocommunicable failure.

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[16] There was, in fact, an 11-year gap in the National Vital Statistics System publishing an official maternal mortality rate. In 2018, the NVSS ended that gap, estimating that the 2018 maternal mortality rate was 17.4 maternal deaths per 100,000 live births. See Chapter 3 for more information on this gap.

[17] In 2019, two years after the Lost Mothers series was published, the CDC dedicated $45 million over five years to the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Initiative, some of which went directly to states to fund MMRCs, and some of which contributed to a partnership with the Association of Maternal and Child Health Programs (AMCHP) to power the MMRIA database.

Once the biocommunicable failure has been identified, the ProPublica reporters position themselves as authorities on what kind of knowledge should be produced and circulated. For instance, they focus on the fact that MMRCs review de-identified data. As discussed in Chapter 3, all MMRCs de-identify the records before review – removing any information that would allow committee members to identify individuals or hospitals involved. Not only is the patient's identity protected, but all information about the healthcare providers involved in the patient's care, the facility where the care was provided, and even the dates on which events in the case occurred are removed from the files before review by a maternal mortality review committee. This allows for buy-in and protection for members of the medical community involved in individual cases.

From the perspective of family members involved in maternal death cases, however, a de-identified review does not provide the information needed by publics. The leading article in LMP focuses on Lauren Bloomstein, a New Jersey woman who died the day after the giving birth to her daughter. Her husband, Larry, is frustrated by the anonymity of the review process, since de-identification is designed to make it impossible to assign responsibility for individual deaths to specific doctors, nurses, or hospitals. Martin and Montagne (2017a) write: "To Larry, this seemed like a critical oversight – or perhaps, willful denial. In a preventable death or other medical error, he said, sometimes the who and the where are as important as the why. 'Unless someone points the finger specifically,' he said 'I think the actual cause [of the problem] is lost.'"

The goals of maternal death review for committee members are likely to differ from those desired by surviving family members. Whereas Larry Bloomstein wishes to identify providers and facilities that are likely to have a maternal death and to assign responsibility for individual deaths – like that of his wife – to particular providers, MMRCs are usually focused on identifying the causes of maternal death overall and providing strategies for preventability across their

jurisdiction. "Still, it's difficult to tell from studies alone how this pattern plays out in real life," writes Waldman (2017a), "The hospitals are never named. The women behind the numbers are faceless, the specific ways their hospitals may have failed them unknown." The kind of knowledge Waldman describes here requires a different practice of knowledge production, one that shares individual stories of maternal harm.

Therefore, the ProPublica team makes it part of their mission to create an alternative biocommunicable space in which knowledge flows from those who have experienced maternal harm and is made accessible to the public.[18] In the article "Why Giving Birth is Safer in Britain than in the U.S." the authors quote Marian Knight, a maternal health researcher in the U.K. Knight tells the ProPublica reporters that stories are essential to producing knowledge that can prevent maternal mortality: "That's what people remember. In the States, they are just collecting numbers. It's all very well to know a woman died of sepsis, but to know that she died of sepsis because nobody measured her temperature, as they had no thermometers on the postnatal ward, that's where the instruction…might make a difference" (Womersley 2017). Much of LMP's work involves collecting and sharing stories from birthing people who have experienced serious complications and loved ones of those who have died due to complications from pregnancy or childbirth.

4.4.1 Collecting Stories of Maternal Harm

The goals outlined in the previous section steered the LMP reporting team to look to laypeople as an important source of knowledge. Hence on February 10, 2017 ProPublica published

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[18] Some MMRCs do recognize that individual stories contain important knowledge about preventing maternal mortality See Chapter 3 for examples of MMRCs who conduct family interviews to collect such narratives for use in their review process.

a call for information entitled, "Do You Know Someone Who Died or Nearly Died in Childbirth? Help Us Investigate Maternal Health" (Gallardo 2017b). The short article included a link to a detailed questionnaire readers could use to share their story with the reporting team. The response to this call was overwhelming: "We heard from 2,500 people the first week, mostly women reporting that they had nearly died" (Gallardo 2017c). Ultimately, the team got over 3,000 responses to this questionnaire, as well as hundreds of emails. The call for information also generated hundreds of comments when it was posted to both NPR and ProPublica's Facebook pages.

The reporting team demonstrates a sense of reflexivity about the nature of their audience and, as a result, the type of people that are likely to respond to their questionnaire. The team notes that it is likely they received so many responses to their call in a short period of time due to NPR's large following on Facebook. However, they write: "we wanted to reach more than just an NPR or ProPublica audience. That's where the shoe-leather journalism started" (Gallardo 2018a). The team partnered with other media outlets (including *Cosmopolitan*, *The Root*, *The Texas Tribute*, and Univision). They also began searching social media for additional stories: "To compile our list of women who died from pregnancy and childbirth-related causes, ProPublica reporter Nina Martin scoured social media – primarily public posts on Facebook and Twitter, and the crowdfunding sites GoFundMe and YouCaring" (Gallardo 2018a). Here the team implies, but does not explicitly state, that relying only on ProPublica and NPR's audience would result in a predominantly White, middle/upper-middle class sample of stories. Despite their efforts to collaborate with other media outlets and use social media, they ultimately acknowledge that their method "falls short at capturing women who live and die on the margins, including homeless women and undocumented immigrants" (Martin, Cillekens, and Freitas 2017). In addition, they note that Black birthing people

are less likely to have their stories posted on social media, even though they die due to complications from pregnancy and childbirth much more often than White people.

These gaps are important to note, since the collection of stories shapes the direction of LMP. The reporters describe a collaborative process between themselves and the people who shared stories for the series: "The questionnaire was just the start of a relationship between reporters and the women who shared their stories. We asked them questions, sent them our articles, even ran ideas by them. Their insights contributed significantly to the series" (Gallardo 2018a). The reporters list specific examples of ways this collaboration impacted the LMP:

> An advice piece emerged from ideas shared by hundreds of women on how to improve maternal care. The Lost Mothers gallery identified 134 women who died in 2016. The questionnaire helped in collecting details and family photos from loved ones. Nearly all the women in our story about near-misses found us first through our questionnaire. We portrayed racial disparities in maternal care through conversations between black women and their families. (Gallardo 2018a)

In addition to serving as a primary source of information to fill gaps in information from official sources, the stories shared by laypeople directed LMP reporting in significant ways, suggesting angles for new stories.

4.4.2 Lost Mothers Project Photo Gallery

The Lost Mothers photo gallery (Martin, Cillekens, and Freitas 2017) is a unique online platform for the LMP reporting team to circulate knowledge produced by narratives of maternal death. The goal of this portion of the project is to identify everyone who died from complications related to pregnancy and childbirth in 2016, the year before the series was published. When the

webpage was published in July of 2017, the team had used social media, obituaries, public records, patient advocacy organizations, and information from readers to identify 134 people. The visual elements of the gallery webpage in particular function both to build a database of new knowledge, but also to make readers aware of what science and technology studies scholars would call ignorance or absent knowledge (Croissant 2014; Gates 2019). As Kelly Gates writes, "absence are not empty; there is something to be found in absences themselves – specific actions, conditions, and assumptions that produce them" (2019, 99). Gates concurs with the LMP reporting team in arguing that more important than absent data are absent people.

The text at the top of the landing page for the LMP photo gallery reads: "Lost Mothers: An estimated 700-900 women in the U.S. died from pregnancy-related causes in 2016. We have identified 134 of them so far" (Martin, Cillekens, and Freitas 2017). Below the text is a visual display, the photo gallery of lost mothers. The visual display consists of a graph with 800 dots, designed to represent the 700-900 people who died from pregnancy-related causes in 2016. The first 134 of the dots are filled in with thumbnail photos or avatars, designed to represent the 134 women the reporting team had identified. Of those 134, 57 thumbnails are filled with images of someone who died (the rest are grayscale avatars). Most of the thumbnails are hyperlinked to obituaries, and 16 of the images are hyperlinked to narratives written by the reporting team, displayed on the same webpage. The remaining 666 dots are simply small gray dots on a black background, representing a statistical estimate of additional people who died due to complications of pregnancy and childbirth in 2017, yet were not identified by the reporting team.

The LMP gallery circulates a type of knowledge that has not been available before. As described in the previous section, the LMP has identified a gap in knowledge that is produced by MMRCs, particularly since they de-identify their data. Here, the reporting team attempts to fill

that gap by identifying and sharing stories of those who have died during pregnancy and childbirth. The authors highlight two forms of previously absent knowledge: 1) knowledge about the stories, lives, experiences, and circumstances of these people; and 2) knowledge about their pregnancy-related complications, along with medical and public health lessons that can be learned from their experiences.

The LMP gallery also represents new knowledge in a different way, by visually representing the absence of knowledge itself. The thumbnail images and avatars that represent identified women and birthing people take up less than four of the 25 rows in the graph, creating a visual effect that forces the reader to recognize how many more unidentified women died from pregnancy-related complications in just one year. Thus, the data visualization shines a light on the gap in our knowledge. The data is absent, but the visualization generates an awareness of that absence. In addition, there is a hierarchy in the amount of information available about each person – ranging from "not identified" (i.e. the gray dots), to "identified but limited information" (i.e. the thumbnail avatars) to "identified with an image" (i.e. the thumbnail images). Therefore, the gallery visually represents texture in the types of presences and absences of information LMP is able to generate.

Below the photo gallery, the webpage also includes 16 narratives about women who died due to pregnancy-related complications in 2016. It is important to note that these narratives are not authored by the friends and family of the deceased. Rather, they are carefully crafted and curated narratives, written by the LMP reporting team based on conversations with loved ones of the deceased and supplemented by obituaries and other publicly available information. While each of the narratives are unique, they all reflect a similar construction pattern.

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Most of the narratives begin by introducing personal information about the life of the woman who died, including their personality, hobbies, occupation, and relationship with their family and friends. This opening is designed to help readers fill out their picture of the woman who died, giving her texture as someone whose life was not primarily about her death. After briefly providing context for the woman's life and her relationships with family, the narratives provide some context for her health status during pregnancy – including complications from previous pregnancies, other health issues that were complicated by the pregnancy, or – in some cases – establishing that there were no unexpected health issues during the pregnancy. This section of the narrative also often provides a sense of the woman's affective state during her pregnancy, especially if the expectant mother was excited or happy about being pregnant. After setting up relevant health details and affective states during the pregnancy, the narratives introduce a complication, which subsequently develops into a crisis. The complication emerges at various stages: towards the end of pregnancy, during labor and delivery, shortly after delivery, a few days after returning home with the baby, or even months postpartum. This section of the narrative often also includes a foreshadowing of preventability, such as reports of feeling ill, doctor visits in which complaints are ignored, or other missed actions.

Following the description of the crisis and its ultimate culmination in a maternal death, the narrative often introduces biomedical facts and statistics as context. For instance, Kira Dixon Johnson died as a result of hemorrhage after a scheduled C-section. After explaining she was hemorrhaging the narrative states: "Obstetric bleeding is one of the most common causes of maternal deaths in the U.S.; 70 percent of such deaths are preventable, researchers in California have found. In Kira's case, her family contends, the medical team delayed treatment too long" (Martin, Cillekens, and Freitas 2017). Dixon's narrative, then, serves as an opportunity to provide

information about a common complication that leads to maternal death. While this supplemental information does not make explicit connections to any of the other stories in the collection of narratives, it provides enough generalizable information for readers to assume that other people in the gallery, even those whose specific stories are not shared publicly, likely died of similar causes and were likely preventable.

4.4.3 Consciousness-Raising about a Public Health Issue

The LMP reporting team emphasizes that its goal in the series is to reframe maternal mortality into a public health issue. In a follow-up to their original callout for stories, the team writes that there are very few spaces where these stories are shared: "people so rarely talk about maternal deaths elsewhere. Even the most popular mommy blogs don't often delve into mortality and near-deaths. We realized that it's part of a pattern: Treating the death of a mother due to pregnancy or childbirth as a private tragedy rather than as part of a public health crisis" (Gallardo 2017c). The authors go on to state that they "wanted to build and convene this community" (Gallardo 2017c). That is, they aspire to build the kind of community where people can share these private stories and recognize they are part of a larger pattern.

In this way, the series as a whole and the LMP photo gallery in particular function as consciousness-raising – a form of discourse in which individual experiences are articulated together in such a way that participants recognize the political relationships between their individual experiences and, as such, can begin to work toward a collective goal (Campbell 2002). This is one of the self-stated goals of LMP – to make public a multiplicity of experiences with maternal harm, so that experiences that people previously believed were private and individual only to them are recognized as a systemic problem that requires collective action by society.

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The rhetorical practice of consciousness-raising is generally associated with the women's liberation movement, in which small, leaderless groups of women would meet to talk about their personal experiences. The goal of these groups was to "make the personal political," and to "create awareness (through shared experiences) that what were thought to be personal deficiencies and individual problems are common and shared" (Campbell 1999, 128). Consciousness-raising in various forms has continued to be a central strategy for the feminist movement, as well as movements for the liberation of other marginalized groups. As Jean Bessette describes in her study on the lesbian activist group Daughters of Bilitis:

> 'Consciousnesses' are 'raised' when the composition of a multiplicity of experiences transforms what was previously felt individually into a foundation for collective identification and action. The famous feminist dictum 'the personal is political,' means that personal experience, when shared and linked with others' experiences, reveals that individual suffering is a product of systemic problems. (Bessette 2013, 31)

The collection of personal experiences, then, in any form, carries potential to raise consciousness.

Consciousness-raising can occur outside of small groups like those typical of the women's liberation movement. Essays, speeches, and other discourses can also reflect the principles of consciousness-raising practice, such as building knowledge from personal experiences, the value of self-exposure, and the value of dialogue and interaction between personal narratives (Campbell 1999). Bessette highlights the way that consciousness-raising can occur not only between individuals in a group, but also between a text and readers of a text: "The women whose experiences were archived in the book and the women who read them were strangers to one another, yet through the conduit provided by the *Lesbian/Woman*, readers exchanged experiences…typically kept private" (2013, 31).

Tasha Dubriwny argues that rhetoric built on the principles of consciousness-raising – which she calls collective rhetoric – is persuasive to the extent that it reframes one's understanding of the world. As she puts it, consciousness-raising gives "individual experiences new meanings by moving them into the realm of social reality" (2005, 401). By gathering together multiple articulations of different individual experiences, a new understanding of the world is formed. "A theory of collective rhetoric," Dubriwny writes, "models a process of persuasion that envisions the creation of novel public vocabularies as the product of the collective articulation of multiple, overlapping individual experiences" (396). As a whole, LMP works to reframe readers' understanding of pregnancy, childbirth, and motherhood.

The formatting of the LMP photo gallery – both the data visualization at the top and the series of narratives – functions as a consciousness-raising tool, emphasizing that each individual story of trauma and death is part of a larger pattern of maternal harm. By gathering the images and avatars in one place, creating a database of maternal deaths and the stories associated with them, the LMP photo gallery emphasizes that there is a common thread linking these stories.

The empty spaces in the gallery, represented by gray dots, serve as constant reminders that there are more of these stories, even if they are stories that may never told publicly. In addition, as the user scrolls down the webpage to read the narratives the reporting team has written about 16 of the people in the gallery, a bar appears at the top of the screen, containing the thumbnail sketches of the photos and avatars from the gallery. As the user scrolls, the images in the bar on the screen also move so that the person whose story is being read is near the center of the bar. As the images move, the user is constantly reminded that there are hundreds of other stories like the one currently on their screen. For every story shared on the webpage, there are at least a dozen other similar stories. The interactive display of the Lost Mothers gallery is designed so that the user is constantly

aware that every one of the specific, individual tragedies described on the website is part of a bigger picture, a piece of a larger public health crisis.

Based on the comments readers posted to the ProPublica and NPR websites, as well as the comments on the articles on ProPublica's Facebook page, LMP generated a significant amount of identification among readers. This identification is important so that the "telling of individual experiences" can make possible "a reframing of one's understanding of the world" (Dubriwny 2005, 396). That is, by reading the series, people who have given birth can not only recognize similarities in their experiences, but also understand those experiences in a new way as a result of recognizing connections between these many narratives. Many readers commented on the photo gallery (Martin, Cillekens, and Freitas 2017) and on Bloomstein's story (Martin and Montagne 2017a) to say that they too could have died from complications like those in the articles. As one commenter notes, when traumatic events happen in birth, new parents often do not have a space in which to share their stories:

> This is really powerful. As someone who just went through a traumatic situation after my delivery in October, I quickly came to the realization that I wasn't alone. And yet, women don't have a forum for discussing what happened, only with family and close friends…It could have been a very different situation if I was in a different place or a different time. Feel very grateful but would love to get the word out about this. (February 10, 2017 4:53 PM, comment on NPR 2017)

There are many reasons such stories are not shared publicly – they contain intimate details about someone's body during a time in which they particularly feel vulnerable, new parents are overwhelmed with their baby and not focused on sharing their story, and many birthing people assume that this is not something others have experienced. It is this gap in understanding that LMP

aims to address – by highlighting the individual stories of women who have died. Both Bloomstein (Martin and Montagne 2017a) and Shalon Irving's (Martin and Montagne 2017b) stories, for instance, contain details about the current lives of the people who survived them – their children, their parents, their partners, their friends – highlighting the devastating impact of losing a mother.

LMP appears to provide needed space for people to share their stories of maternal harm. Hundreds of readers, in addition to the thousands who completed ProPublica's questionnaire, posted their stories of maternal morbidity in comment threads on these stories.

> Wow! I could have been one of these unfortunate women! In 1973, a week after having my son, I hemorrhaged. I was ill from the day I gave birth, having a high fever, blacking out, dizziness & having a foul odor that smelled like death. I was 20 years old, looking many years younger, and my complaints were disregarded by my doctor…I am so fortunate to be here today, as I thought I was leaving this world. After reading these stories, I am happy that I did get the medical help I needed, despite the doctor's advice of laying down with ice on my belly. (comment on Martin, Cillekiens, and Frietas 2017)

The advice to pregnant and birthing people to listen to their own bodies and to advocate for themselves if doctors and other medical staff won't listen is very common. "Listen to what your body is telling you," wrote one commenter in response to a story crowdsourcing advice for pregnant people from readers, "BE THE SQUEAKY WHEEL." (August 3, 2017 9:32 AM, comment on ProPublica 2017a)

Many of the comments also resonated with a point made in the series – maternal harm may be the result of prioritizing care for the infant over the care for the person who just gave birth. One commenter points out that she received far more education about caring for her son than she did about caring for herself:

2 years later, I still have folders full of paper about how to care for my son. He's my fourth,

I didn't need instructions. But for me? A wheelchair to the car and a pat on the shoulder

basically sums up what we're sent home with for ourselves. My kids all saw their

pediatrician within the first week they were alive, but standard care for us is seeing our OB

6 weeks later. That's a long time to let issues ride. (August 3, 2017 9:29 AM, comment on

ProPublica 2017a)

Even people who experienced serious complications from childbirth often felt they did not receive

enough support following their hospitalization: "once I was out of the hospital a week later, there

was no support for my healing. There was some breastfeeding support, but nothing for recovering

from surgery and HELLP. I'm finding out only now about some long-term ramifications of that

lack of postpartum care. The U.S. MUST do better" (May 12, 2017 11:44 PM, comment on

ProPublica 2017b). The identification these readers feel with the stories in LMP leads them to add

their own stories to the collective rhetoric, striving to raise awareness for the women and birthing

people who come after them: Listen to your body. Prioritize yourself. Things need to change.

The LMP reporting team makes an effort to connect the individual stories they share with

larger political concerns. This is an essential aspect, since consciousness-raising requires "that the

personal be transcended by moving toward the structural, that the individual be transcended by

moving toward the political" (Campbell 1999, 131). To start, the series ties individual maternal

deaths to a larger trend of high rates of maternal death in the U.S. "By many measures, the United

States has become the most dangerous industrialized country in which to give birth" writes Adriana

Gallardo (2017b) in the article featuring ProPublica's call for readers to share their stories about

maternal harm and death. She further highlights this point with comparisons to other industrialized

countries: "American women are more than twice as likely to die of pregnancy-related causes as

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British women, three times as likely as Canadians and six times as likely as Norwegians and Poles" (Gallardo 2017b).

As described above, the project repeatedly highlights the lack of maternal death review as a political issue – more funding for maternal death review would allow for a more accurate picture of the circumstances surrounding maternal deaths and, presumably, the creation of strategies to prevent them. In comparing maternal death review in the U.K. with that in the U.S., they write: "In many parts of the U.S., such enquiries do not have the same prominence and clout. There is no federal-level scrutiny of maternal deaths, and only 26 states have an established committee (of varying methodlogy and rigor) to review them. Not do all U.S. hospitals routinely examine whether a death could have been avoided" (Womersley 2017). Furthermore, the costs of maternal care in the U.S. are far higher than those in the U.K., a point that highlights larger issues with the healthcare system in the U.S. Although the U.K. has superior outcomes for preventable pregnancy-related conditions, the team writes, "the U.K. has achieved these results while spending less on delivering babies" (Womersley 2017). According to the article, the average cost of an uncomplicated, vaginal birth in the U.S. is $30,000. In the U.K. it is $2,300. The problems with the U.S. healthcare system are again alluded to on the photo gallery page, where the authors write that the stories they have published "underscore the potential repercussions for women and families as Republicans in Congress push to revamp the health care system and roll back Medicaid" (Martin, Cillekens, and Freitas 2017).

The LMP reporting team also connects the effectiveness of their rhetoric with political actions taken by New York City in 2018 to reduce racial disparities in maternal death. In July 2018, the city announced plans to spend $12.8 million on an initiative designed to eliminate "the Black-White racial disparity in deaths related to pregnancy and childbirth and [cut] the number of

complications in half within five years" (Waldman 2018). The initiative included training for staff at the city's public hospitals, strengthening prenatal and postpartum care in those hospitals, and a maternal safety public awareness campaign. The LMP team directly connects this commitment to public pressure as a result of their research published in the article "How Hospitals are Failing Black Women" (Waldman 2017a). ProPublica reporter Annie Waldman (2018) writes: "The city's initiative is the latest in a wave of maternal health reforms following the 'Lost Mothers' series. Over the past few months, the U.S. Senate has proposed $50 million in funding to reduce maternal deaths, and several states have launched review committees to examine birth outcomes." Thus, the LMP reporting team argues that the collective rhetoric it generated led to political change.

It is important to note, however, the limitations of the kinds of solutions advocated by LMP as compared to the more sweeping political change posed by reproductive and birth justice activists. The arguments and practices of these activists will be further addressed in Chapter 5. Here, however, it is important to note that they have been calling for a wide range of legislative action, ranging from more funding for transportation, childcare, and nutrition programs to "divesting from the system of over-policing Black, Brown and indigenous people" (Ross et al. 2020). While there is some overlap in the kinds of action proposed by reproductive justice activists and LMP (for instance, anti-bias training for health professionals), the divergences highlight one of my key concerns in this project – that the ways in which maternal mortality is made public also impacts the ways it is made actionable and the kinds of possibilities we can imagine as appropriate solutions.

4.5 The Lost Mothers Project's Rhetorical Double-Bind

LMP appears to succeed in reframing a private trauma as a public health tragedy that many readers can identify with; however, it also faces a fundamental tension, one that is shared by other movements for social change. To enact change, a group needs a wide range of people to identify with and support their cause. To rhetorically unite such a group often means eliding the differences in the lived experiences of members. In the case of LMP, the series simultaneously indicates that anyone who becomes pregnant is vulnerable to maternal harm and death and also that some people are uniquely vulnerable.

The opening text to the photo gallery emphasizes the diversity in types of people who experienced a maternal death in 2016. Martin, Cillekens, and Freitas (2017) write: "Together these women form a picture of maternal mortality that is more racially, economically, geographically and medically diverse than many people might expect. Their ages ranged from 16 to 43; their causes of death, from hemorrhage to infection, complications of pre-existing medical conditions, and suicide." The point here seems to be that all types of women and birthing people, even those you least expect, could die as a result of complications during pregnancy and childbirth.

This argument, however, clashes with the headlines in later articles in the series, such as "Nothing Protects Black Women from Dying in Pregnancy and Childbirth" (Martin and Montagne 2017b) and "How Hospitals are Failing Black Mothers," (Waldman 2017a) which emphasize that some people – Black women and birthing people – face particular challenges and dangers. Thus, there is an implicit tension between uniting all people who have wombs with the challenges particular to some birthing people because of their race.[19]

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[19] The rhetoric of the women's liberation movement provides a key example of this tension (albeit not the only one). Campbell (1999) argues that feminist discourses must serve to unite women across their differences:

As a result, readers of LMP might be left with a sense of uncertainty. The first article in the series – the one focusing on Bloomstein's story (Martin and Montagne 2017a) – is published on May 12, 2017. For the next six months, while many articles mention racial disparities, they do not focus on the issue. Then, in December 2017, a series of three articles focusing on racial disparities in detail is published (Gallardo 2017a; Martin and Montagne 2017b; Waldman 2017a). After six months of stories emphasizing that all women in the U.S. are likely to experience maternal harm and death, the focus suddenly shifts to emphasizing that some are actually at far more risk.

Briggs and Hallin note that, while most health and medical reporting is overtly *deracialized*, statistics about racial disparities can often function to authorize new outlets to talk about race. "Statistics figure prominently in many health stories that invoke race and ethnicity," they write (2016, 170). Like LMP, news stories "that foreground race and ethnicity often have their origin in research studies highlighting racial and ethnic differences" (170). The triggering frames that Briggs and Hallin (2016) note in news stories about race are related to Jackson's (2006) argument that, when portraying bodies (particularly Black bodies) media rely on racialized scripts. By scripts, Jackson (2006) is arguing that there is already of subtext of narratives into which bodies – particularly Black bodies – are expected to fit.

These representations become so embedded in our popular imaginaries about Black bodies that they become very difficult to subvert. Jackson asks: "What does one do with fictive corporeal representations that eventually become so fixed in the public imagination that they are no longer

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"women are divided from one another by almost all the usual sources of identification - age, education, income, ethnic origin, even geography… If a persuasive campaign directed to this audience is to be effective, it must transcend alienation to create 'sisterhood'" (Campbell 1999, 128). In contrast, Crenshaw (1991) argues that this emphasis on unity has caused the movement to "conflate or ignore intragroup differences" (1242) in ways that are particularly harmful to Black women.

considered false? In fact, after constant inundation of such images, these glyphic caricatures become verifiably true portraits of Black bodies that require transcendence before they can even be considered false again" (2006, 50). Jackson also wants to highlight that both audiences and creators are often not aware of how much they are invested in these fictive corporeal representations: "to be Black and to be American is to be forced to participate in a public game of charades in which all interactants are subjected to subliminal vagaries of the mind" (51). Here he highlights that many Westerners have latent, subtextual scripts about racialized bodies.

Although members of the LMP reporting team do not explicitly invoke common racial stereotypes of bad Black mothers (Collins 2000; Roberts 1997), both they and their readers are affected by the kind of subliminal vagaries that Jackson describes. By centering the stories of women like Bloomstein, for instance, LMP builds its narrative around the norm of White motherhood. Scholars have noted that there is a dominant model of White motherhood in media representations (Glenn 1994). Raka Shome (2014), for instance, points to the way representations of Princess Diana function to establish a myth of White upper-/middle-class motherhood in which the mother is independent of the need for state or community support and is expected to be the primary person who is hands-on and active in the raising of her children. Shome argues that this model is universalized in a way that "marginalize[s] or render[s] invisible non-western, ethnic, immigrant minority maternal experiences that are so present, yet ignored, in Western national landscapes" (54).

Natalie Fixmer-Oraiz (2019) emphasizes that the ideology of White, middle-/upper-class motherhood – what she calls intensive mothering – is dependent on assigning pathology and criminality to "Other" mothers. As she writes: "Intensive mothering feeds acute and exacting demands, but it also functions powerfully to codify the trope of the 'bad' mother as its constitutive

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outside" (13). Because they are unable to appear to fulfill the demands of intensive motherhood, people who are parenting outside of wealth, whiteness, U.S. citizenship, or heteronuclear family formation are parenting in a fundamentally different world than White, middle-/upper-middle class women. The ideology of intensive mothering is damaging for *all* mothers, but the privileges it does afford White mothers are reliant on the demonization of women of color.

Thus far, I have identified the biocommunicable cartography in the LMP as one consistent with the social movement model, aiming for consciousness-raising around maternal mortality. However, processes of consciousness-raising do not unfold in a vacuum. In fact, the ways Western consciousnesses have already been raised to blame Black women for social ills provides additional context to this surface-level map of knowledge production and circulation in the LMP. In Chapter 2, I argued that racism is the dark matter that makes it possible to make maternal mortality public. This is in alignment with Simone Browne's (2015) work on surveillance, in which she demonstrates that blackness is the "dark matter" on which Western society is built. Browne is drawing on work by Howard Winant, who describes race as dark matter, "the often invisible substance that in many ways structures the universe of modernity" (2015, 605). Charting a map that accounts for this invisible dark matter is a challenge for a rhetorical critic – it requires some knowledge of how that dark matter might operate. It also requires reading for absences – what is unsaid in addition to what is said. It requires identifying places where the gravitational pull of anti-Black racism is at work.

Towns (2020) highlights some of this absence, demonstrating how the gravitational pull of anti-Black racism is deeply embedded in media itself. Media scholar Marshall McLuhan famously held that the "medium is the message," arguing that technologies of communication – not just their

content – are central to shaping human understanding and social life.[20] Revisiting McLuhan's project, Towns points out that McLuhan's conception of the human was based on an assumption that the use of technology by Euro-Americans was proof that they were distinct from other groups of people – "that they, and they alone, had emerged out of a state of nature" (859). Other people, "the African, the Kenyan, the tribal, or the natural," would never become civilized humans, would never become separate from nature (856). Of course, most of the uptake of McLuhan's media theory renders race invisible, occluding our perspective on how use of media technologies may implicitly structure subsequent communication and understanding about race.

Towns emphasizes that Western media function as contracts that transmit and reinforce certain understandings about who constitutes Western man (or human) (2020, 853). Rachel Alicia Griffin elaborates a similar argument: "media as a social institution is positioned as a conduit through which whiteness is calculatingly preserved, fortified, and disseminated as superior" (2015, 150). Furthermore, Towns argues that the Black body functions to support this transmission of whiteness. As he puts it: "There is no such thing as whiteness that exists outside of a context of racial violence" (2020, 855). That is, upholding whiteness as the norm of humanity can only be done by oppressing and committing violence against other racial groups.

For media to function as a conduit for whiteness, Black bodies are treated as objects – commodities or raw material: "the Black body is that which does not sign the contract, but the *item, commodity*, or *medium* for which the contract is drawn up to begin with. Put simply, white people sign contracts, Black bodies (state of nature) are what contracts are drawn up for and about"

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[20] Note that the title of the best-selling book with this title is actually "The Medium is the Massage." Reportedly, this was actually a mistake made by the typesetter, but McLuhan was so thrilled by the typo he asked that it be left alone. McLuhan's eldest son Eric writes "Now there are four possible readings for the last word of the title, all of them accurate: 'Message' and 'Mess Age,' 'Massage' and 'Mass Age'" (McLuhan 2021).

(Towns 2020, 864). The contract Towns refers to is the racial contract described by Charles Mills (1997), which ensures that White Europeans are protected as uniquely human while other racial groups are bound to the natural world. In essence, he argues, Black *bodies* are needed in order for White *people* to exist. In the following section I argue that LMP relies on the figure of the unhealthy/irresponsible Black body to anchor their news frame, which functions to reproduce White motherhood.

4.5.1 Reproducing White Motherhood in Lost Mothers Project

LMP is part of the social institution of media through which whiteness is reinforced. Briggs and Hallin point out that part of the reason health news stories are so often deracialized is that the audience for many mainstream news outlets is predominantly White (2016, 179). Reporters, they write, sometimes feel the need to 'sell' stories on 'minority' health to readers by emphasizing how they will affect readers' *own* health" (179). Similarly, it is likely that the readers of LMP are predominantly White, based on the demographic makeup of ProPublica's readership in general. ProPublica's audience is predominantly older, highly-educated, White people.[21]

LMP functions not only to transmit whiteness, but to reproduce White motherhood as an idea norm. Scholars have noted that there is a dominant model of White motherhood in media representations (Glenn 1994), one in which mothers are active and hands-on in raising their children and do not need additional support outside of their nuclear family. Shome (2014) argues

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[21] Among the readers who completed ProPublica's 2019 reader survey, 64% were over age 55. Only 12% were younger than 35. Most of those who completed the survey had a college degree (86%) and many had a postgraduate degree (49%). 84% of the survey participants were non-Hispanic white. While the survey does not provide a complete picture of ProPublica's audience, it does give us a general sense of ProPublica's average reader profile (Shepherd 2019).

that this model is universalized in a way that "marginalize[s] or render[s] invisible non-western, ethnic, immigrant minority maternal experiences that are so present, yet ignored, in Western national landscapes" (54). As the ensuing analysis will show, LMP works to reinforce this dominant, White model of motherhood.

Whiteness, and White motherhood, project themselves as the normative, neutral, or default state of human being. "As long as race is something only applied to non-white peoples," writes Richard Dyer, "as long as white people are not racially seen and named, they/we function as a human norm. Other people are raced, we are just people" (1997, 1). Communication scholars Thomas Nakayama and Robert Krizek argue that the invisibility whiteness is what makes it strategic – "it functions to resecure the center, the place, for whites" (1995, 295). As Dyer explains it, because whiteness is seen as normal or default, it reproduces itself "regardless of intention, power differences, and goodwill" (1997, 10).

This imagination of whiteness as the normative state and its resulting transmission is dangerous. In Chapter 1, I argue that when bodies are made public, Black bodies are often rendered either invisible or hypervisible, both of which function to make Black life un-visible. The invisibility of White bodies in public, however, only serves to reinforce the notion that White humans are something transcendent of their bodies. Dyer elaborates on the danger of viewing whiteness as a norm:

> White people have power and believe that they think, feel, and act like and for all people; white people, unable to see their particularity, cannot take account of other people's; white people create the dominant images of the world and don't quite see that they thus construct the world in their own image; white people set standards of humanity by which they are bound to succeed and others are bound to fail. (1997, 9)

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Dyer's quote here emphasizes the danger of LMP's reproduction of whiteness. The collective consciousness that is developed through the series – described above – is one that is imagined to be universal by White readers, but is in fact only the consciousness of White women who assume that their experience can stand in for all people's, who fail to see their particularity, who have created the dominant images of motherhood in their own images and, in the process, have set standards for pregnancy, birthing, and parenting by which they are bound to succeed and others are bound to fail.

Whiteness, and White motherhood, are projected in LMP as the normative state of being while also being unmarked. Here it is instructive to look at the lead article in the series, the one outlining the story of Lauren and Larry Bloomstein, which is designed to draw in readers. The article, published on May 12, 2017, is headlined "The Last Person You'd Expect to Die in Childbirth" (Martin and Montagne 2017a). Rhetorically, of course, this implies that there might actually be some people that you *do* expect to die in childbirth. One commenter on ProPublica's website, in fact, points this out: "Great article but really BAD title. Please use the NPR title instead. The idea that middle class white women should have a lower 'expectation' of dying really must be challenged" (comment on Martin and Montagne 2017a).[22]

As this comment alludes to, the article focuses on the story of Bloomstein, a 33-year old NICU nurse. Bloomstein is White, heterosexual, married, and middle/upper-middle class. She and her husband both work in healthcare – he is an orthopedic surgeon. Tragically, she died within 24 hours after giving birth to her daughter from severe postpartum preeclampsia.[23] The events

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[22] It is unclear what "NPR title" the commenter is referring to since the story on NPR's website has the same title as the one on ProPublica's.

[23] Preeclampsia is a pregnancy complication in which someone who is pregnant (usually 20 weeks or more) or has recently given birth develops high blood pressure and begins to show signs of damage to one or more organ systems. If left untreated, preeclampsia can develop into eclampsia, causing seizures. Bloomstein was diagnosed with HELLP syndrome, a related complication that can result in seizures, strokes, and liver rupture.

presented in the ProPublica article reveal a clear series of medical errors, from ignoring elevated blood pressure readings when she was admitted to the hospital to assuming her severe abdominal pain (a classic symptom of preeclampsia) was a result of reflux.

Bloomstein likely fulfills reader's expectations for a typical pregnant woman. First, of course, the headline for her story implies that she is healthy and well-supported financially and socially. As a NICU nurse, she is presumably the kind of person who is well-prepared to care for a newborn child. The beginning of the story describes her excitement to have a child and her uncomplicated pregnancy. Her husband, Larry, describes Lauren's emotional state during pregnancy as "giddy," saying she was "the happiest and most alive I'd ever seen her" (Martin and Montagne 2017a). Bloomstein was also healthy – she experienced expected pregnancy symptoms like nausea and fatigue, but nothing out of the ordinary. She was spending her free time preparing for the baby to arrive: "picking out strollers and car seats, stocking up on diapers and onesies" (Martin and Montagne 2017a). She and her husband go on a "pre-baby vacation to the Caribbean" and hunt for their "forever home," which turned out to be "a brick colonial with black shutters and a big yard" in suburban New Jersey (Martin and Montagne 2017a).

For many middle/upper-middle class White readers, Bloomstein's experience with pregnancy probably sounds very familiar and typical, the way pregnancy is supposed to go. Lauren has specific characteristics – she is feisty, determined, calm under pressure. But these characteristics all serve to highlight the likelihood that she will fulfill a White ideal of motherhood. She seems able to take on an active, hands-on role, being the primary person to care for and raise her child without state intervention or extensive community support.

This, of course, is the point of the article. Bloomstein is an ideal expectant-mother, not someone who expected to experience any major complications as a result of her pregnancy, and

certainly not someone who expected to die after giving birth to her daughter in the very hospital where she worked. Her death is intended to work as a representative example to which readers can relate. The conclusion of the story about her life and death includes a quote from a member of New Jersey's maternal mortality review committee: "The death of a new mother is not like any other sudden death. It blasts a hole in the universe…it has ripple effects for generations to come" (Martin and Montagne 2017a). Lauren's story – a story of White motherhood denied – is one of a family and community that has been deprived an ideal mother.

Importantly, though, Bloomstein's whiteness is unmarked. Nowhere in the story do the authors specifically mention her race. There are a few moments in the article, however, that function as legibility cues for the reader that that they should read Bloomstein as White. The article includes pictures and video in which Bloomstein appears to have light skin and brown hair. Toward the end of the article, her daughter, Hailey, is described as having "Lauren's brown hair and clear green eyes" (Martin and Montagne 2017a). The article also includes a somewhat odd story about a modeling gig Bloomstein did as a teenager. Apparently, one of her neighbors worked for a publishing company and recruited Bloomstein to model for the cover of a series of books based on Louisa May Alcott's *Little Women*. She ended up being cast as the eldest sister, Meg: "She appeared on the covers of four books, looking very much the proper 19th-century young lady with her long brown hair parted neatly down the middle and a string of pearls around her neck" (Martin and Montagne 2017a). The article describes Bloomstein as a physical model for a classic coming of age story about White women, yet never explicitly mentions or highlights Bloomstein's race. In contrast, the stories about Black women in my sample of articles from LMP are all primarily about racial disparities and therefore highlight the race of the women in the narratives either in the headline or early on in the article.

As noted above, the unmarked whiteness is Bloomstein's story matters because the dominant model of motherhood in the U.S. is a White one. Shome calls this model the myth of White motherhood, and argues that it is a site through which Western nations reproduce their modernity, while simultaneously vilifying other forms of motherhood (particularly, those of working-class, single, lesbian, and non-white mothers) (2014, 47). In the case of Bloomstein, because her life appears to fulfill the myth of White motherhood, the text implies that we should not expect her to die. We do not expect White, middle-class, healthy women whose husbands are doctors to die.

Conversely, the text implies that if there are some people we do not expect to die, there must be some people we *do* expect might die in pregnancy and childbirth. Presumably, these are people whose professions, family life, pregnancies, and reproductive choices look different than Bloomstein's. If the primary responsibility of parenthood – to keep one's baby safe – begins during pregnancy, we know that this task is not equally difficult for all parents. As Shome points out, for women of color, particularly poor women of color, "there is often a lack of safety – physical, emotional, social, and interpersonal – in their communities and homes" (2014, 58-9).[24] This is part of why reproductive justice activists call for going beyond advocating for people's right to choose whether or not to give birth, to address further rights of all parents to raise children in safe environments.

Chapter 2 describes arguments from Dorothy Roberts and Patricia Hill Collins that Black mothers are often rhetorically demonized – figured as promiscuous, hostile, lazy, and/or incompetent. In LMP's coverage of Lauren Bloomstein's story, however, we see the opposite. Bloomstein is employed taking care of other people's children, but she is autonomous and capable

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[24] See Chapter 3 for more details about how the infrastructures for identifying and tracking maternal deaths erase violent deaths.

in that role. She is a medical professional, whose primary job is to ensure the infants in her care are physically healthy and well. The descriptions of Bloomstein that we are provided imply that she is not promiscuous, nor is she ever implied to be someone who is hostile, angry, or abusive. She has secured a man. She and her husband both have good jobs, so they are able to support themselves without any dependence on the state. Therefore, she is someone White culture both expects and encourages to reproduce.

The preceding analysis shows how, partly by virtue of being published in a news outlet whose audience is predominantly White, LMP centers whiteness and White motherhood as norms. The ideal of the active, hands-on, emotionally available middle-/upper-middle class White mother is reproduced in Bloomstein's story. Her whiteness is unmarked, unmentioned, but is used to imply that she "should" be safe from the physical dangers of pregnancy and delivery. Shome (2014) emphasizes that this ideal White motherhood reproduces Western nationhood and vilifies other forms of motherhood. As a result, we can see that the collective consciousness that is described in the first half of this analysis is one that is imagined to be universal by White readers, but it likely excluding and vilifying other's experience with pregnancy, childbirth, and parenthood.

4.5.2 Lost Mothers Project's Racist Sub-Text

LMP does not explicitly invoke the rhetorical figures of bad Black mothers that Collins and Roberts describe. However, the reproduction of White motherhood in the series relies on those rhetorical figures as subtext. The LMP team recognizes that it is impossible to ignore the persistent racial disparities in maternal health in their series. In December 2017, a series of three articles focusing on racial disparities in maternal mortality are published. The first article bears the headline: "Nothing Protects Black Women from Dying in Pregnancy and Childbirth" (Martin and

Montagne 2017b). The subtitle of the article reads: "Not education. Not income. Not even being an expert on racial disparities in health care."

The article focuses on the story of Dr. Shalon Irving, a CDC epidemiologist who studied racial health disparities. Tragically, Irving died weeks after giving birth to her daughter, Soliel, as a result of preventable complications related to hypertension. Readers of LMP would recognize the format of this article, as it parallels the format of the article on Lauren Bloomstein. Whereas the article on Bloomstein interspersed data about maternal mortality in with her narrative, the article about Irving weaves information about racial disparities in maternal mortality in with her story.

This article, as well as the rest of the articles in the series, goes out of its way to highlight an important fact: racial disparities in maternal mortality persist regardless of factors like wealth, education, obesity, and neighborhood. From what we can tell in the article, Irving did not live in poverty growing up – her parents were both graduates of Dartmouth and her father was the pastor of a Black church in Portland, Oregon. Shalon took her education seriously, both as a child and as an adult. "She read voraciously," says the article, "wrote a column for a black-owned weekly newsletter and skipped a grade" (Martin and Montagne 2017b). She went on to obtain two master's degrees and a dual subject Ph.D. Although she was "overweight and anxious" as a teen, she lost nearly 100 pounds in college after realizing how many of her family members were dying at a young age. The article quotes one of Irving's closest friends, Raegan McDonald-Moseley, who at the time of LMP's publication was also the Chief Medical Officer for Planned Parenthood Federation of America: "The fact that someone with Shalon's social and economic advantages is at higher risk highlights how profound the inequities really are…'It tells you that you can't educate your way out of this problem. You can't health-care-access your way out of this problem" (Martin

and Montagne 2017b). It is significant that the article emphasizes this point as strongly as it does, since many researchers and critics have responded to the statistics about racial disparities by arguing that they are really just a reflection of socioeconomic status, education, and/or healthcare access.

The article does focus on two other social determinants of health however: stress and racism. Based on the responses from readers, the reporting team argues, Black birthing people are facing racial discrimination in the healthcare system: "Over and over, black women told of medical providers who equated being African American with being poor, uneducated, noncompliant and unworthy" (Martin and Montagne 2017b). This discrimination costs lives but, LMP argues, it is possible that racial discrimination outside of the healthcare system is costing even more:

> But it's the discrimination that black women experience in the rest of their lives – the double-whammy of race and gender – that may ultimately be the most significant factor in poor maternal outcomes. An expanding field of research shows that the stress of being a black woman in American society can take a significant physical toll during pregnancy and childbirth. (Martin and Montagne 2017b)

This basic principle – that the stress of racism and sexism takes a physical toll that contributes to serious complications during pregnancy and childbirth – is the focus of Geronimus's (1992) weathering hypothesis. Thus, LMP's narrative argues, racism, not education or wealth, can explain racial disparities in maternal health.

On the surface, LMP is making an essential point, one that aligns with major arguments that reproductive and birth activists have also been centering in their work. Yet even in making this point, LMP relies on the subtext of rhetorical figures that demonize Black mothers. The context of this dark matter that has and continues to justify violence against Black women must be

accounted for in a rhetorical analysis of the text. This requires reading the silences and assumptions — the legibility cues — that allow readers to make sense of the text.

Although the article about Shalon Irving does not explicitly script Irving as a bad Black mother, her positioning as a potentially good Black mother relies on a subtext of racist beliefs about Black women. Because these rhetorical figures that demonize Black women are part of the subtextual vocabulary of American culture they can be activated even when they are not explicitly invoked. In order to understand why this is the case, we must return briefly to the arguments made by Hortense Spillers (1987), introduced in Chapter 2.

Spillers emphasizes that the ways we think about Black women are rhetorical investments for Americans. The stereotypes of Black women as Jezebels, Sapphires, and Mammys, she writes, describe "a locus of confounded identities, a meeting ground of investments and privations in the national treasury of rhetorical wealth. My country needs me, and if I were not here, I would have to be invented" (1987, 65). The ways we talk about and describe Black women "demonstrate a sort of telegraphic coding," Spillers writes, "they are markers so loaded with mythical prepossession that there is no easy way for the agents buried beneath them to come clean" (65). That is, the way we describe Black women is laden with baggage – a baggage that is shaped to justify the violence and oppression of Black people. This baggage makes it almost impossible for the actual life of Black women to be seen and appreciated.

Spillers' (1987) emphasis on the rhetorical investments of White culture is why she sub-titles her essay "An American Grammar." She writes: "the symbolic order that I wish to trace in this writing, calling it an 'American Grammar' begins at the 'beginning' which is really a rupture and a radically different kind of cultural continuation" (68). The "beginning" she speaks of is the

beginning of American consciousness, which was formed in the violence of chattel slavery. This violence is a grammar, forming system or structure of our understanding.

Spillers (1987) critiques the 1965 Moynihan Report for blaming matriarchal Black family structures for social ills in the U.S. (for more on this, see Chapter 2). Texts like the Moynihan Report only make sense to Americans reading them because our grammars consist of a set of associations that were developed in order to justify the violence of chattel slavery. As Spillers puts it: "Moynihan's 'Negro Family,' then, borrows its narrative energies from the grid of associations, from the semantic and iconic folds buried deep in the collective past, that come to surround and signify the captive person" (69). The grammar of the American consciousness has been designed to support white supremacy. This is the root of Spillers' critique of family structure. Black families cannot be families, in the American grammar, because they do not function to reproduce whiteness and maintain the supremacy of the White race. The "dominant symbolic order" of white supremacy, Spillers argues, "forces 'family' to modify itself when it does not mean family of the 'master' or dominant enclave" (75).

This subtextual grammar is built on racist associations. The introduction to Shalon Irving's story provides a demonstration of how this works. Even as the text explicitly seeks to work against negative racial stereotypes, those same rhetorical figures are activated in the mind of the reader. The story opens with these lines: "On a melancholy Saturday this past February, Shalon Irving's 'village' — the friends and family she had assembled to support her as a single mother — gathered at a funeral home in a prosperous black neighborhood in southwest Atlanta to say goodbye and send her home" (Martin and Montagne 2017b). Irving would have been a single mother – a situation that is common to women of all races but is often associated with Black mothers. However, the text emphasizes that Shalon had actively worked to build herself and her child a

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supportive community, a "village." The story also deliberately notes that the funeral was taking place in a "prosperous" black neighborhood. In informing readers about Irving's proactivity and responsibility, as well as the financial prosperity of the people she was close with, the text simultaneously reminds us that we might otherwise have assumed that a Black, single mother was also a poor and neglectful mother.

The text also goes on to highlight how educated Irving and her community were. She was a lieutenant commander in the Commissioned Corps of the U.S. Public Health Service, and she wore her uniform in the portrait displayed at her funeral. The article notes that "many of the mourners were similarly attired" (Martin and Montagne 2017b). Irving's father is quoted in the article, marveling at the level of education and prestige his daughter had achieved, "I've never been in a room with so many doctors…I've never seen so many Ph.D.s" (Martin and Montagne 2017b). So, this is a story about an educated, prosperous, well-supported single mother.

Interestingly, Irving's professional commitments give the article space to explicitly name the kinds of race and class stereotypes that are often evoked in discourses about racial health disparities. Shalon's work at the CDC had focused on the role of structural inequalities, trauma, and violence in creating health disparities. Her mentor at the CDC, Rashid Njai, describes her work: "she wanted to expose how peoples' limited health options were leading to poor health outcomes. To kind of uncover and undo the victim blaming that sometimes happens where it's like, 'Poor people don't care about their health'" (Martin and Montagne 2017b). Later on, the article demonstrates that Irving *did* care about her health, losing weight in college when she realized how often members of her family were dying at a young age.

In many ways, the article casts Irving as an exception to the rule. This is similar to the way Shanara Reid-Brinkley (2012) describes her experience with the media as a member of the Urban

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Debate League. "I was well versed in the script the reporters seemed to like most" she writes, "I was an inner city kid that faced situational and structural obstacles on the road to success, an 'at-risk' youth that might have been lost to the ills associated with poor, Black communities if it had not been for debate participation" (78). That narrative, however, did not fit Reid-Brinkley's own perspective on her life. "If being black and working-class was all that made one 'at-risk'," she writes, "then the narrative made sense. But, there is more implied by that characterization, including assumptions about my family and community background that were often inaccurate" (3). The media cast Reid-Brinkley and her Black peers in a redemptive narrative, in which they "transcend the negative stereotypes so prevalence in news coverage of Black culture" (17). That narrative, however, depends on "the normative intelligibility of the young black body in order to highlight UDL students as exceptional. Even as the UDL students are notable because of their difference from the norm as constructed within the frame, they are simultaneously unable to escape it as a defining narrative of their success" (94).

The LMP's narrative about Shalon Irving functions in a similar way. The text highlights that Irving is unique, an exception: "Even Shalon's many advantages — her B.A. in sociology, her two master's degrees and dual-subject Ph.D., her gold-plated insurance and rock-solid support system — had not been enough to ensure her survival. If a village this powerful hadn't been able to protect her, was any black woman safe?" (Martin and Montagne 2017b). Irving is positioned as exceptional – she was financially well-off, professionally successful, highly educated. The overemphasis on these points only makes sense to the reader because of the normative intelligibility of the Black birthing body as one that is irresponsible and unhealthy.

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4.5.3 Rhetorical Tensions and Tense Solutions

Texts are polyvocal – meaning that they can work in multiple ways at the same time. This is part of the value of charting multiple maps of knowledge production through LMP. The stories about racial disparities in LMP are doing important work, emphasizing a medical fact – racial disparities in maternal health persist, even after accounting for factors like socioeconomic status, healthcare access, education, and even chronic health conditions. At the same time, however, in highlighting exceptions to dominant narratives about Black women, the text must activate reader's rhetorical investment in those dominant narratives.

In the article "How Hospitals are Failing Black Mothers," (Waldman 2017a) the reporting team engages directly with common racist assumptions about racial disparities in maternal health in order to disprove them. Like other articles in LMP, this one features a series of personal narratives, but the primary focus is an investigation conducted by the LMP team. The team examined discharge data from hospitals in three states – Florida, Illinois, and New York – and found that hospitals that are more likely to serve Black people have, on average, worse outcomes and higher complication rates than hospitals that serve relatively few Black people.[25] Waldman (2017a) writes: "in New York, on average, high black-serving hospitals had complication rates 21 percent higher than low black-serving hospitals. In Illinois and Florida, high black-serving hospitals had complication rates 11 percent higher."

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[25] The team goes into more detail about their methods in the article "How We Measured Birth Complications" (Waldman 2017b). They focused specifically on complications from obstetric hemorrhage, since it is a common complication and is easily preventable. It is also less strongly associated with race of socioeconomic status than other complications. They examined how many birthing people at each hospital hemorrhaged during birth and how many had major complications as a result. The assumption is that "the lower the number of cases that include these major complications, the better that hospital is at managing these hemorrhages." Thus, their goal is to focus on disparities in care and treatment people received during birth.

One of the common arguments from hospitals about why this is the case is that they take on more difficult patients. As the reporting team describes it: "A complicating factor in understanding how hospital care figures in is that hospitals take on different proportions of tough cases — patients who have less access to consistent, quality prenatal care or have chronic health issues, like diabetes or heart disease, that make pregnancy and childbirth riskier" (Waldman 2017b).

It is important, therefore, to note that in LMP's analysis, higher rates of complications persisted even when only looking at the data for people of "average birthing age" (between 25 and 32) and at people who "did not have any chronic conditions like heart disease or diabetes" (Waldman 2017b). Again, the text here activates racist stereotypes about the health of Black birthing people in order to subvert them.

Thus, there is a rhetorical tension between the explicit arguments LMP is making – that racial health disparities are a result of racism – and the racist subtext that narrative relies on, along with the centering of White motherhood elsewhere in the series. This also ultimately results in a tension in the kinds of solutions that are proposed. One of the primary solutions suggested by LMP is to educate birthing people to advocate for themselves.[26] Gallardo, Martin, and Montagne (2017) explain: "Hospitals, medical organizations and maternal safety groups are introducing a host of initiatives aimed at educating expectant and new mothers and improving how providers respond to emergencies. But as McCausland's experience illustrates, self advocacy is also critically important." At the same time, it is made clear that this will not always work. It does not always work for highly educated, White, middle-class medical professionals like Lauren and Larry Bloomstein. It is even less likely to work for Black women and birthing people, whose healthcare

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[26] The maternal mortality review committees I study in Chapter 3 also highlight patient education and self-advocacy as major prevention strategies.

providers are likely to have the same rhetorical investments about Black motherhood that I have described elsewhere.

Nevertheless, one of the primary ways the reporting team engaged the thousands of people who completed questionnaires was by asking them to share their advice for others who are pregnant or may become pregnant. The article, provocatively titled, "If You Hemorrhage, Don't Clean Up," describes this process:

> We asked survivors: What can people do to ensure that what happened to Lauren Bloomstein doesn't happen to them or their loved ones?...What do they wish they had known ahead of their severe complications? What made a difference in their recovery? How did they get medical professionals to listen? Here is a selection of their insights, in their own words. (Gallardo, Martin, and Montagne 2017)

The advice varies. Readers recommend researching data about the hospital where you plan to deliver in order to make sure they have protocols in place to prevent maternal deaths, having conversations with your provider about warning signs for common complications, understanding the healthcare system so that you can ask your providers appropriate questions, exaggerating your pain in order to get doctors to listen to you, learning what constitutes high blood pressure and the proper ways to take blood pressure, getting therapy for the postpartum period. In short, LMP readers describe an exhausting list of to-dos for someone who is already dealing with the physical, mental, and emotional load of preparing for a new baby to arrive.

In addition, it is also clear throughout the series that these strategies do not work equally well for everyone. In the article that tells Shalon Irving's story, the authors also reference Patrisse Cullors' experience. Cullors is a co-founder of the Black Lives Matter movement who has also become an activist to improve Black maternal healthcare. Cullors underwent an emergency C-

section in March 2016, and she states that the surgeon did not explain the procedure to her and that her mother had to yell at the doctors in order to give her an appropriate level of pain medication. Reflecting on this experience, Cullors explains that self-advocacy has a racial dynamic: "When white people advocate for themselves or their family members, she said, providers 'think they're acting reasonably. When black people are advocating for our family members, we're complaining, we're being uppity, we don't know what we're talking about, we're exaggerating.'" (Martin and Montagne 2017b). The rhetorical act of self-advocacy – of persuading medical professionals to attend to your medical needs – is interpreted differently when it is being articulated from a Black body, argues Cullors.

In an episode of NPR's podcast *Code Switch* that accompanied the publication of LMP's article on Shalon Irving, Monica McLemore describes her work conducting focus groups with Black birthing people, stating that feeling disrespected, not being believed, and having signs and symptoms ignored are all common themes. She tells the story of one woman in particular, who states that throughout her life, she has learned to curtail her emotional reactions so that people will not perceive her as angry and hostile. McLemore explains:

> But one of the things that was really difficult during her birthing experience was she was working so hard to not appear to be angry or to not appear to be in pain that every time she spoke to the nurses and requested pain medicines, they didn't believe her. And so she really was trying to suppress what her natural facial expressions and responses were because she didn't want people to be buying into stereotypes about black women and particularly whether or not we're angry. ("This Racism is Killing Me Inside")

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The story McLemore tells here highlights the rhetorical challenge Black birthing people face because of the ways the American grammar for reading Black bodies is grounded in racist assumptions and caught in the gravitational pull of dark matter.

Ultimately, Black birthing people face a double-bind. In an article highlighting New York City's announcement of an initiative to address racial disparities in maternal health, nurse-midwife Patricia Loftman describes it this way: "If you are a poor black woman, you don't have access to quality OBGYN care, and if you are a wealthy black women, like Serena Williams, you get providers who don't listen to you when you say you can't breathe" (Waldman 2018).[27] Either way, the solutions for education and self-advocacy proposed by LMP and others will likely continue a deadly trend. Even as overall rates of maternal mortality decline, racial disparities persist, which indicates that solutions being implemented are likely working to prevent maternal deaths among White people. This is not surprising, when the consciousness-raising of media projects like LMP generates a White collective consciousness that purports to be universal, but is actually based on the exclusion of Black life.

4.6 Conclusions

This chapter has sought to examine the limitations and possibilities of producing, circulating, and receiving knowledge about racial disparities in maternal death through investigative reporting by mainstream media sources. The LMP responds to a biocommunicable failure by MMRCs and other public health surveillance systems. However, Towns reminds us that

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[27] This is a reference to Serena Williams's interview with *Vogue* in 2018, where she details her harrowing, near-death experience following an emergency C-section (Haskell, 2018).

knowledge produced and circulated by White media outlets will primarily function to reinforce whiteness. When attention is focused on places where the gravitational pull of anti-Black racism is at work in the LMP, we see that the collective consciousness generated by LMP is based on a premise of racial exclusion. LMP relies on the figure of the unhealthy, irresponsible Black mother to anchor their news frame.

Therefore, this chapter highlights the need for methods of reading the dark matter of race and racism in order to understand how the subtext of rhetorical investment in the demonization of Black motherhood imbues discourses about social ills in the U.S. Chapter 2 describes the myriad ways that Black women have been framed as bad mothers – promiscuous, angry, lazy, uncaring, and/or incompetent. This chapter demonstrates that even a text that does not explicitly invoke stereotypes about bad Black mothers relies on the existence of those tropes in the rhetorical vocabulary of their audience. The bad Black mother trope is still leveraged through legibility cues in order for the LMP's narrative of racial disparities to make sense.

The ways in which maternal mortality is made public also impacts the ways it is made actionable and the kinds of possibilities we imagine as appropriate solutions. The primary solutions put forth in LMP include increased funding for MMRCs. As we saw in Chapter 3, however, the existence of an MMRC does not guarantee that the committee will interrogate the way racism functions in the healthcare system or in broader society to put Black birthing people in situations where they are more likely to be unhealthy. Rather, the material infrastructure of the MMRCs I examined situated racial disparities in maternal health in individualized bodies and emphasized medicalized solutions.

In addition, LMP also emphasizes the need for women and birthing people to educate themselves and advocate for themselves with their healthcare professionals. The stories and

experiences of women who had severe medical complications during pregnancy, labor, and delivery are funneled into an advice column format. NPR and ProPublica readers recommend, among other things, researching your provider and the hospital where you plan to deliver, questioning your doctor about their protocols and warning sights for common complications, and learning what constitutes high blood pressure and the proper way to take blood pressure. In many ways, the advice column exemplifies what happens when a mainstream news source turns to their predominantly White audience to produce and circulate knowledge about their experiences with maternal healthcare. As we will see in the next chapter, much of this advice fails to account for racism and discrimination in the maternal healthcare system.

Both the medical review process examined in Chapter 3 and the process of investigative reporting examined here centered the experiences of White women as they made maternal mortality public. In the process, they obscure the role of racism in contributing to high rates of maternal mortality. In the next chapter, I turn to an effort to make maternal mortality public that *begins* from the issue of racial disparities. Reproductive and birth justice activists, like those affiliated with the Black Mamas Matter Alliance, highlight the failings of past legislation on maternal mortality as well as the limitations of self-advocacy as a solution to racial disparities in maternal health. Because they center the experiences of Black women and birthing people, the maternal mortality that they make public is distinct from that made public by the MMRCs and the LMP.

5.0 Centering Black Maternal Mortality

In the summer of 2020 the United States faced an inerlocking series of national upheavals. The death toll from the COVID-19 pandemic was continuing to rise, many Americans were suffering economically due to the effects of pandemic restrictions, and protesters across the country were gathering following the murder of George Floyd by a White policeman in Minneapolis in late May. On July 25, print readers of *The New York Times* opened their papers to find the following headline on a full-page open letter: "How Many Black, Brown, and Indigenous People Have to Die Giving Birth?" The open letter was circulated online, and to this date, it has received over 12,000 signatures on the Every Mother Counts website ("How Many Black, Brown, and Indigenous People Have to Die Giving Birth?" 2021). The letter, titled "Call for Birth Justice and Accountability" merged the national reckoning with police violence and the national consciousness about maternal mortality, arguing that the root causes of both crises were the same.

The last chapter explored how news media make maternal mortality public, in particular in ProPublica and NPR's Lost Mothers Project (LMP). By charting biocommunicable cartographies in LMP, we saw that while LMP functions as a consciousness-raising tool around the issue of maternal mortality, the collective consciousness that is generated is based on racial exclusion. Like MMRCs, which functioned similarly to produce and circulate knowledge about maternal mortality while simultaneously obscuring significant factors that contribute to racial disparities, LMP began from a perspective of normative whiteness. That is, the maternal mortality of White women was taken as the norm, and racial disparities were only addressed when they became salient to the team reporting on the series.

This chapter focuses on efforts to make maternal mortality public that *begin* from the issue of racial disparities. Reproductive and birth justice activists, like those behind the National Call, have for decades argued that the reproductive futures of people of color are uniquely regulated and controlled. Birth justice, which is one particular focus of reproductive justice, centers the experiences of Black, Brown, and Indigenous women and aims to eliminate obstetric violence, mistreatment, and human rights violations in childbirth. This chapter focuses on the work of key birth justice groups associated with the Black Mamas Matter Alliance (BMMA), which formed in 2016. BMMA describes itself as "a national network of black women-led organizations and multi-disciplinary professionals who work to ensure that all Black Mamas have the rights, respect, and resources to thrive before, during, and after pregnancy" ("Black Maternal Health Virtual Conference" 2021). BMMA has been actively working to make the Black birthing experience more publicly visible, for instance, instating National Black Maternal Health Week in mid-April. Nearly half of the contributors to the National Call were in some way affiliated with BMMA.

This chapter will explore how BMMA and their partner organizations are making Black maternal mortality visible and how the picture they present of racial disparities in maternal mortality contrasts with those of the MMRCs and LMP. In addition, we will examine the possibilities and limitations of BMMA's attempts to advance reproductive and birth justice through legislation. Ultimately, BMMA aims to change policies and legislation in order to improve Black maternal health, but implementing their suggestions through local, state, and federal governments has potential to compromise some of their primary goals.

In the next section, I will contextualize this chapter with a brief overview of key concepts related to reproductive/birth justice and Black public/counterpublic spheres. I will then turn to an analysis of the overall arguments made by BMMA in their Toolkit. Next, I will explore how these

arguments work when they are made public and brought into contact with governmental institutions, in particular state and federal governments. Examining how these arguments play out when making appeals to federal and state officials reveals that governments in the U.S. are eager to be seen taking action on racial disparities in maternal health. However, dominant publics also tend to co-opt specific suggestions from birth justice organizations like BMMA without implementing their core principles, such as centering marginalized women when developing programs.

5.1 Background

Chapter 2 described the development of the reproductive justice movement, in particular the formation of Sistersong: Women of Color Reproductive Health Project. Sistersong formed because its founders recognized that the reproductive rights movement was not addressing the needs of women of color and marginalized people in the U.S. and around the world. Reproductive justice work touches on health issues that impact women throughout their lifespan, including the provision health services as well as improvements in living conditions that impact health, such as food justice, environmental justice, and criminal justice.

In 2013, SisterSong began a partnership project with the Center for Reproductive Rights to address Black maternal health and birth outcomes. After a 2015 convening, this group became known as Black Mamas Matter, and in 2016 the Black Mamas Matter Alliance (BMMA) formed as its own entity. BMMA's goal is to recognize, amplify, and support existing Black women-led organizations doing work that is rooted in reproductive justice, birth justice, and the human rights framework. Currently, there are 30 member organizations allied as "Kindred Partners" and 25

individual collaborators (Black Mamas Matter Alliance 2021). Over the last four years, BMMA has amplified the birth justice work that has been going on across the country for decades, increasing the visibility of Black women leaders and supporting collaboration by stakeholders invested in improving Black maternal health. Their work has also functioned to make Black maternity more publicly visible, for instance, by instating an annual national Black Maternal Health Week in April.

In this chapter, I view the network of birth justice activists connected with BMMA as a Black public sphere – a space in which Black people have discussions about the public issues that concern them specifically. Squires (2002) argues that there is not one Black public sphere or one type of Black public sphere, but multiple Black public spheres that all function differently based on their responses to dominant social pressures, legal restrictions, and other challenges from dominant publics and the state. This chapter will focus on BMMA in the sense that they function as a counterpublic – publicly communicating with other marginal spheres and the dominant public. In this capacity, Squries argues, they "test the reactions of wider publics by stating previously hidden opinions, launching persuasive campaigns to change the minds of dominant publics, or seeking solidarity with other marginal groups" (460). At the same time, however, counterpublics can be shaped by their interactions with wider publics, often in ways they do not choose: "The state and dominant publics can undermine counterpublic discourses, performances, and movements. In addition to censoring and attacking counterpublic discourses, dominant publics or the state often appropriate selected aspects of counterpublics' imagery, opinions, ideas, and performances in ways that harm counterpublics" (462). Thus, counterpublics often maintain an enclave where they can "regroup and rethink strategies" (463) when facing pressure from other publics. Certainly, members of BMMA and other birth justice activists maintain this kind of

enclave. By nature, however, this enclavic communication is not accessible to the general public or (at least currently) to me as a White researcher.

Like Squires (2002), other scholars of Black public spheres have noted that although making the experiences of the Black community visible can challenge exploitation and oppression of Black people, certain forms of visibility are easily co-opted. As discussed in Chapter 1, Pough (2004) emphasizes that though spectacle can be a powerful strategy for obtaining cultural representation, it also becomes a "double-edged sword" that only works as long as the counterpublic "controls the gaze" (30). Otherwise, the spectacle can be easily co-opted in ways that damage the group's political goals. Morrissey and Kimball (2017) demonstrate that even when rhetorical strategies of visibility achieve a group's immediate goals – as in the case of the Blacktivists in Detroit pressuring Medolac to retire their campaign to buy breastmilk from Black women – the dominant public can still frame the group as difficult and uncooperative in ways that reproduce negative rhetorics. In this case, Morrissey and Kimball argue that Medolac employed the "Black mothering rhetorics that place blame on Black mothers for the failure of their own communities" (63). The rhetorical resources for demonizing Black women and mothers are readily accessible in the U.S. national imaginary and therefore are easily employed against Black women when they resist appropriation and co-option.

Jennifer Nash (2019) has pointed out that there are indeed certain opinions and ideas affiliated with the birth justice movement that dominant publics have begun to appropriate. BMMA advocates for large scale systemic changes in the healthcare system, including but not limited to expanding pipelines for perinatal healthcare workers. In addition to nurse midwives, lactation consultants, nutritionists, and physical therapists, doulas are a key part of that pipeline. Local, state, and federal governments, however, have latched on to the work of Black birth doulas

in particular as the solution to the Black maternal health crisis. Nash argues that feminist scholars must "interrogate how doulas are called upon by the state even as they are uncompensated by the state, as evidence of a state effort to ameliorate medical apartheid" (2019, 46-7). The analysis in the section below indicates that doulas are but one element of a much larger framework for birth justice, yet as the arguments of birth justice activists are made public, in some cases Black doulas come to serve as symbols of state investment in Black maternity.

5.2 Birth Justice Activism in the United States

Since its formation, BMMA and its partner organizations have played a central role in elevating racial disparities in maternal health as a key policy issue and advocating for solutions. In June 2017, BMMA collaborated with the Congressional Black Caucus and the Congressional Caucus on Black Women and Girls to host a Congressional Hill Briefing on Maternal Mortality from a Reproductive Justice and Human Rights Framework. In April 2019, Representatives Alma Adams (D-NC 12th District) and Lauren Underwood (D-IL 14th District) formed the Congressional Black Maternal Health Caucus (BMHC). The goal of the caucus is "to raise awareness within Congress to establish Black maternal health as a national priority, and explore and advocate for effective, evidence-based, culturally-competent policies and best practices for health outcomes for Black mothers" (Office of Congresswoman Alma Adams 2019). At the 2020 Stakeholder Summit for the BMHC, half of the stakeholder speakers were staff at BMMA or leaders of partner organizations, including Aina.

In this section, I will analyze the primary arguments made by BMMA in a toolkit they published in 2018, entitled "Black Mamas Matter: Advancing the Human Right to Safe and

Respectful Maternal Health Care" (Center for Reproductive Rights 2018). The toolkit is one of the primary works of the BMMA, as their initial gathering in 2015 identified a need for advocacy tools that would advance a human-rights based maternal health policy agenda. The toolkit was initially published in 2016, and was reprinted in 2018. The toolkit consists of a series of briefs that distill the BMMA conversations on race, reproduction, parenting, and human rights. It is designed as a "menu of options" that maternal health advocates can explore and adapt to the priorities in their state and local communities. The toolkit includes a summary of the human rights framework for advancing maternal health, an overview of research on maternal mortality and morbidity in the United States, a series of policy recommendations proposed by various stakeholders (the "menu of options"), resources for more information, talking points on maternal health, and suggestions for collaborating with other stakeholders.

The toolkit has been widely distributed across the U.S., "used to train doulas and maternity care providers, sensitize state and federal policymakers to the issue, inform local legislation, and equip stakeholders to effect change" (Center for Reproductive Rights 2018, 5). The main talking points and discussion prompts featured in the toolkit are being adopted by people and organizations outside of BMMA's membership. The toolkit is a significant site of rhetorical analysis because it is explicitly designed as a rhetorical resource – to assist birth justice advocates across the country in developing and delivering arguments to state and local officials, healthcare administrators, and legislators. As such, it functions as a resource for rhetorical invention, for discovering and developing arguments. Therefore, analysis of the toolkit not only provides insights into the views of BMMA, it also provides insight into the kinds of arguments that are being made by birth justice activists around the country when they attempt to appeal to mainstream audiences.

Like SisterSong, BMMA approaches maternal health as a human rights issue. Since 2011,

the United Nations Human Rights Council has formally recognized a human right to maternal

healthcare (de Mesquita and Kismödi 2012). As BMMA's line of reasoning goes, the rights to life,

health, equality, and non-discrimination all indicate that "every woman has the right to safe and

respectful maternal health care" (Center for Reproductive Rights 2018, 9). Furthermore, they point

out that governments that have made human rights commitments have a responsibility to respect,

protect, and fulfill those rights. In the case of maternal health, this means that governments are

responsible for "creating and enabling conditions that support healthy women, healthy

pregnancies, and healthy births" (Center for Reproductive Rights 2018, 9).

First, BMMA argues that because the right to life is one of the fundamental human rights,

"government has a duty to protect individuals from arbitrary and preventable loss of life, including

preventable deaths related to pregnancy" (Center for Reproductive Rights 2018, 10), and that in

order to protect that right governments must take "proactive measures to address both the causes

and prevalence of maternal mortality" (10). Second, BMMA notes that the international governing

bodies have recognized a human right to health. The 1946 Constitution of the World Health

Organization (WHO) defines health as "a state of complete physical, mental, and social well-being

and not merely the absence of the disease or infirmity" and states that all human beings have the

right to "the enjoyment of the highest attainable standard of health" (Office of the United Nations

High Commissioner for Human Rights and World Health Organization 2008, 1). The drastic racial

disparities in maternal health clearly indicate that at least some people in the United States have

not been able to achieve this right. BMMA argues that in order to fulfill the human right to health,

governments have an obligation to "ensure that health facilities, goods, and services are available

in sufficient quantity throughout the state, accessible to all, ethically and culturally acceptable, and of good quality" (Center for Reproductive Rights 2018, 11).

Finally, there is a universal human right to equality and non-discrimination. BMMA argues that discrimination both in the healthcare system and outside of it is impacting Black women and birthing people's ability to achieve their highest attainable standard of health. As they describe it: "The racial disparities that surround maternal health in the United States are intertwined with deeply rooted inequalities in social, economic, and political life… structural inequalities can have negative impacts on the health of Black women, even before they encounter the health care system" (Center for Reproductive Rights 2018, 11). BMMA elaborates on these inequities throughout the toolkit, and their overall argument is that because social determinants of health have a drastic impact on people's health outside of the medical system, solutions to high rates of maternal mortality and morbidity cannot be focused only on the healthcare system. That said, they do also emphasize that discrimination within the healthcare system is negatively impacting Black women's health: "Inside the U.S. health care system, contemporary discrimination against Black women manifests as barriers to timely and affordable health care, lower quality maternal health care services, disrespectful treatment, and ultimately, negative medical outcomes" (Center for Reproductive Rights 2018, 11).

The human rights framework for addressing racial disparities in maternal health is distinct from the approaches that we have observed so far in this project. Both the MMRCs we examined and the LMP view racial disparities in maternal health as a disturbing anomaly. In this sense, the approaches by the MMRCs and LMP follow the logic of civil rights discourses in the U.S. as described by Jacquelin Royster and Molly Cochran (2011). Civil rights in the U.S. context have predominantly developed as a response to the legacy of chattel slavery. Because chattel slavery is

typically framed as an unfortunate anomaly within the overall narrative of America as the bastion of freedom, liberty, and progress, civil rights too are "positioned inside the United States as annoying, as an inconvenient and unfortunate weakness in our national rationale" (Royster and Cochran 2011, 216). As such, civil rights have often been tangential to the nation's priorities, unless a massive event, such as a civil war, protest, or disaster, surprises the nation and forces attention on civil rights. Even then, however Royster and Cochran note: "As surprises, spillovers can be set aside as innocuously as possible within the national purview, as abnormal and not in the interest of human rights at home. Attention is re-directed to acknowledging annoying imperfection while sustaining national image and authority" (216). While these spillover situations force attention to civil rights, they are still framed as abnormal – anomalies that are unfortunate yet not fundamental to life in the United States or to human rights around the world.

The distinction between civil rights and human rights is significant because in the U.S. national imaginary, human rights are a coherent and universal concept.[28] As BMMA is quick to point out, the U.S. is highly invested in maintaining human rights (including the right to maternal health) abroad and addressing human rights abuses in foreign countries. The tension between maintaining human rights abroad while neglecting them at home is maintained by keeping civil rights and human rights discourses distinct. Royster and Cochran argue, "there remains a deeply seated tendency to keep these discourses in separated categories, with civil rights considered to be distinct from and peripheral to human rights debates, focused on the consequences of a peculiar history within the national arena and occupying, as it were, a different conceptual space—as a

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[28] As Arabella Lyon and Lester Olson note, there are significant controversies around the basic questions of human rights, including: what are human rights?, are certain human rights so fundamental as to be 'universal'?, and how can communities and nations deal constructively with tensions between conflicting human rights? (2011, 203). Here, however, I am simply noting that for the average American, an appeal to human right is on its face an appeal to an indisputable moral good.

sidebar or an afterthought" (2011, 217). This allows neglect of human rights to continue domestically while also maintaining that the U.S. is a moral leader for countries around the world.

However, Black activists and writers in the U.S. have repeatedly connected the movement for civil rights with the global agreement to protect universal human rights. Royster and Cochran argue that Black women in particular have often made this move, "indicating in their writings an abiding ideological commitment to the idea that all human beings, regardless of personal identity or geographical location, are endowed with the dignity of being human and innately deserving of rights by virtue of being human" (2011, 214). Because Black people were positioned as non-human in order to justify the practice of chattel slavery, early abolitionists like Maria Stewart, Francis Ellen Watkins Harper, Mary Church Terrell, and Ida B. Wells had to articulate their own humanity and the resulting right to dignity (218). This advocacy built the foundation for a future connection between civil rights discourses – emerging in response to the aftereffects of chattel slavery – and human rights discourses emerging in the early twentieth century.

Following his conversion to orthodox Islam, Malcolm X also made a rhetorical and strategic move to draw on human rights rhetoric to advance the liberation of Black people in the U.S. After he parted ways with the Nation of Islam and converted to Orthodox Islam late in his life, one of Malcolm X's primary projects was to "elevate the black liberation struggle within the United States from the civil rights level to the international human rights level" (Nier 1997, 153). The struggle for Black liberation, he thought, needed to be removed from the jurisdiction of the U.S. Malcolm X also thought that by making an argument based on the premise that human rights are natural rights applicable on a universal basis, he could win support from countries in Africa, Asia, and Latin America. Malcolm X petitioned the Organization of African Unity (OAU) to

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support a case against the U.S. with the United Nations, but the African heads of state involved in the OAU ultimately declined.

Shifting arguments about racial justice in the United States from a civil rights to a human rights framework has potential to be a powerful rhetorical move. In particular, this move relocates the authority for evaluating claims about injustice beyond the jurisdiction of governments in the U.S., instead appealing to a global power to determine the morality of U.S. government (in)actions. For Malcolm X, this was a primary reason to bring the case for Black liberation to the U.N., challenging the moral authority of the U.S. government by attempting to address racial oppression in a global court. In making such a shift, Malcolm X "warranted his argument for equality on international values that exceeded the ideological boundaries and judicial authority of America's White-controlled government" (C.M. Condit and Lucaites 1993, 301-2). Similarly, BMMA affiliates also have begun making their case to the U.N. For instance, Joia Crear-Perry, Founder of the National Birth Equity Collaborative and BMMA Steering Committee Member, has addressed the UN Office of the High Commissioner regarding the relationship between anti-blackness, gender oppression, and the Black maternal health crisis.

5.3 Using Human Rights to Reframe Maternal Health

BMMA's human rights rhetorical strategy attempts to reshape the national conversation about maternal health. Re-framing maternal health as a human rights issue expands the definition of maternal health to encompass health throughout the lifespan and in every aspect of life. The human rights frame also situates U.S. national and local governments in the context of international values, agreements, and laws, altering the view of their role in protecting the human right to health.

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Along with the expanded definition of maternal health, this re-situating of the U.S. government's role warrants BMMA's expansive policy agenda: improving healthcare access and quality, addressing underlying determinants of health, eliminating discrimination, ensuring accountability, and including and empowering Black women.

First, BMMA emphasizes that maternal health cannot wait until a woman becomes pregnant. Much of the discourse around maternal mortality has noted high rates of chronic illness among women of childbearing age, illnesses that create additional complications when women get pregnant, especially if their conditions are not well managed. For BMMA, ensuring that women are as healthy as possible when they become pregnant requires a) that they have the ability *not* to become pregnant at any given time; and b) that they are able to identify, manage, and treat health conditions they may experience before they become pregnant. This requires access to family planning, abortion services, and primary healthcare.

Significantly, BMMA points out that women of color are more likely than White women to lack health insurance, and Black adults are more likely than any other racial group to fall into a health insurance coverage gap – earning too much to qualify for Medicaid coverage, but not enough to purchase private health insurance (Center for Reproductive Rights 2018, 23-4). As a result, poor women in the United States are more likely to experience an unintended pregnancy, which can "raise the risk of complications, and can contribute to poorer health outcomes for both mothers and their babies" (Center for Reproductive Rights 2018, 24).

Furthermore, people without health insurance are far less likely to visit their primary care doctor who would identify health issues and provide recommended care for disease prevention and management. For BMMA, lack of access to health insurance, and therefore to appropriate medical care, is a significant reason Black women living in the South are "more likely to have chronic

health conditions that are risk factors for maternal health, such as diabetes and chronic hypertension" (Center for Reproductive Rights 2018, 24). On top of lack of access to family planning services and primary healthcare, Black women also receive relatively low rates of prenatal care in the first trimester, which is important for identifying serious co-morbidities and pregnancy complications and treating them appropriately (24).

Second, BMMA emphasizes that a high percentage of Black maternal deaths are preventable. Health care professionals in the U.S. know how to prevent and manage common pregnancy complications, such as gestational diabetes, pre-eclampsia, and even obstetric hemorrhage. As BMMA writes: "When serious complications like hemorrhage or stroke are identified, monitored, and treated efficiently and appropriately, women are more likely to survive them" (Center for Reproductive Rights 2018, 24). There are standards of care and best practices for handling obstetric complications and emergencies, but they are not consistently practiced in all birthing spaces or for all birthing people.

This inconsistency in standards of care, BMMA argues, is at least partially due to discrimination. They write, "even when health care is accessible to them, women of color may not receive appropriate, timely, quality care on an equitable basis" (Center for Reproductive Rights 2018, 24). The kinds of standards and practices being discussed here are the kind being developed by the MMRCs discussed in Chapter 2. BMMA emphasizes they need to be consistently practiced for all people. While that previous chapter focused on the development of such standards from an administrative perspective, BMMA reframes the issue from the perspective of the women involved: "Without standard approaches to handling such emergencies, some women receive appropriate, high quality care while others do not" (25). From BMMA's perspective, the problem is not a lack of protocols or standards, since these exist and are being practiced in some places.

Rather, the problem is that uneven and discriminatory adherence to such standards of care leads to a high rate of maternal mortality.

All these factors combine to indicate that Black women's health is being neglected throughout their lives. BMMA writes, "Combined, these disparities in access expose a pattern in which Black women have more limited access to adequate health care at every point along the reproductive life course, raising the likelihood of a higher risk pregnancy, maternal morbidity, and maternal mortality" (Center for Reproductive Rights 2018, 24). The picture portrayed by BMMA's assessment of the problem, then, zooms out from the moment of labor and delivery, and even past prenatal care, to ask how women are getting the healthcare they need before they become pregnant. As a result, while the BMMA toolkit explicitly advocates for addressing health insurance gaps for maternal and reproductive health care, their arguments also raise the question of healthcare access for all, since all people, including people who may become pregnant, need to be able to identify, prevent, and manage health conditions.

Furthermore, a human rights approach to maternal health does not focus solely on the healthcare industry, since the context in which a person lives their daily life directly impacts their health. The United Nation's 1948 Universal Declaration of Human Rights frames the right to health as intrinsically linked with living conditions: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services" (United Nations General Assembly 1948, Article 25). This approach justifies BMMA's argument that a human rights approach must address social determinants of health.

For BMMA, social determinants of health are fundamental to understanding "why some people are healthier than others, or at a minimum, not as healthy as they could be" (Center for

Reproductive Rights 2018, 22). BMMA defines social determinants of health as "the social and economic conditions in which people are born, grow up, live, work and age" (22). Housing, transportation, nutrition, water, environmental pollution, violence, poverty, as well as exposure to racism, are all social determinants of health. Because all of these factors are shaped by social hierarchies, economics, and policy decisions, BMMA argues that Black women in particular are negatively impacted. "In the United States," they write, "racial disparities in health are closely linked to economic disadvantage, reflecting systemic obstacles to health that disproportionately affect women of color" (22).

Unlike the MMRCs and LMP, who view racial disparities in maternal health as one concerning aspect of a larger maternal mortality problem, BMMA argues that the high rates of maternal mortality among Black women *are* the maternal mortality problem. They write: "It is this disproportionate risk that Black women face during and after childbirth that drives the maternal mortality and morbidity crisis in the United States" (Center for Reproductive Rights 2018, 21). According to their argument, addressing high rates of maternal mortality among Black women will result in overall improvements in maternal health for everyone. This is an inversion of the approach taken by some MMRCs, which assume that the interventions needed to reduce maternal mortality overall will also reduce racial disparities in maternal mortality.

Over the last few years, approaches to improving maternal health that attempt to be race-neutral have been proven to fail. In New York City, for instance, overall rates of maternal mortality have declined; racial disparities, however, have increased (Boyd et al. 2010). Efforts across the city to improve maternal healthcare primarily benefitted White women, bringing down overall rates, but not improving outcomes among Black women. BMMA argues that taking an inverse approach – prioritizing practices that improve health for Black women – will result in overall

improvements in maternal health outcomes: "understanding and addressing factors impacting maternal mortality and morbidity among Black women will not only reduce disparities, it will improve MMR and SMM rates overall" (Center for Reproductive Rights 2018, 21).

In addition to reframing the problem of maternal health, BMMA also reframes the government's role in addressing it. As Celeste Condit and John Lucaites argued about Malcolm X, BMMA seeks to warrant their argument for equality on "international values that exceed[ed] the ideological boundaries and judicial authority of America's White-controlled government" (1993, 301-2). BMMA emphasizes that the maternal health rights they argue for are "grounded in a set of fundamental human rights contained in international treaties and consensus documents" (Center for Reproductive Rights 2018, 10).

In BMMA's framework, high rates of maternal mortality and drastic racial disparities in maternal mortality are human rights violations for which federal, state, and local governments in the U.S. should be held accountable. Again, BMMA is rhetorically moving the conversation outside of the jurisdiction of the U.S. government so that the U.S. government itself can ostensibly be taken to court for its actions and inactions. In contrast to the U.S.'s positioning as a protector of human rights around the globe, BMMA points out that poor maternal health conditions have been cited by international bodies as a human rights problem: "During recent reviews of the U.S. human rights record, independent human rights bodies have highlighted the persistent racial disparities in maternal health as a form of racial and gender discrimination and called on the U.S. to improve access to quality maternal health care" (Center for Reproductive Rights 2018, 13). In fact, they say, UN groups have been calling on the U.S. since 2014 to improve monitoring and accountability mechanisms and ensure equal access to quality maternal health services.

BMMA builds on their argument that poor maternal health outcomes can be prevented by changing laws, policies, and institutional practices. It is clear that medical providers are able to prevent and treat pregnancy complications which means that the negative maternal health outcomes in the U.S. are not inevitable. BMMA argues that the failure to do so constitutes hypocrisy on the part of the U.S. government, since the U.S. has been actively involved in holding other national governments accountable to improving maternal health outcomes:

> The U.S. government directs substantial resources towards combatting preventable maternal mortality around the world, and its efforts include aid for development projects, technical assistance, and partnerships with the global health community. In recent years, the United States has exercised considerable leadership on global maternal health through special initiatives, the work of USAID and other government agencies, and a sizeable global health budget. (Center for Reproductive Rights 2018, 14)

The U.S., however, has not applied the same standards domestically. As BMMA puts it, "a comparable commitment to improving maternal health within the U.S. is currently lacking" (14).

Instead, BMMA argues that federal, state, and local governments in the U.S. have placed the onus on individuals, in this case women and pregnant people, to counter the negative health effects of their social environment and racism in the healthcare industry. They write: "Government demands for women to take greater 'personal responsibility' for their own health are not effective solutions to the problems of preventable maternal death and illness" (Center for Reproductive Rights 2018, 10). This quote stands in contrast with a key solution to the problem of maternal mortality touted by both the MMRCs and LMP – self advocacy. Women need to be more educated about potential complications, this line of reasoning goes, so that they can be better prepared to compel their healthcare providers to pay attention to them and take appropriate action.

From BMMA's perspective, the self-advocacy solution burdens Black and brown women with the responsibility of navigating a racist healthcare system that is already biased against them. Instead of forwarding personal responsibility arguments, BMMA suggests that governments who have made human rights commitments have a responsibility to respect, protect, and fulfill the human right to maternal health. First, governments should respect (i.e. not interfere with) residents' ability to access needed health care services or with access to positive determinants of health such as safe communities, affordable housing, employment, social support and other factors. Furthermore, they must also protect people's ability to access safe and respectful maternal healthcare. For BMMA, this means the government should be preventing third parties from interfering with this right. And finally, the government should fulfill its commitment to the human right to maternal health by taking "positive steps (passing legislation, ensuring adequate funding for programs, training health care providers, etc.) towards the full realization of the right to safe and respectful maternal care" (Center for Reproductive Rights 2018, 10). That is, it is the government's responsibility to address unhealthy living conditions, racism in the healthcare system, and uneven access to healthcare.

We have now examined BMMA's overall framework for making arguments about racial disparities in maternal health. They approach maternal health as a human rights issue, expanding the focus of the discussion. The framework emphasizes the need for healthcare access as well as the importance of attending to factors outside of the healthcare industry that contribute to negative health outcomes for birthing people. In the next section, we will examine how these arguments play out when addressed to dominant publics.

5.4 State and Federal Legislation

BMMA's human rights framework for addressing maternal mortality differs from the frameworks used in much of the public health literature and practice. Therefore, it is important to investigate how the arguments produced by BMMA as a Black counterpublic function when they interact with dominant publics. In this case, the dominant public spaces I will be examining are state and federal government bodies. There are two primary sites I use for the analysis in this section: discourses surrounding New York State's attempt to implement Medicaid coverage for doula services in 2018-2019 and United States Commission on Civil Rights (USCCR) briefing on Racial Disparities in Maternal Health, held in November 2020.

On April 23, 2018, New York State governor Andrew Cuomo's office announced a Comprehensive Initiative to Target Maternal Mortality and Reduce Racial Disparities in Outcomes. The plan included multiple elements, many of which involve information-gathering: creating a taskforce on maternal mortality and disparate racial outcomes, establishing a Maternal Mortality Review Board, scheduling a "Best Practice Summit," and launching a series of Listening Sessions with the Health Commissioner. But the most concrete – and highly touted – initiative in this plan was a pilot expansion of the state's Medicaid program to cover doula services.

Doulas are trained professionals who provide "continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible" (DONA International 2021). Doulas are typically hired by the birthing person to provide this support and to serve as an advocate during the birth process. As the governor's office notes, doulas have been linked to positive health outcomes, including reducing birth complications for both mother and baby.

The doulas discussed in this chapter will primarily be community-based doulas working in New York City. Monica Basile notes that the work of community based doulas usually arises "out of explicitly feminist, class conscious, and antiracist politics" and that such doulas tend to "situate their practice in terms of larger community organizing and activist projects" (2012, 2). Community-based doulas differ from traditional doulas in that they focus on meeting the specific needs of the community they serve at low or no cost. Through the pilot, Medicaid-eligible pregnant women in Erie County (Buffalo) and King's County (the Brooklyn Borough of New York City) would receive four prenatal visits with a doula, doula support during labor and delivery, and four postpartum visits.

Ancient Song Doula Services (ASDS), one of the oldest and most prominent community-based doula organizations in New York City, is also a BMMA member organization. In addition to support during labor and delivery (the primary focus of traditional doulas), Ancient Song doulas also usually offer prenatal and postpartum home visits, childbirth and breastfeeding education, and referrals for needed health or social services (Bey et al. 2019). Village Birth International (VBI) is the other BMMA member organization providing community-based doula services in New York State. While ASDS operates solely in New York City, VBI offers services in New York City and in Syracuse, as well as in neighboring New Jersey. Both ASDS and VBI also offer doula trainings with a particular focus on reducing health inequities, as well as birth/reproductive justice education, advocacy, and training (Ancient Song Doula Services 2018; Village Birth International). ASDS, particularly founder Chanel Portia-Albert, are frequently featured in media coverage of doula services, maternal health inequities, and birth justice (Greenburg 2018; Meyerson 2020; Waldman 2018).

BMMA member organizations and other birth justice activists have also played a key role in making Black maternal health a priority on the national legislative agenda. Staff of BMMA and its member organizations have been consulted by the Black Maternal Health Caucus as they put forward bills to address racial disparities in maternal health. When the USCCR held a briefing on Racial Disparities in Maternal Health in November 2020, BMMA staff and leaders of member organizations were invited to give testimony.

The USCCR was created as part of the Civil Rights Act of 1957, and is an independent, bipartisan, fact-finding agency of the U.S. government, charged with advising the President and Congress on civil rights issues and reporting annually on federal civil rights enforcement. The USSCR states, "We pursue this mission by studying alleged deprivations of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, or national origin, or in the administration of justice" (U.S. Commission on Civil Rights 2018). The USCCR specifically held this briefing "to examine federal role in addressing racial disparities in maternal health outcomes, including negative pregnancy-related health outcomes and pregnancy-related deaths of women in the United States" (U.S. Commission on Civil Rights 2018).

Four of the speakers at the briefing are explicitly affiliated with BMMA: Aina, Crear-Perry, and Portia-Albert are joined by Jennifer Jacoby, Federal Federal Policy Counsel for the Center for Reproductive Rights (BMMA's parent organization). This analysis will focus primarily on the portions of the hearing where these four individuals testified. That said, I also consider testimonies of other reproductive justice advocates where relevant, in particular the testimony of Nan Strauss, the Managing Director of Policy, Advocacy, & Grantmaking for Every Mother Counts and Nicolle L. Gonzales, Executive Director and Founder of Changing Women Initiative. There were 13 total speakers at the briefing, with presentations split into three panel sessions.

During the briefing, these birth justice activists both implicitly and explicitly advocate for passage of the Black Maternal Health Momnibus Act (H.R. 959/S. 346). The Momnibus contains 12 bills designed to address different aspects of the Black maternal health crisis, including investments to address social determinants of health, support for community-based organizations, funding to grow and diversify the perinatal workforce, resources to improve health care and support for incarcerated moms, and initiatives to improve continuity of insurance coverage for postpartum people. The current version of the bill (H.R. 959/S. 346) was introduced in both the U.S. House and Senate in February 2021.

BMMA has explicitly articulated its support for the bill; below is BMMA Aina's enthusiastic endorsement:

> The Momnibus, put forward by the Black Maternal Health Caucus, has the potential to be transformative for Black maternal health because it goes beyond addressing maternal death and helps to advance maternal health equity. By centering black women-led organizations like BMMA in the process, this package takes a proactive approach to addressing many of the systemic public health challenges, workforce development issues, and everyday experiences of Black birthing persons before, during, and after pregnancy. Thank you to the Black Maternal Health Caucus for prioritizing the needs of those most impacted by the maternal health crisis in the Untied States. (Black Maternal Health Caucus 2020)

While the Momnibus has the potential to advance birth justice causes, there is a long road ahead before it is likely to be passed. In addition to examining the USCCR hearing, I also include an analysis of the challenges surrounding New York State's doula pilot program here. Analysis of the doula pilor program allows us to examine the way birth justice arguments are received and incorporated by dominant publics as policies are implemented. The USCCR hearing and the

discourse around the doula pilot are key points where members of BMMA have tested their human rights framework in a dominant public sphere, explicitly addressing federal or state officials. My angle of inquiry here focuses on points where the arguments used by birth justice activists are a point of disorientation or tension with the mechanisms of state and federal bureaucracies.

5.5 Appeals to State and Federal Governments

The USCCR briefing on Racial Disparities in Maternal Heath was held virtually in November 2020. The briefing consisted of three panels, each of which included four or five expert testimonies. The panelists were organized thematically: Panel 1 focused on policy and legislation, Panel 2 included service providers and other private organizations, and Panel 3 focused on Lived Experience. Each panel lasted for an hour, including testimony from the experts on the panel and a question and answer session with the Commissioners. U.S. Representative Ayanna Pressley's (D-MA 7th District) testimony, cited below, was included in Panel 1. Angela Aina and Joia Crear-Perry both participated in Panel 2, while Chanel Portai Albert, Nan Strauss, Jennifer Jacoby and Nicolle Gonzales all participated in Panel 3.

During the USCCR briefing, the question of the role of the federal government in addressing Black maternal health is the source of the most tension/disorientation between the members of the Commission and the activists on the panels. Even when it is clear that the officials in the USCCR buy the arguments made by birth justice activists about the dire state of Black maternal health and the role of racism and discrimination, they are still grappling with the best ways for the government to intervene.

Commissioner Debo Adegbile introduces the goals of the briefing by saying that the Commission is asking the panelists to help the Commissioners determine causes and drivers of racial disparities. He goes on to add, "most importantly, we will ask our witnesses to help us think about what more can be done. What are the remedies and solutions so that we can improve maternal healthcare outcomes and reduce disparity? And in particular, use the levers of the federal government to the extent that the federal government plays a role in these things, to improve these outcomes" (U.S. Commission on Civil Rights 2020, 9). Throughout the briefing, while panelists often share knowledge from both data and experiences, the commissioners look for concrete solutions and models. In both of the panels that include BMMA members, panelists are specifically asked both about the role of the federal government and for particular examples of model programs deserving of federal government investment. Commissioner David Kladney, for instance, asks, "is there a model program in the country, in the community, that you could cite that handles this problem better than anyone else? And where would that be, and if there isn't one, is there somebody who has proposed a program to move this problem forward?" (84).

The birth justice activists are reluctant to provide the Commissioners with one standardized model in which they believe the federal government should invest. Aina, for instance, responds to Commissioner Kladney's question by saying: "There is not one solution to this very complex problem…we know that the solution really to make these necessary changes is based at the local level. So that's why we really do emphasize really uplifting and supporting the work of community-based organizations that had been doing first equity work, providing midwifery services for decades to their communities" (U.S. Commission on Civil Rights 2020, 88-9). For community-based doulas, for instance, their approach is highly tailored to the challenges and conditions in their local communities.

Crear-Perry also emphasizes locally-based solutions, this time referencing the existing model of the Healthy Start Association. She states: "this idea that you can actually give money to communities and they can fix their own problem. It was actually a Republican idea. This was amazing. We had never scaled it up, we never invested in it and we've never, and it keeps showing that healthy start communities have better birth outcomes. We know that through the data and yet we've never actually invested in it" (U.S. Commission on Civil Rights 2020, 104). For the activists, then, the goal is to invest more money and resources in already existing local programs, all of which might look different.

In general, the activists advocate for community based care which, based on their comments, has two major components. First, it is situated in the patient's local community. Having healthcare providers that are situated in the community is important for multiple reasons. It ensures that quality maternity care is physically accessible. Wealthier women have choices about what kinds of providers they see during their pregnancy. They might choose between different hospitals or birth centers, for instance. However, as BMMA highlights in their toolkit: "for many Black women, these choices about care are constrained by level of income, geographic location, an under-resourced health care infrastructure, transportation barriers, and a deficit of providers who understand their needs" (Center for Reproductive Rights 2018, 47).

The second component of community-based care is that it is holistic and person-centered. In particular, the activists point to midwifery-based models and doula care. Both midwifery and doula care have been associated with positive health outcomes, but "low-income women of color are often unable to use these types of care because they cannot get to them, cannot afford them, or they are not aware of them" (Center for Reproductive Rights 2018, 47). Therefore, BMMA argues

expanding access to midwifery and doula care for low-income, Black and Brown birthing people is a central component of improving maternal health outcomes.

The holistic care provided by midwives and doulas, the birth justice activists argue, can provide the kind of person-centered care Black women are not experiencing in traditional maternity care settings. Porchia-Albert describes her own journey to becoming a doula: "I was ushered into this work because of my own birthing experience with a midwife and a doula. The care that was given to me was unlike anything I had experienced. I was listened to. I was centered. I was shown genuine care and warmth" (U.S. Commission on Civil Rights 2020, 118). These basic aspects of care are exactly the ones Porchia-Albert and the other activists describe Black women lacking in other settings.

One of the reasons holistic care from community-based midwives and doulas is important is because they are already addressing one of the central needs in the maternity care industry – a focus on implicit bias and culturally competent care. While the birth justice activists support implementing implicit bias training in hospitals and training obstetricians and maternity care nurses in culturally competent care, they also emphasize that community-based midwifery models are already part of the solution. Strauss points out:

> I think also one of the other ways of approaching this issue of getting at implicit bias and getting at really truly person-centered models, models that center the needs, the perspective, and the respect and dignity for the pregnant and childbearing person is to advance models that have that at their core. That means making community-based doula support and perinatal support workers available. (U.S. Commission on Civil Rights 2020, 158)

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By making midwifery and doula care more accessible, increasing racial diversity in the perinatal workforce, and training current maternal healthcare workers in implicit bias and culturally competent care, Strauss argues, we will be "coming at this issue from all different directions" (U.S. Commission on Civil Rights 2020, 159).

Nash suggests these arguments about community-based care are ripe for co-option by state and local governemnts. She writes: "the contemporary moment is one where black doulas' work has been taken up – incorporated – by the state as a crisis-mediation tactic" (2019, 31). As governments seek to respond to the increasingly public statistics about racial disparities in maternal death, they have often zeroed in on women of color doulas – like Chanel Portia-Albert and her colleagues – as the solution. As Nash puts it, "black women – both mothers and doulas – continue to perform symbolic labor for the state, allowing the state to gesture to a commitment to ameliorating the 'crisis' while the conditions of the present persist" (47). Doulas are, of course, important birth workers and likely are crucial to furthering the work of birth justice. The point here, however, is that it is easy for governments to symbolically invest in women of color doulas (often without the necessary significant material investment) in order to signal to the public that they are serious about addressing the Black maternal mortality crisis. This defuses the crisis while also allowing for governing bodies to avoid dealing with larger systemic issues, such as racism in the healthcare system and in society that leads Black women and birthing people to live in conditions that make them unhealthy.

Strategic appropriation of doula labor is evident in the rhetoric surrounding the New York State Doula Pilot Medicaid program. In the statements, press releases, and other descriptions of the program put out by Governor Andrew Cuomo's office, the practical experience of doulas is diminished and their actual labor elided. Cuomo's office describes doulas as "non-medical birth

coaches who assist a woman before, during, or after childbirth if needed" (New York State 2018).

News articles highlighting the program similarly describe doulas as birth coaches who "do not

replace medical practitioners" (Adams 2019). These descriptions frame doulas as an optional part

of birth who are not medically necessary. Yet, the announcements go on to list a number of benefits

for birthing people who utilize doula care: "shorter labors, lower rates of Cesarean sections, fewer

requests for pain medication, improved assessments of newborn well-being, and greater likelihood

for breastfeeding" (Adams 2019). Here, the labor the doulas provide seems to truly be symbolic,

as if simply by invoking them, birth outcomes in the state will improve.

In reality of course, the physical and emotional labor of both traditional and community-

based doulas is substantial. Doulas emphasize the importance of continuous support for the

laboring pregnant person and their other support people. Continuous support means that the doula

is present and available for physical and emotional support for the birthing person's entire labor,

which can last days. Doulas provide birthing people with physical comfort measures (e.g. applying

pressure, helping into comfortable positions, applying ice or heat), emotional comfort measures

(i.e. guided breathing or visualization), and serve as a guide to help the birthing person navigate

decisions during the birth process and avoid any unwanted or unnecessary medical interventions.

Both traditional and community-based doulas aim to spend a significant amount of face

time with clients prior to birth in order to establish the relationship and trust needed for the doula

to serve this role during the birth process. Many doulas perform post-partum support visits to their

clients to assist with breastfeeding and infant care. In addition, community-based doulas also spend

time engaging with local resources available in their community (including transportation

assistance, mental health resources, substance abuse counseling, immigration assistance etc.) so

that they can connect their clients with relevant social services.

In February 2019, New York State's Medicaid Redesign team released the Final Pilot Design for Medicaid coverage of doula services (Medicaid Redesign Team 2019). By this point (nearly a year after the program was announced), it was already evident that the administration was facing some challenges in working with doulas to launch the program. In the Final Pilot Design, the team writes that the pilot will "be implemented through a phased-in approach in order to ensure access to this new benefit" (Medicaid Redesign Team 2019). Phase 1 of the pilot launched in Erie County on March 1, 2019. According to the final pilot design, Phase 2 in Kings County would launch "when provider capacity is reached" (Medicaid Redesign Team 2019). Kings County (Brooklyn Borough) has the second highest percentage of Black people in the state of New York (the only exception being the Bronx Borough). The population of Brooklyn Borough is 33% Black, whereas the population of Erie County is 14% Black (United States Census Bureau 2019).[29] Therefore, it is significant to note that an initiative touted to improve birth outcomes for Black women failed to get off the ground in an area of the state where a high proportion of Black women live. As of this writing, the Medicaid pilot expansion for doula services has not launched in Kings County.

In addition to doulas, the birth justice activists at the USCCR hearing advocate expanding the pipeline for other types of maternity care providers. In general, the birth justice activists emphasize that physicians are not the only healthcare providers who are needed to ensure women are receiving proper healthcare during pregnancy, labor, and postpartum. "[W]e know that we need to start creating more pipelines around providing an opportunity for maternity care providers," states Aina, "and not just investing only in producing more and more physicians" (U.S.

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[29] The doula pilot areas were chosen based on the areas in the state that had the highest infant and maternal mortality rates, along with significant numbers of Medicaid births (Medicaid Redesign Team 2019).

Commission on Civil Rights 2020, 88). Perinatal health support workers include not only midwives and doulas, but also nurse practitioners and clincal nurse specialists, mental and behavioral healthcare workers, dieticians/nutrition professionals, lactation consultants, and physical therapists. During the USCCR briefing, the BMMA affiliates emphasize that community-based models need to be funded adequately so that midwives, doulas, and other birth workers are being adequately reimbursed. Because these workers often are not accounted for in our standard insurance systems, there are "gaps within the maternity care workforce" says Aina (U.S. Commission on Civil Rights 2020, 66). She argues that we need to integrate the various approaches for eliminating equities and improving maternal health outcomes.

Among the major challenges in launching the pilot program in New York was achieving reimbursement rates that made providing services worthwhile for doulas in the area. Doulas who provide services for low-income women often offset the losses they incur serving these families by also taking on wealthier clients who can afford to pay premium rates for their services. Black, brown, and indigenous doulas are more likely to take on a financial burden by serving families in their communities: "highly paid doulas laboring in White agencies are often able to sustain full-time doula work, and black solo practitioners generally must seek other employment to do the work they want" (Nash 2019, 40). Women of color doulas are more likely to work with community-based programs that provide low-cost or free doula services to their community, like ASDS or VBI.

While many of the doulas who work with organizations like ASDS see their work as a calling, the low reimbursement rates in the Medicaid expansion program are still a major barrier. The total reimbursement for comprehensive services during pregnancy, labor and delivery, and postpartum is $600 - $30 per visit for 4 prenatal and 4 postpartum visits and $360 for support

during labor and delivery (Medicaid Redesign Team 2019). An experienced doula in New York City can easily charge families they serve a total of $2,000-4,000 depending on the services they provide. The three programs already compensating community-based doulas in Brooklyn pay their doulas between $25 and $37.50 an hour and provide a total compensation rate of anywhere between $900 and $1,555. Thus, even in programs already designed to compensate doulas less so they can serve low-income women, the rates of compensation are, on average, double the amount provided by Medicaid.

In general, funding local, community-based programs through state- and federal governments, however, presents a number of challenges. In fact, at the USCCR briefing, Commissioner Michael Yaki lays out this very challenge in one of his questions to the panelists.

> I come at this from sort of two different angles here. One, I used to be in local government, so I understand and really appreciate and quite championing the idea of locally based, community-based organizations in delivering really critical services to communities. The other part of me is when I was at the federal level working for the speaker and talking about how do we get the resources necessary to make that happen. And that tension between funding…studies, who controls the studies, this kind of stuff, if we want that information. And then sort of the control. Where is it going to be distributed is really sort of the crux of how do we address this…I guess, is, are there things out there that the feds can latch on to and say, this is how we want to be able to figure out a way to distribute the dollars necessary to meet this critical health need? (U.S. Commission on Civil Rights 2020, 102-3)

Here, Yaki is pointing to the expectation that programs funded by the government produce clear data to show they are effective. Furthermore, expectations about what counts as data and how effectiveness is demonstrated are typically determined by the government, not local communities.

This, of course, creates challenges for activists, like those on the panel, committed to the need for locally-developed solutions.

In the case of the New York state doula pilot program, the mechanism for distributing state government funds is an expansion of Medicaid coverage.[30] Using Medicaid coverage to pay doulas, however, makes it difficult to provide them with a living wage. The final version of the pilot program proposed reimbursing doulas $600 per client, for all prenatal and post-partum as well as support during labor and delivery. This rate is based on a percentage of the rate that other medical professionals providing maternity care receive. Because doulas are unlicensed, they receive 54% of the total Medicaid fee that licensed medical professionals (i.e. physicians, nurse practitioners, and midwives) would receive (Meyerson 2019b).

The pro-rated fee system however, ignores the aspects of doula care that make it such an effective tool. In particular, it ignores the significant role that continuous care during labor plays in improving birth outcomes. No health professional (doctors, nurses, or midwives) in a hospital or clinic is expected to be with a patient during their entire labor, which can take days and averages eighteen hours. In fact, many birthing people labor at home for many hours before ever seeing their physician or midwife. Doulas typically go to a client's home for this early stage of labor, and to continue support by traveling to the hospital or birth center where the client plans to give birth.

In addition, the targeted support provided by community-based doulas requires even more time with clients. The low-income women enrolled in the Medicaid program, for instance, are likely to need more attention than those who are able to pay higher rates to hire doulas privately.

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[30] In most states, including New York, people who are pregnant qualify for Medicaid coverage at higher income rates than people who are not pregnant. For instance, in New York a pregnant person living in a two-person household would qualify for Medicaid coverage if their household income was $38,446 or less. If they were not pregnant and had no disabilities, they would only qualify for Medicaid coverage if their household income was $23,792 or less ("Medicaid" 2021). The doula pilot program in New York would add doula services to the services covered by Medicaid for pregnant people.

Doula Tia Dowling-Ketant emphasizes that helping clients connect with resources in the community takes time: "It's about helping someone find access to a food pantry, to mental health care, to housing. You need to cover a lot of stuff" (Meyerson 2019b). Given the significant time investment needed for doulas to do the tasks that make them most valuable in reducing racial disparities, a $600 reimbursement rate is unsustainable.

In March 2019, both ASDS and VBI collaborated in publishing a white paper pushing back against the low reimbursement rates in the state's pilot plan. In it, the organizations emphasize that that there are major flaws in reimbursing doulas based on a comparison with medical professionals. They write: "this approach overlooks fundamental differences between the workflow, costs incurred, and employee status of the two groups" (Bey et al. 2019, 18). The three major points emphasized in the document are: 1) doulas, and especially community-based doulas, spend far more time with their clients than physicians or midwives in clinics and hospitals; 2) that doulas are independent contractors who do not receive healthcare or other benefits and incur out-of-pocket expenses to run their business; 3) doula work includes uncompensated time (such as the time spent traveling to the client's home for a home visit) that should be accounted for.

ASDS and VBI calculate that a physician attending a birth would spend a little under 6 hours total with a patient, including prenatal and postpartum visits as well as the labor and delivery.[31] In contrast, a community-based doula would plan to spend 2 hours per visit with a client, and would be continuously supporting the client and their family for the entire labor, which averages 18 hours. Doulas also make themselves available to support their client remotely, taking phone calls and answering texts or emails. This amounts to a total of 36 hours spent with a client, before accounting for the additional time needed for transportation.

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[31] This is assuming the patient attends 14 prenatal visits and 1 postpartum visit that last 15 minutes each, and that the physician spends 2 hours with the patient during labor and delivery.

In addition, the nature of doula work makes it difficult to work other paid jobs. Doulas are on call for weeks at a time around the time their client is expected to give birth, and they strive to provide home visits at the convenience of the family they are serving. This can "make it difficult or impossible to schedule other work into the available gaps, inevitably creating pockets of time when the doula cannot schedule paid work" (Bey et al. 2019, 20). Again, it is important to emphasize that this time spent with patients is central to the doula's role and is the reason they are able to produce the positive birth outcomes that are so commonly touted as being valuable in reducing maternal mortality and racial disparities in maternal health.

ASDS and VBI calculate that, when accounting for the realities of spending time and money on transportation, reimbursing $30 for a prenatal visit is the equivalent of being paid $8.17 per hour, which is well below New York City's $15 an hour minimum wage. This rate also doesn't account for doula's lack of employee benefits. Yael B. Yisrael, a New York City doula, stated that the rates being offered assume that the doulas do not need to survive: "It's a business and it's not that I can be passionate and caring and loving, but I have two children and they also deserve to be able to eat" (Adams 2019). Similarly, Ali Anderson points out that providing services through Medicaid would not be enough to offset the costs of childcare and commuting, and therefore was not in her best interest (Adams 2019).

Statements from Cuomo's administration seem to imply that doulas are to blame for delaying the launch of the pilot program in Brooklyn. Spokespeople from the governor's office have stated that the pilot was postponed because "not enough doulas signed up" (Meyerson 2019b) or "not enough doulas signed up in time for the launch" (Slattery 2019). Officials have emphasized, however, that the program in Buffalo is "thriving – with more than 40 women receiving doula services since March" (Slattery 2019). The implication, of course, is that Brooklyn could have a

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thriving program as well, if doulas in the area were willing to sign up. As a result, Cuomo's administration attempts to position the doulas in Brooklyn as difficult and uncooperative. This framing parallels Medolac's reaction to Black breastfeeding activists' in Detroit resistance to the Medolac campaign to buy breastmilk from Black mothers:

> When Black mothers and Blacktavists, uninvited, voiced their concerns about the campaign, they were charged with creating a 'toxic environment' and labeled difficult community partners who spoiled low-income Black mothers' opportunity to improve their circumstances. In this way Medolac reproduced Black mothering rhetorics that place blame on Black mothers for the failure of their own communities. (Morrissey and Kimball 2017, 63)

While Cuomo's government has not made any such explicit arguments, the implicit argument can be even more powerful. In addition to comparing the doulas in Brooklyn with the doulas in Buffalo (two cities which have very different costs of living), city officials also offered their own calculations of the hourly rate the Medicaid reimbursement would provide: "According to state official's calculations, the $600 reimbursement fee would come out to $23 an hour, which is $7 above New York State minimum wage." (Meyerson 2019b). This calculation appears to be based on the assumption that each of the 8 pre- and post-natal visits will take one hour, and obviously does not account for transportation, childcare, or lack of employee benefits the way the CBD doula's calculation did. As a result, this official makes it appear as though the doulas were simply being difficult or uncooperative with the program.

If the doula's paraprofessional status is the basis for their low reimbursement rate, an obvious solution would be to professionalize doula practice in order to compensate the doulas more fairly. At the USCCR hearing, however, Aina and Gonzales specifically express skepticism

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about increased standardization and professionalization for birth workers. As Aina states: "I know it was mentioned earlier about really investing in a lot of evidence-based models and honing in on a standardized training and things of that nature. I do want to lift up that those also actually serve as structural barriers to a lot of our, for a multitude of communities. Most especially Black and indigenous communities" (U.S. Commission on Civil Rights 2020, 108-9). Regulations about midwifery practice, for instance, vary across states, and Aina argues that Black and indigenous midwives of varying levels of certification and professionalization are important for providing maternity care, especially in rural communities in Southern states (U.S. Commission on Civil Rights 2020, 110). Gonzales concurs, pointing out that traditional indigenous birth attendants are common in other countries. Their role is important because they "are actually addressing this maternal health crisis in their own communities and it's from a community center while including cultural knowledge and preservation of their traditional indigenous ways" (U.S. Commission on Civil Rights 2020, 152).

Aina and Gonzales argue that standardization and professionalization may, in fact, create unnecessary limitations in terms of the human labor needed to address the maternal mortality crisis. For Gonazles, the question of professionalizing midwifery is a question about limiting the possibilities for distributing skills and services in her community:

> We have trained doulas, we have trained birthing assistants, we have trained lactation people. So how are we training community people without the labels and the education and all the credentials to actually provide skills and services to their community. They are actually very hungry for this information. It's just do we have funding focused on those areas and are we thinking about innovative ways to use the funding and not just focusing

no people who are medically trained. It costs a lot of money to train a nurse midwife. (U.S. Commission on Civil Rights 2020, 153)

She argues that the focus on professionalization is creating "barriers…and holes in services in our communities" (U.S. Commission on Civil Rights 2020, 154).

Assembly Bill A364B, introduced in the New York State Assembly in January 2019, would have created a state process for certifying doulas. The bill's sponsor, Assemblywoman Amy Paulin, viewed the bill as a step towards a mandatory state licensing process, which would ultimately allow the state to use federal matching funds to raise the doulas' reimbursement rate: "The rationale…is that mandatory state licensure could pave the way to guaranteeing that doulas would be able to get Medicaid reimbursement from the federal government for their work with low-income women…The next step would be to do a law after this…that says doulas are entitled to Medicaid reimbursement and can get a federal match" (Meyerson 2019a). Federal matching funds would make it more likely that the doulas would be able to make a living wage serving Medicaid patients. The proposed 2019 bill, however, would not establish a licensing process, but a certification program, which is less intensive. The requirements for certification listed in the bill are: attending classes at an educational program approved by the Health Department, passing a state examination, being "of good moral character as determined by the department," and paying a $40 fee.

Doulas in New York State, however, were not consulted in crafting the bill, nor were they informed that the bill was being introduced. Community-based organizations like ASDS and VBI did not even hear about the bill until it was on the verge of passing the state Assembly and Senate. An ASDS doula founder was particularly frustrated by the lack of collaboration: "You have to be clear about language, especially when you use black maternal mortality as a reference…Did you

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speak with anyone?... The answer was no. 'We spoke with the Department of Health.' That's not community… That's not a reflection of people who are disproportionately affected" (Meyerson 2019a).

The question of professionalization is a complicated one for doulas. Nash (2019) argues that their paraprofessional status "is precisely what allows many doulas to describe their labor as both radical and invaluable" (34). For some doulas, the ability to resist standardization and regulation is central to the work they do. In commenting on the Medicaid expansion, several doulas expressed concern that any affiliation with the government would result in a level of regulation that compromised the role of the doula. Samantha Huggins, a traditional doula working in New York City, stated that the state certification bill was so controversial because "We are not beholden to the medical-industrial complex and that's why this bill is very triggering for us…it will make it different to earn our clients trust and function the way we currently do" (Meyerson 2019a). For Huggins, affiliation with hospitals, insurance companies, and the state has drawbacks because doulas fundamentally serve the birthing person and their family, and accountability to any group outside of that is in tension with that philosophy.

Crucially, at the USCCR hearing, Aina emphasizes that the fact that she is raising questions about standardization and professionalization does not mean she wants to abandon the notion of standards altogether. The question, for her, is about who is creating the standards and on what basis. She states: "I do agree with you that we need standards…We need to make room for looking at different models of research that uplifts those (telephonic interference) from these communities that are most impacted" (U.S. Commission on Civil Rights 2020, 114-5).

Similarly, both ASDS and VBI argue that increased standardization and professionalization – without input and support from the community-based doulas themselves –

would negatively impact people of color disproportionately. Both organizations penned open letters regarding the doula certification bill (Bey and Brill 2019; Porchia-Albert 2019). First, they note that there are multiple organizations in the country that certify doulas, and any doulas certified by these organizations use the title "certified doula." The certification bill specifically states that "only a person certified under this section shall be authorized to use the title 'certified doula.'" Such a narrow definition of a certified doula, argue VBI and ASDS, discredits the role of the many certifying organizations in the state and nationwide. VBI writes: "Doula care is a longstanding tradition for communities, specifically communities of color, who collective gather to support one another during reproductive transitions…Doulas practice in NY State and nationally from varied backgrounds and certifications based on who and how they will serve families as individuals" (Bey and Brill 2019). As a result, ASDS argues, "We don't believe New York State can lay claim to [the term 'certified doula']," although they suggest possible alternatives such as "state-certified" or "NYS-certified." (Porchia-Albert 2019).

Because there are already multiple organizations that certify doulas, the proposal for a state to administer its own examination is redundant. ASDS writes: "Proof of certification from a credible organization is evidence of a high level of training and preparation for doula work." Furthermore, the bill's requirement that a certified doula "be of good moral character, according to the department" is problematically subjective. Both ASDS and VBI note that the vague language is a barrier for people seeking to work as community-based doulas. "What are the standards of 'good moral character' as stated by this department?" asks VBI. "Standards of practice and expectations should be clear and concise so that interpretation is not left open for individual review. We are concerned that subjective thinking and implicit bias will impact judgement in determining who is 'good' (Bey and Brill 2019). ASDS founder Chanel Porchia-Albert also specifically

mentions her concern that the line about good moral character could deter or prevent formerly incarcerated people from being certified as doulas. This concern is especially central to ASDS's work, since the organizations runs a program for incarcerated people in Riker's Island Rose M. Singer's Women's Jail.[32]

In the end, although the bill passed the New York Assembly and Senate, the bill's sponsor – Amy Paulin – actually asked the governor to veto the bill in light of intense pushback from the doula community. Not only community-based doulas, but more traditional doulas were concerned by the legislation. Ravae Sinclair, president of DONA International, the largest doula-certifying agency in the world, notes that the bill's passage was challenged when "the talking with multiple groups of doulas happened after the legislation was written and passed."

The New York State doula pilot program is certainly a clear example of a government entity appropriating the work of doulas to demonstrate a sense of commitment to reducing racial disparities without fairly valuing the work that doulas do. As Dowling-Ketant says of the program, "you're trying to do something but not really" (Meyerson 2019b). However, it is also an example of community-based doulas in New York City resisting that appropriation. The program is not active in Brooklyn because these doulas have a counterpublic in which they can discuss the pros and cons of participating in such a program and develop robust rhetorics of resistance that value their work. Therefore, the situation in New York City also demonstrates a need for methods of integrating local, community-based approaches to questions of standards and evidence.

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[32] ASDS supports incarcerated pregnant people through one-on-one doula consults, childbirth education, prenatal support, art therapy, meditation, birth planning, prenatal nutrition, and pain management priot to birth. Incarcerated women in New York are not allowed labor and birth support services from doulas or family members ("Prison Doula Services" 2018).

5.6 Conclusions

This chapter has examined the way that BMMA functions as a Black counterpublic. Their human rights framework for addressing maternal health reframes the government's responsibility for protecting and supporting maternal health and specifically the U.S. government's accountability for failing to do so. Squires distinguishes types of Black public spheres by their function; counterpublics interact with other publics, testing their messaging, persuading members of the dominant public, or seeking solidarity. Therefore, this chapter focused on the way arguments by BMMA are taken up, challenged, and transformed as birth justice activists interact with members of dominant publics, particularly national and state government officials. We found that the activists' arguments for community-based care have the potential to be co-opted, and that governments can leverage women of color doulas while also eliding the realities of their material labor. Furthermore, even government officials who are overall supportive of the birth justice agenda, such as many of the officials on the USCCR, still struggle to envision the possibilities for funding locally-based programs run by women of color without increasing standardization and professionalization in ways that thwart birth justice activists' primary goals.

The analysis in this chapter highlights the distinction between the picture of maternal mortality portrayed by BMMA's rhetoric and the picture of maternal mortality that emerges from the MMRCs examined in Chapter 3 and the LMP in Chapter 4. The human rights framework used by BMMA assumes that all people – including pregnant women and birthing people – have a right to be as healthy as they can be. It also assumes solidarity between people of color in the U.S. and in developing nations around the world, which challenges dominant discourses in the U.S. that maternal mortality "shouldn't be happening here." As Khiara Bridges notes, such assertions carry a latent racism, given the racialization of the developed world as White and the developing world

as Black and Brown (2020, 1267). In addition, the race-neutral perspective taken by the MMRCs and LMP frames Black birthing bodies as sites of risk, whereas the human rights frame advocated by BMMA situates risk in the society and environment in which those bodies live. Therefore, the perspective on social determinants of health and what we should do about them is different. BMMA's agenda provides more focus on improving living environments and healthcare access for all people, rather than placing responsibility on individuals to mitigate the harms of their environment.

In Chapter 2, I argued that racism is the dark matter that makes it possible to make maternal mortality public. BMMA's discourse, however, makes racism visible matter that must be accounted for in order to address not only racial disparities in maternal health, but maternal mortality *overall*. That is, Black maternal mortality rates are driving up the overall maternal mortality rate in the U.S. Therefore, addressing Black maternal health will have an overall positive impact. Policy-level changes that provide improvements to living conditions, access to quality healthcare, a larger and more diverse perinatal workforce, and accountability for discrimination and mistreatment in the healthcare system will ultimately benefit all of the most vulnerable women and birthing people in the U.S.

On this account, the Black Maternal Health Momnibus (H.R. 959/S. 346) is a promising policy for the members of BMMA. As described above, the Momnibus has received enthusiastic support from the organization, and BMMA members – along with other community-based birth justice organizations – were involved in crafting the legislation from the beginning. However, there is a long road ahead before the legislation is passed. At the time of this writing, the Momnibus is still being reviewed by committees in the House. The process of passing such a large package of legislation will certainly require changes, adjustments, and compromises. Currently, many of

the bills in the Momnibus would provide funding to community-based organizations to address housing, nutrition, mental health, substance abuse, stressors due to climate change, and racial equity. The organizations that are funded would need to report back results, and the analysis presented in this chapter raises many questions about that process.

What kind of data would the organizations be asked to report? By what criteria would that data be evaluated for success in improving health and birth outcomes? Who would conduct the evaluations? Would communities have a say in what kind of criteria matter to them? These questions all reflect back on the challenges raised by members of the USCCR, who wanted to support local programming, but worried about how to maintain standards for how federal money is spent.

The Momnibus does represent a substantial change to the way we think about maternal health in this country. Overall, such a change would result in an approach to maternal health that is more representative of the human rights framework used by BMMA. However, the analysis of the implementation of New York State's doula pilot program provides some warnings as we look ahead to possible passage and implementation of the Momnibus. The two situations have some distinct differences – for instance, birth justice activists and community-based service providers have been far more involved in designing the legislation in the Momnibus. Nevertheless, the doula pilot program demonstrates the potential for governing bodies to co-opt the rhetoric and goals of birth justice organizers.

Based on my analysis of the doula pilot program, it seems likely that either the arguments of birth justice activists will be co-opted and appropriated or some aspects of government bureaucracies would have to fundamentally change. The challenges associated with funding doulas through Medicaid demonstrates that the particular form of birth work doulas perform is difficult

to account for in the system as it is currently designed. The tension that emerges during the USCCR hearing around how to account for success in achieving birth equity also demonstrates that our current dominant notions of evidence and standards are unlikely to account for the work many birth justice activists are doing. Aina and Gonzales highlight that we need methods for integrating the knowledge of local, community-based minority-focused groups into the way we think about necessary standards for achieving birth equity and the kinds of evidence that contribute to our notion of success. In the process, we might need to redefine ideas about standards and evidence. Researchers are beginning to study ways for public health and medical institutions to successfully collaborate with community-based organizations and organizers in order to advance birth equity (Collie-Akers et al. 2021; Fuchs et al. 2020). More research is needed in this emerging area, as well as critical attention to evaluate the ways in which the knowledge and experience community members are being integrated.

6.0 Conclusion

This study's introduction called attention to the Preventing Maternal Deaths Act of 2018, which provides $12 million annually over five years to state and local Maternal Mortality Review Committees (MMRCs). The passage of the Preventing Maternal Deaths Act and surrounding discourse highlighted some of the U.S. stakeholders attempting to make maternal mortality public: medical review committees, news media, and birth justice activists. Each set of stakeholders has different, and sometimes conflicting, experiences, assumptions, priorities, and visions for the future, raising the question: how is maternal mortality made legible as an issue for public action? The question of legibility is significant, because each of these efforts to make maternal mortality public enables the issue to be read, viewed, or understood in different ways. As we have seen through this project's three case studies, each of these stakeholders presents a different picture of maternal mortality, illuminating some aspects of the problem while obscuring others. In integrating the perspective of race as the dark matter that makes it possible to make maternal mortality public, I have attempted to take a step toward highlighting aspects of the maternal mortality issue that are obscured by race-neutral approaches. Of particular interest to me is the way that each way of making maternal mortality public also impacts the kinds of public action that are then thought to be appropriate and effective.

Chapter 2 addressed the racialized nature of public visibility. Given that this project studies the ways racial disparities in maternal mortality are made legible to broader publics, it is important to acknowledge that historically, when Black women's reproduction becomes the focus of public attention, it has contributed to an increase in oppression and discrimination. Therefore, I argued that our nation's oppressive legacy against Black people – and women and birthing people in

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particular – is the dark matter that makes public action around reproductive health possible. This dark matter manifests in scientific and social scientific research, media, and reproductive rights advocacy, allowing white middle- and upper-middle class women to benefit from the oppression of and violence against Black birthing people.

Chapter 3 addressed how the infrastructure MMRCs use for data collection and assessment shapes the public health framework for addressing maternal mortality. I traced the infrastructural objects involved in data collection and assessment for two of the largest states in the country (California and Texas) as well as two smaller jurisdictions (Delaware and Philadelphia). This angle of inquiry highlighted two key assessment conundrums: 1. How do we determine which deaths and pregnancy related? and 2. How do we determine which deaths are preventable? I argued that the infrastructural objects of public health surveillance, such as death certificates, case selection algorithms, standard case definitions, standards for accuracy, and contributing factors attune committee members to pregnancy-related death as a purely physiological or medicalized phenomenon.

Chapter 4 explored NPR and ProPublica's Lost Mothers Project (LMP), an effort to make maternal mortality public that centers qualitative data in the form of stories of people who have died during pregnancy and childbirth, as well as the experiences of those who have suffered severe complications during their pregnancies and deliveries. I followed Charles Briggs and Daniel Hallin's (2016) recommendation that scholars identify and describe the maps of knowledge production, circulation, and reception that are embedded in health news reporting. Black media scholars such as Armond Towns (2020) and Ronald Jackson (2006) draw our attention to the fact that this knowledge is produced by predominantly White media outlets. Combining these approaches reveals that there are two biocommunicable cartographies at work in LMP. There is a

social movement map that achieves the reporting team's goal of transforming maternal mortality from private tragedy to public health issue. At the same time, when we account for the dark matter of racism, we can see that the collective consciousness generated by LMP purports to be universal but is actually rooted in the exclusion of Black life.

Chapter 5 focused on the rhetoric of birth justice activists affiliated with the Black Mamas Matter Alliance (BMMA), especially the way BMMA functions as a counterpublic, communicating with other marginal spheres and dominant publics. Analysis of BMMA's toolkit showed how the group uses a human rights framework to address racial disparities in maternal health. This chapter's analysis brought attention to how these arguments worked when addressed to state and federal officials in two venues: the United States Commission on Civil Rights briefing on Racial Disparities in Maternal Health and New York State's Pilot Doula Medicaid program.

6.1 Findings

Given the sharp uptick in national conversations about maternal mortality over the last five years, this dissertation is designed to study the way racial disparities in maternal mortality are framed in public communication. We have seen through this dissertation that the process of making maternal mortality legible as an issue for public action is complex and layered. One consistent theme is that across the case studies racial violence functions as dark matter that enables public action on reproductive issues. Overall, the race-neutral approaches taken by the MMRCs and LMP discursively configure Black maternal bodies as risky.

In contrast, by centering the experiences of Black women and birthing people and making the dark matter of racism visible, birth justice activists like BMMA highlight societal and

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environmental risk factors. In fact, individuals affiliated with BMMA have argued that over the last decade, race-neutral approaches to reducing maternal mortality have been proven not to work. In their framing, racial disparities in maternal health are not just one concerning aspect of a larger maternal mortality problem; high rates of maternal mortality among Black women *are* the maternal mortality problem.

Therefore, there is a relationship between the frames used for making maternal mortality publicly legible and the solutions proposed for preventing maternal deaths. Since race-neutral approaches configure the Black maternal body as risky, the proposed solutions are designed to mitigate that risk for individuals. One oft-proposed solution, for instance, is to educate women and birthing people to better advocate for themselves with their healthcare professionals. While empowering women with knowledge about their bodies and health is, in many contexts, a laudable goal, this approach also elides the additional barriers Black women, birthing people, and their families face in attempting to advocate for better care with their healthcare providers. In her testimony at the USCCR hearing, for instance, Chanel Portia-Albert describes witnessing "police officers called to escort partners out of a birthing room when trying to center their family's rights and that of their newborn child" (U.S. Commission on Civil Rights 2020, 119). The possibility of being faced with institutional violence when attempting to push back against the decisions of your healthcare provider is one that is simply not apparent in a race-neutral perspective.

In the case of the MMRCs, because the infrastructural objects attune committee members to pregnancy-related death as a purely physiological or medicalized phenomenon, they reinforce the idea that Black women's bodies are medically risky. As Thornton's study of discourses around depression in Black communities highlights, there is a fine line between saying that one's race puts one at risk for disease and illness, and saying that one's racialized body makes one a risk to the

rest of society. In addition, the assumption that pregnancy related death is a purely medical phenomenon explicitly elides violent deaths – homicides and suicides – which are experienced more often by vulnerable pregnant people, including Black women. As noted in Chapter 3.0, homicides are among the leading causes of death for pregnant women and new mothers in some parts of the country (Cheng and Horon 2010), indicating that there is another side to the issue of maternal mortality that is going largely unexamined. Excluding such deaths from the picture of maternal mortality that is communicated to the public also shapes our view of the experiences of women and other people who become pregnant, focusing attention only on medicalized approaches and solutions, not to mention prompting many to read data in a way that understates racial disparities in mortality rates.

In the case of the LMP, an attempt to build collective consciousness around maternal mortality reveals the extent to which consciousness-raising around reproductive rights issues is based on an ideal of whiteness. Towns's question to media scholars is prescient: "whose form of mediation is the ground for comprehending whose knowing and being?" (2020, 852). The implication for this project is that attempts to mediate maternal mortality by predominantly white reporters, for predominantly white audiences, are necessarily going to exclude the knowledge and lived experience of Black birthing people.

Finally, analyzing how arguments made by members of the Black Mamas Matter Alliance (BMMA) are taken up by governing bodies reveals that – at least in some cases – the public action taken on maternal mortality requires jettisoning BMMA's human rights framework. In incorporating calls for more doulas of color, state governments can simultaneously take advantage of the labor of birth doulas while also appearing to their White constituents that they are taking racial disparities in maternal health seriously. In fact, by the end of the saga in New York, Black

doulas were implicitly blamed for neglecting to sign up for a program that would not have provided them with a living wage. In essence, Black women who have already spent many years attempting to improve birth outcomes in their communities were being blamed for not participating when they state finally decided to attend to the issue of Black maternal health.

In isolation, the racism in each of these situations is problematic, but reading across multiple sites in which maternal mortality is made public reveals the extent to which racism shapes public understanding of the phenomenon. An inter-textual analysis reveals how processes of medical review, investigative journalism, and birth justice activism interact and inform one another. In addition, comparison and contrast between the three approaches allows us to see more clearly the role of racism in shaping the public legibility of maternal mortality in predominantly White spaces. Furthermore, a reading strategy that emphasizes historical and material context – the dark matter of racial violence – also addresses aspects of each text that we might not see if we were examining it in isolation.

The arguments in this dissertation highlight that researchers, physicians, journalists, policy-makers, and activists cannot assume that making Black women's reproduction more visible will result in improvements in their lives and experiences. Discourses about racial disparities in maternal mortality that do not address this historical context have the potential to reproduce the same kinds of violence, discrimination, and oppression. In the sections below, I will discuss the ways that this study can provide insight in three areas of salient research surveyed in Chapter 1: public health, publics/counterpublics, and rhetoric of health and medicine. Each area provided critical tools essential for tailored case study analysis. Now, at the conclusion of the study, it may be useful to reflect on how research presented here relates to ongoing conversations in these three strands of scholarly literature.

6.1.1 Public Health

The public health literature on racial disparities in maternal death suggests multiple hypotheses as to the possible causes of those dramatic disparities. Although the preceding analysis did address accuracy of mortality rates that exclude violent deaths, overall the project was not designed to resolve uncertainty in the literature or to identify the primary causes of racial disparities in maternal health outcomes. Rather, I investigate the processes by which the issue of racial disparities in maternal health is framed in public discussions about maternal mortality and maternal health. Such a project is impossible, however, without addressing the variety of explanations public health researchers have posited for racial health disparities and the public health strategies for action that have been proposed.

My findings, however, do reinforce arguments already made by both communication and public health researchers: it is important to focus on *racism*, not race as a social determinant of health. Michael Omi explains that "the idea of 'race' and its persistence as a social category is only given meaning in a social order structured by forms of inequality – economic, political, and cultural – that are organized, to a significant degree, along racial lines" (2001, 254). Racial inequality contributes – through a variety of mechanisms – to worse health outcomes among Black people and other racial minorities. Nevertheless, Black race itself (or "African American descent") is often listed as a risk factor for diseases and illnesses. As Joia Crear-Perry (2008) writes, "We – in health, advocacy, and media – need to stop saying and teaching that being Black is a risk factor for illness and death…Instead, we need to start telling the truth: It's exposure to racism that is the risk factor." This study has demonstrated the significant implications of assigning intrinsic health risk to Black people.

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Therefore, a major task for public health researchers and scholars who write about public health is to make the health effects of racism legible without endorsing race as a legitimate measure of intrinsic risk (Cooper and Kaufman 1998; Green and Darity 2010). Rhetorical scholar Kelly Happe has critiqued "discourses of disparity" in health communication scholarship, arguing that they function to reify false biological notions of race and to deflect attention from the historical and material conditions that cause racial minorities to experience poorer health (2017, 80). The case studies in this dissertation reveal the way this phenomenon operates: approaches to communicating maternal health that focused on race without attention to racism (MMRCs and LMP) fell back on discourses that blame Black women and mothers for societal problems – either implicitly or explicitly.

Birth justice activists like BMMA, however, do not hesitate to name and address racism in society and the healthcare system, which provides a very different picture of the maternal mortality problem in the U.S. By centering the dark matter of racism this study contributes to the historical perspective Merlin Chowkwanyun (2011) argues is needed by public health researchers. In particular, I hope that the analysis of dark matter in this chapter along with attention to the discourse of reproductive and birth justice activism both undermines the aura of inevitability associated with drastic racial disparities in health outcomes and highlights potential forces for change.

Addressing racial health disparities – including disparities in maternal health – requires making racism legible without endorsing race as a legitimate measure of intrinsic risk. Therefore, any measure proposed to address racial health disparities should be critically examined in order to identify how the dark matter of racial violence may be operating. One prominent example includes attempts by public health researchers to systematize measurements of allostatic load. Allostatic

load is an attempt to operationalize chronic stress by measuring physiological wear and tear on the body (Carlson and Chamberlain 2005). There is not yet a single standard index for measuring allostatic load, but various indexes are being studied (McLoughlin, Kenny, and McCrory 2020). Because the weathering hypothesis is such a prominent explanation for racial disparities in maternal health, measurements of allostatic load have the potential to play a key role in medical approaches to addressing racial disparities.

The weathering hypothesis posits that Black women are more likely to suffer complications during pregnancy and childbirth because of the chronic stress they experience due to living in a world where they are discriminated against based on both race and gender (Geronimus 1992). The process of developing an index for measuring allostatic load, as well as the incorporation of information about allostatic load into healthcare systems, are all sites where evidential cuts will be made. Without attention to the dark matter of racism, allostatic load algorithms could be coded to make evidential cuts that result in a form of digital redlining. Those with high allostatic loads could be marked as high utilizers of healthcare resources, leading insurance companies to raise rates or cut off access. Simultaneously, people with high allostatic loads could become vulnerable to higher levels of surveillance by medical and social systems, a phenomenon already experienced by many poor women who receive Medicaid to cover healthcare costs during pregnancy (Bridges 2011; King 2018).

6.1.2 Publics and Counterpublics

In addition, drawing attention to the dark matter of racism as it functions in public discussions about maternal health provides insight into the way publics operate. One of my goals in this project was to interrogate and critique the limitations of White spaces in making maternal

mortality legible as a public problem and shaping public action. Contrasting two predominantly white publics with the discourse of a predominantly Black counter-public provided a clear demonstration of the differences in the picture of maternal mortality that was presented as well as the proposed solutions.

The publics examined in this dissertation are formed by their shared attention to maternal mortality as an issue of common concern. As Hauser describes it, society consists of "a lattice of interconnected, permeable spheres where participants engage in conversations in which they identify and discuss their opinions and interests as well as the ways in which differences in opinions and interests may be accommodated based on principles of reasonableness and tolerance" (Hauser 1999, 60-1). However, the case studies included here highlight that the differences in the way members of the public view an issue of common concern – like maternal mortality – can be so drastic that people almost appear to be discussing different problems. The dark matter of racism shapes the way predominantly White publics – such as the MMRCs and LMP – address the issue of maternal mortality. It also shapes and morphs the issue itself as Black counterpublics – such as BMMA – interface with dominant institutions, like state and federal governments.

Nancy Fraser's (1990) approach to subaltern counterpublics emphasizes that what counts as an issue of common concern is up for debate. Only those participating in a public conversation, she writes, can "decide what is and what is not of common concern to them" (71). Futhermore, those participating in such discussions will not necessarily agree. "What will count as a matter of common concern," she writes, "will be decided precisely through discursive contestation" (71). I would extend Fraser's argument to add that even once a common concern is identified and agreed upon, the nature of that problem is still a site of discursive contention. In addition, because health concerns span multiple spheres of public conversation, power differentials dictate who gets to

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decide the nature of a health problem. Biomedical institutions, for the most part, claim authority in making health issues like maternal mortality legible. This dissertation, however, has demonstrated the variety of ways the picture of maternal mortality communicated by MMRCs (the primary body responsible for reviewing maternal deaths) obscures significant factors related to maternal health, including violent deaths (homicides and suicides).

My findings also highlight the importance of attending to multiple processes by which publics form around issues in general and health issues in particular. First, this study highlights that individuals participate in medical publics through a variety of processes. The medical publics described by Keränen (2014), Malkowski (2014), and others (Lawrence, Hausman, and Dannenberg 2014; Spoel, Harris, and Henwood 2014; J. Johnson 2016) are relatively coherent groups that may not ever meet or interact with one another, but who tend to align around the medical issue in question or a shared goal. Even so, the publics they describe are layered in and among healthcare and public health institutions, media outlets, academic research centers, service providers, and activist groups. In my study, the processes of medical review, investigative journalism, and birth justice activism all intersect at particular points. However, many participants in birth justice activism may not think of themselves as part of a public formation alongside members of MMRCs or journalists and vice versa.

Here, Michael Warner's view of publics, in which publics are not assumed to have any sense of unified collectivity, is useful. He writes: "a public enables reflexivity in the circulation of texts among strangers who become, by virtue of their reflexively circulating discourse, a social entity" (2002, 12). The rhetoric of the MMRCs, NPR and ProPublica, and BMMA all interact with each other as they circulate. Not only do members of each of these groups become part of publics, but anyone reading, listening, or otherwise engaging with their rhetoric does as well. People who

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are concerned about the problem of maternal mortality are unlikely to engage with only one of these sources, they are likely to encounter information about maternal mortality in multiple places. The same is true of other health and medical issues as well. Therefore, in order to get a sense of the way in which health issues are made public, we must continue to examine multiple processes by which this occurs.

Secondly, examining the way discourse circulates through different types of spheres gives us additional insight into the ways that social change occurs. Karma Chavez (2011) has demonstrated that communication has multiple functions within marginalized publics and amongst various social movement groups. A marginalized public might cycle through different forms of communication: focusing on enclavic communication within the group, counterpublic communication to test messages, persuade others, and form coalitions, and back to enclavic communication to debrief, debate, discuss, and regroup based on what they have learned. In fact, all these processes could be taking place simultaneously.

This is similar to the way that Jean Cohen and Andrew Arato (1992) describe the practices of what they call new social movements. All social movements face a challenge in that when their work gains enough momentum that dominant institutions seek to incorporate it there is a risk of co-option or the bureaucratization of the movement. Cohen and Arato, however, suggest that new social movements might experience co-option of some of their ideas and goals, but that does not automatically result in the end of the movement. Rather, when co-option occurs, they are able to adjust by cultivating learning strategies for the future. As they write: "Instead of conforming to the linear model of development, the feminist movement has shifted back and forth between mass action and political pressure, depending on the available political opportunities and the issue at

hand" (558).[33] In the case of BMMA, the co-option of doula labor in some places, such as New York State, has likely contributed to shaping their rhetoric, arguments, and strategies to contribute to the Momnibus. In addition, as Cohen and Arato note, "legal reform and political inclusion hardly suffice to define or secure success" (558). Members of BMMA are also involved in providing services, organizing in their local communities, and conducting research to further their causes. Future research addressing internal discussions by reproductive justice and birth justice organizations can shed additional light on the way that are navigating potential for co-option of their goals and labor by dominant institutions.

Finally, the human rights framework utilized by BMMA challenges notions of "public" as commonly evoked in the concept of public health. Malkowski has already argued: "public health policy is often conceptualized, mobilized, and addressed in terms of one united mission that positions humanity against disease…however, in practice, this site is often populated by competing health practices, multiple publics, and resistant communication" (2014, 69). The reproductive justice framework was developed because of women of color in the U.S. perceived that they were not members of the American public as it is evoked in the notion of public health. In fact, they identified more with women of color in developing countries around the world than they did with the white women leading the reproductive rights movement in the U.S. Ironically, as BMMA points out, U.S. foreign aid leans forward in addressing maternal health in developing nations, but neglects to guarantee the positive right to health for women and birthing people in the U.S.

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[33] Cohen and Arato describe the distinction between mass action and political pressure in more detail by saying: "The dual logic of feminist politics thus involves a communicative, discursive politics of identity and influence that targets civil and political society and an organized, strategically rational politics of inclusion and reform that is aimed at political and economic institutions" (1992, 550). Thus, the category of mass action includes processes of meaning-making, fostering resistance, and strategic planning that rhetorical scholars (Squires 2002) and (Chávez 2011) suggest occur in enclaved publics.

As a result, BMMA's human rights framework challenges the dominant thinking about the public of "public health." It specifically challenges the implicit notion that the goal of efforts to promote public health in the U.S. is to protect and advance the nation-state. Natalie Fixmer-Oraiz (2019) makes a parallel point in highlighting the way motherhood and reproduction are valued for the extent to which they build and secure the nation. If the goal of public health is national security, this approach will not actually serve everyone in the nation. In the case of maternal health, Fixmer-Oraiz highlights the ways that homeland security culture policies the motherhood of marginalized women in particular. Thus, nationalistic ideologies of public health do not actually serve everyone within the borders of the nation-state, and certainly do not advance the human rights of people outside those borders.

6.1.3 Rhetoric of Health and Medicine

Finally, this project contributes original insight to rhetoric of health and medicine scholarship, particularly in addressing social justice issues. RHM scholars have long critiqued the way race functions as a variable in biomedical and social science research (C. Condit 1999, 2008) and the relationship between race and genetics in popular discourse (C. Condit, Lynch, and Winderman 2012; C. Condit, Parrott, and Harris 2002; C. Condit et al. 2004). This dissertation highlights the need to continue the work of identifying, critiquing, and addressing racism in discourses of health and medicine.

Much of the literature in medicine and public health has moved away from overtly relying on genetic models of race. However, racist assumptions are still embedded in discourses of health and medicine. As Sharon Yam points out, "there has not been sustained engagement on how rhetorical practices in health and medicine differentially influenced the experiences of patients and

audiences who occupy intersecting positionalities" (2020, 21). Thus, RHM scholars need to be alert to the ways that the dark matter of racist violence morphs and changes its manifestation. Dylan Rodrigeuz (2020) calls this process "white reconstruction," where a formal politics of inclusion can trigger epigenic evolution of White supremacist institutional phenotypes. Here Rodriguez posits that although manifestations of racism (the phenotypes) may shift, the dark matter of violence against Black persons persists, driving the process forward.

Scholars like Yam have highlighted the need for RHM to further engage with marginalized discourses outside of dominant biomedical institutions:

An RJ-informed model of rhetorical analysis, thus, actively seeks out objects of study that lie outside dominant legal and institutional contexts. By engaging with artifacts from the margin, rhetorical scholarship can mount more poignant critiques on oppressive networks of power, and further illuminate possibilities for coalition across different social movements. (2020, 21)

I agree with Yam's point, but I would also argue that there is value in examining dominant discourses in conjunction with resistant discourses, as I have done here. This critical approach enables scholars to more clearly articulate the ways racism, sexism, ableism and other injustices pervade dominant discourses, even when they are not readily apparent.

For instance, in the case of LMP, we saw that even a text that does not specifically invoke stereotypes about bad Black mothers still relies on the way such tropes circulate in their audiences' rhetorical vocabulary. The story of Shalon Irving, as it is told in the series, makes sense to the reader because of the normative intelligibility of the Black birthing body as one that is irresponsible and unhealthy. There is an ongoing rhetorical tension in the LMP – the reporting team does argue that racial health disparities are the result of racism. But the subtext of LMP articles simultaneously

reinforces a racist narrative and centers White motherhood. This is, ironically, exactly the kind of racism that contributes to the unhealthy conditions in which Black women and birthing people live. Juxtaposing this discourse with the human rights framework advocated by BMMA makes implications of LMP's exclusion of Black life particularly apparent.

Another significant area that RHM scholars might pursue in addressing racism and other injustices in health and medical discourse pertains to evidential cuts. Previous work by scholars like Christa Teston and Colleen Derkatch highlights the significance of the question of evidence for RHM scholars. While evidentiary assessment conundrums were the focus of Chapter 3 on MMRCs, such conundrums continued to emerge for LMP and BMMA. What do we do with information about lower quality of care in hospitals that serve a high proportion of Black women (Waldman 2017a)? How do we incorporate the stories Black women share about their mistreatment in the medical system into the rest of what we know about maternal mortality? How can we center the knowledge and experience of Black women and other women of color who have been doing birth justice work in this country for decades? Christa Teston's (2017) study highlights the way that even when certain types of evidence exist and are available to publics, they can still be sidelined because our infrastructure for developing medical and health knowledge cannot account for them. Addressing racism and other social inequalities in the context of health and medicine will require additional attention to this issue.

6.2 Limitations and Future Research Opportunities

This project has taken a specific approach to examining how maternal mortality is made legible as an issue for public action. An in-depth rhetorical analysis necessarily requires that

selected case studies be limited. In addition, each case study called for a specifically tailored analytic approach that built out the general theoretical platform outlined in Chapter 1. For instance, out of the over 50 MMRCs in the country, I only examined four, and I focused on the way infrastructural objects shaped the results of review. Analysis of their public-facing reports and websites or the internal discussions they engage in during the review process would also provide additional insight into the processes by which MMRCs make maternal mortality public.

In my study of news media, I focused on one prominent series, rather than including a broader range of the newspaper articles, magazine articles, and blog posts that have been written on the subject. In addition, social media likely plays a key role in the way knowledge about maternal mortality is produced, circulated, and received. An analysis of a broader range of artifacts could reveal more about how maternal mortality is made public to different audience demographics, as well as further interrogate the role individuals who have experienced maternal harm play in circulating stories and information.

In examining the discourses around birth justice activism, I specifically limited my study to counterpublic communication by focusing on the way BMMA presents their arguments to the general public and how their arguments are received and incorporated by dominant publics. I did not study enclavic discourse among BMMA members, where they engage in processes of meaning-making, foster resistance, and create strategies for future engagement. I also did not closely examine the ways that reproductive and birth justice organizers build solidarity with other movements, such as movements for environmental or criminal justice. The work of reproductive and birth justice activists is a rich and fruitful site of discourse which deserves further attention by communication and rhetorical scholars.

Finally, I did not thoroughly examine the many policies being put forth to address maternal mortality. While I briefly addressed the Preventing Maternal Deaths Act of 2018 and the Black Maternal Health Momnibus currently being introduced in Congress, there were a total over a dozen bills introduced over the last two years of Congress intended to improve maternal health outcomes and address racial inequities. Each of these bills is the result of a process by which maternal mortality was made legible as an issue for public action, and closer attention to the process behind each bill, as well as the contents of individual bills, would reveal more about the kinds of approaches that lead to policies that support Black women, birthing people, and their families.

The aim of my study was to highlight the interaction between the processes of medical review, investigative journalism, and birth justice activism in making maternal mortality public. Comparison and contrast between these three different processes was important for revealing the role of racism in shaping the form of maternal mortality that became public in predominantly white spaces. This process made the project more difficult to execute, because it also required bringing tailored conceptual tools to each case study. Yet the result in providing insight that stretches across settings and contexts is valuable because issues of common concern are made legible in multiple spheres of discourse.

Since I began working on this project, the COVID-19 pandemic has further exacerbated inequalities in maternal health – from changes in maternal healthcare delivery to economic hardship across the country to the increased mental and emotional labor demanded of many mothers. In addition, new MMRCs have formed and momentum has built in efforts to share best practices and information between MMRCS ("Maternal Mortality Review Information Application - MMRIA"). The Lost Mothers Project has continued to circulate, being recognized for multiple industry awards and publishing updates as new information about maternal mortality

is released (Martin 2020). The Black Mamas Matter Alliance continues to work toward reproductive justice for Black women and birthing people, not only advocating for the Black Maternal Health Momnibus and other legislation but also educating and mobilizing researchers, providers, and activists across the country. Communication and rhetorical scholars must continue to interrogate the health-equity discourses that emerge in light of the COVID-19 pandemic. As Rep. Ayanna Pressley (D-MA-7th District) emphasized during the USCCR briefing, "As we work towards a COVID-19 recovery, we must reject the notion of simply returning to normal. We know that normal was unjust and unequal in the first place" (U.S. Commission on Civil Rights 2020, 15).

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