UNDERSTANDING THE SOCIAL AND CULTURAL FACTORS RELATED TO AFRICAN AMERICAN INFANT MORTALITY: A PHENOMENOLOGICAL APPROACH

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DEDICATION

This work is dedicated with love and affection to my maternal grandmother, Mrs. Zylphia Epps Randall Primus. She was an educator, an activist in her community, a musician, and a leader in her church. My grandmother was a mother who experienced the pain of infant mortality--she lost two infant daughters. As a young child, I used to sit in her living room and read from her huge collection of books. The story of Pandora's box was one I always enjoyed and the subtle messages from that story deeply influenced my life and my research. I have learned that when one is curious, one will find boxes to open and sometimes very disturbing things will fly out. Rather than run, or pick a safe topic, I have decided to try and find out some of the truths and messages hidden in such boxes. Keeping things in boxes does not mean they do not exist, rather it means we are not conscious of their existence. It is my belief that some of the answers we struggle with as we attempt to explore areas like infant mortality are tucked away in boxes that must be opened. My grandmother had two sayings that she often repeated to me. They were: "try as you can you just can't keep a good woman down" and "don't take any wooden nickels." These words while spoken many years ago made me determined to be as accurate as possible in conducting the research that has become this dissertation.
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Countless African American women are angels in my life. Mrs. Ileen Watty, my mother-in-law, is one of them. I admire the dignity and grace that she personified and I thank her for the support and encouragement that she gave me during the many years that I was blessed to have her in my life. There are other women who have gone to another dimension, women I never knew, but whose shadows continue to exist. Women, who bore the babies in the fields, cleaned the bathrooms, sharecropped, were midwives…all the women who bore unspeakable burdens so that another generation of African American women could have a better life. See a brighter day. Become researchers. I thank them and hope that I too will pave the path for a generation of researchers yet to come.
ABSTRACT

Glenna Lebby Barnes

UNDERSTANDING THE SOCIAL AND CULTURAL FACTORS RELATED TO AFRICAN AMERICAN INFANT MORTALITY: A PHENOMENOLOGICAL APPROACH

Twice as many African American infants die each year when compared to white infants. While infant mortality rates have declined for all ethnic groups in the United States over the past fifty years, the racial gap has remained persistent, and is not fully understood despite numerous quantitative studies. The purpose of this study was to understand the lived experiences of African American women in relationship to the black gap in infant mortality. Thirteen African American women participated in either a focus group or in-depth interviews. Women were asked to use their life experiences to identify factors that would increase the understanding of African American infant mortality. Several themes emerged indicating that the experience of stress and racism are constant factors in African American women's lives and are inseparable from their pregnancy experience. Social workers must form strong interpersonal relationships with African American women and advocate for comprehensive health care regardless of pregnancy status. Providing health care during prenatal and postpartum periods has not addressed the issues surrounding infant mortality in a holistic manner. It is paramount that research methods be expanded to adequately explore the complexities of race and the impact of racism on health.

Margaret E. Adamek, Ph.D., Chair
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CHAPTER 1: INTRODUCTION

It is the year 2005 and a disturbing trend prevails: In America black infants continue to die before their first birthday at rates twice that of white infants. Preliminary data for 2002 reveals that a total of 27,977 infants in the United States died before their first birthday (Kochanek & Smith, 2004). A disproportionate number of these deaths were to black infants: 14 black infants died out of every 1,000 births; 6 white infants died out of every 1,000 births. Death before age one is termed infant mortality and the number of infant deaths per 1,000 births is termed the infant mortality rate.

Overall, infant mortality has declined during the last fifty years. Alarming is preliminary data indicating that for the first time since 1958 infant mortality rates have slightly increased. The overall rate was 6.8 in 2001 and was 7.0 in 2002. Reports are forthcoming addressing this increase (Kochanek & Smith, 2004). The rate of overall decline in infant mortality has differed significantly for blacks and whites, with blacks benefiting the least. National Center for Health Statistics data in Figures I (Mathews, Curtain, & MacDorman, 2000) and II (Mathews, MacDorman, & Menacker, 2002) indicate that the gap between white and black infant mortality has persisted while overall rates have dropped. Because the infant mortality rate during the last four decades has declined faster for white infants than for black infants the black-white ratio increased from 1.6 in 1950 to 2.2 in 1991 (Polednak, 1996; Singh & Yu, 1995). This trend continues. The black-white ratio increased from 2.4 in 1995 to 2.5 in the year 2000 (Iyasu, Tomashek, & Barfield, 2002). One of the goals of Healthy People 2000 (National Center for Health Statistics, [NCHS] 2001) was that white infant mortality would reach
7%. Fortunately, that goal was achieved. The Healthy People 2000 (NCHS, 2001) goal for African American infants was 11%. Unfortunately, that goal has not been achieved.

The relationship between race and health tends to be very complex and in the area of infant mortality this is indeed the case. After three decades of research attempting to untangle this complex web between race and infant mortality, investigators conclude that the racial disparity in infant mortality is consistent, persistent, and remains unexplained by poverty alone (Geronimus, 1996; Hummer, 1993; LaViest, 1993; McGrady, Sung, Rowley, & Hogue, 1992; Ren, Amick, & Williams, 1999; Schoendorf, Hogue, Klienman, & Rowley, 1992). As a result, investigators find it crucial to further understand the connection between race, racism and infant mortality (David & Collins, 1991; Gates-Williams, Jackson, Jenkins-Monroe, & Williams, 1992; Hogue & Hargraves, 1993; Hummer, 1993; Murrell, Smith, Gill & Oxley, 1996; Rowley, 1994). One example of this complex relationship can be seen from recent data.

Data from National Center for Health Statistics (Mathews, MacDorman, & Menacker, 2002) indicate that women who are married, give birth between the ages of 20-35, have at least a high school education, do not smoke and receive early prenatal care have lower rates of infant mortality. These data confirm the results of studies that often examine these maternal characteristics. Upon closer examination of the data, what becomes apparent is that these maternal characteristics have different effects on infant mortality depending on the race of the mother. Two observations can be made. First, overall infant mortality rates can decline without changing the gap between white and African American infants. The disparity gap remains twofold. This implies that the causal factors for the overall decline are different than those responsible for the racial disparity
(Gates-Williams et al., 1992; Wise & Pursley, 1992). Secondly, African American women do not benefit as positively from their education, marriages and other characteristics as their white counterparts in terms of birth outcomes.

As indicated by National Center for Health Statistics data (Mathews, MacDorman, & Menacker, 2002) in Figures III-VIII, African American women who are at the lowest risk for infant death appear to have infant mortality rates that are higher than white women who are at highest risk for infant death. This phenomenon referred to as the "paradox of the well-off black mother" (David & Collins, 1991) indicates that African American women who are low risk for infant death may experience additional risks unique from those of white mothers. In other words, African American women who are college-educated have a higher infant mortality rate than white women with considerably less education. African American women who do not smoke cigarettes have higher rates of infant mortality than white women who smoke cigarettes. In the same manner, age at pregnancy, entry into prenatal care, and marital status are all characteristics that have different effects on infant mortality depending on the race of the mother. Male infants are more likely to die than females; however, the racial gap still remains and African American males have the greatest risk of all infants of dying before their first birthday.

Overview of Research in the Area of African American Infant Mortality

Research indicates a direct relationship between low birthweight and mortality (Boone, 1989; Rowley, 1994; Wilcox & Skjoerven, 1992; Zimmer-Gembeck & Helfand, 1996). In 1998, 65% of all infant deaths occurred to the 7.6% of infants born with low birthweight (Mathews, Curtain, & MacDorman, 2000). Data from the 1999 period linked birth/infant death set (Mathews et al., 2002) also indicate that of the five leading causes
of death (congenital malformations, low birthweight/short gestation, sudden infant death syndrome, maternal complications and respiratory distress of newborns), African American infants continued to die more often of low birthweight. This finding comes despite indications that the number of black women who received prenatal care met the special population target set by the Centers for Disease Control (CDC) to reduce disparities in this area. Declines in the percent of women not receiving prenatal care during the first trimester were greater for black women than other groups (Keapel, Pearcy, & Wagener, 2002).

Low birthweight is associated with premature birth and permanent physical disabilities. African American infants were more likely to die of medical disorders related to premature birth and low birthweight in 1991 than in 1981 (Blane, 1995). Thus, most studies in the area of African American infant mortality focus on low birthweight (Gates-Williams et al., 1992). Despite the connection between low birthweight and infant mortality, the overall declines in infant mortality rates are from improved neonatal technology, not from significant reduction of low birthweight (Alexander, Tompkins, Allen, & Hulsey, 1999; Kliegman, 1995).

The importance of socioeconomic variables and other social variables to the incidence of low birthweight has been documented (Ahmed, 1992; Chomitz, Cheung & Lieberman, 1995; Hogue & Hargraves, 1993; LaVeist, 1993; Michielutte, Moore, Meis, Ernest, & Wells, 1994). The majority of studies found that racial disparities in low birthweight are not due to socioeconomic status alone, but concludes that race and socioeconomic status have separate, independent effects on low birthweight (Bird, 1995;
Geronimus, 1996; Hummer, 1993; LaViest, 1993; Schoendorf et al., 1992; Ren et al., 1999).

A meta-analysis of research conducted in the late 1970's and the 1980's by Gates-Williams et al. (1992) analyzed studies of infants with low birthweight. The research included epidemiological studies, studies advocating prenatal care, and ethnomedical (cultural) studies. These investigators concluded that despite the contributions that these studies made to the understanding of infant mortality, they ignored the sensibilities of African American and feminist thought and "they rarely question why, let alone how, it is that African-American women have become so poor and at high risk in the first place" (Gates-Williams et al., 1992, p. 353). They join other investigators in asking that the mandate for research in the area of African American infant mortality move beyond examining the factors that contribute to poor infant health and address the causes of the disparity directly (Davidson & Fukushima, 1992; Fiscella, 1996; Julia, 1992; LaViest, 1993; Murrell et al., 1996; Polednak, 1991). Race must be critically examined in health research (Gates-Williams et al., 1992; Wise & Pursley, 1992).

Selected studies from an extensive literature review that I conducted follows after a section on key terms used in infant mortality studies. This review was not intended to be an exhaustive review of the hundreds of studies that document the need to understand the connection between race and infant mortality. Rather, the purpose of the literature review was to examine studies conducted after the Gates-Williams (1992) meta-analysis to understand how race is currently being studied in relationship to infant mortality. The studies reviewed were conducted between the years 1990-2003 and were selected because they responded to the need to address the racial disparity by examining less
studied indicators, for example, mother's place of residence and levels of segregation within a community. These reports also discuss the difficulties and complexities in researching the social construct of race.

The studies analyzed fell into four categories:

- Studies that compared the infant mortality rate among black women born in the United States with that of black women born in other countries;
- Studies that examined socioeconomic characteristics presumed to be linked to race (effects of segregation, education, place of residence);
- Studies that evaluated the quality and outcomes of prenatal care received by black mothers; and
- Studies that looked at specific medical/health conditions prevalent in black women that increase the risk of poor pregnancy outcomes.

References were retrieved from a variety of sources authored by physicians, nurses, and social scientists. A computer-assisted search of Medline for the years after 1990 was conducted. Key phrases used were African American infant mortality, black infant mortality, low birthweight, racial disparity in health, and African American women and health. To ensure that the research reports were from investigators representing various racial and ethnic groups, two additional sources were used to review studies--The New Jersey Blue Ribbon Panel Report of Black Infant Mortality Reduction and the bibliography that has been compiled by the National Fetal-Infant Mortality Review Program addressing ethnic and racial factors on infant mortality. These two sources indicated there were teams of multiracial investigators and African American community members that assisted in writing reports.
Key Terms Used in Infant Mortality Studies

Infant mortality rates are reported in two forms—cohort and period data. A birth cohort is comprised of infant deaths that occurred before the age of one in the year of birth or the following year in a specified calendar year. As an example, the cohort rate for 1998 would consist of all births for 1998 in the denominator and the numerator would consist of deaths that occurred to infants for the year 1998 and 1999. Thus every death up to age one is accounted for. This cohort data is the most accurate, but it takes more time to produce. It is the first choice of data for data collectors and researchers. Period mortality rates are based on births and deaths from a single calendar year. These data can be produced faster and meets the needs of consumers. In practice very little difference is found in the rates of period and cohort data (Mathews et al., 2002).

An infant that dies before the age of one does so either during the neonatal period or the postneonatal period. Neonatal mortality refers to death on or before the 27th day of life and accounts for two-thirds of the infant deaths in the United States (David & Collins, 1991; Mathews et al., 2002). Postneonatal deaths are those deaths that occur from day 28 of life to one year. They are often associated with environmental factors, such as inadequate housing and food (Mathews et al., 2002). African American infants have higher mortality rates than white infants during both the neonatal and postneonatal periods.

Birthweight and gestational age are terms found in infant mortality studies and are the two most important predictors of an infant’s subsequent health and survival. Low birthweight (LBW) is weight at birth that is less than 5lbs.8oz. Very low birthweight is a weight at birth that is less than 3lbs.4oz. (Mathews et al., 2002; Paneth, 1995). The latest
available data from the NCHS (Mathews et al., 2002) indicates that low birthweight is the leading cause of death among African American infants.

Gestational age refers to the age of an unborn infant at birth or death and is measured in weeks (Mathews et al., 2002). Infants born at 37 weeks and above are considered full term; those born before 37 weeks are considered preterm (Mathews et al., 2002). Preterm (premature) birth is associated with a higher risk of infant death and long-term health disabilities. African American women have a 50% greater risk of having a preterm birth when compared to white women (Collins & Hammond, 1996; Mathews et al., 2002; Rowley, 1994).

Studies that discuss the effects of prenatal care often use the term "adequacy of care." Prior to the early 1990's, most studies indicated that the Kessner Index (Kotelchuck, 1994) was used to measure the adequacy of prenatal care. This index combines two continuous numeric measures (month prenatal care begins and number of prenatal visits, adjusting for length of gestation) and links them into an index with three levels of adequacy (Adequate, Intermediate and Inadequate). To be rated Adequate on the Kessner Index, one must start prenatal care during the first trimester and have nine prenatal care visits for a normal-length pregnancy (Kotelchuck, 1994). The Kessner Index has some inherent problems because of its reliance on prenatal care beginning in the first trimester. It does not distinguish timing of initiation from poor subsequent utilization. A more accurate measure of adequacy of prenatal care that is also utilized in studies is the Kotelchuck Adequacy of Prenatal Care Utilization Index. This index tends to capture more completely the nature of prenatal care visits as it takes into account visits started at any point during the pregnancy (Kotelchuck, 1994).
CHAPTER 2: LITERATURE REVIEW

Infant Mortality Among U.S. Native Born Black Women
and Foreign Born Black Women

Despite the small number of studies conducted in this area, their importance
should not be underestimated. Investigators are attempting to explore theoretical links
between race, ethnicity, racism and health. These studies also emphasize that black
women are not a homogenous group or one delineated by a specific "gene pool." Foster
(1997) indicates that the racial identification of African Americans is at best speculative.
African Americans tend to cover the spectrum from having very little genetic makeup
from Europeans to having a bloodline that is nearly all European. In addition, a large
percentage of African Americans have Native American lineage (Foster, 1997). Thus, to
look for genetic causes before sociocultural questions are answered is premature. Culture,
group history and ethnicity are among the variables that must be considered in
understanding birth outcomes.

Friedman and colleagues (1993) examined maternal ethnicity and birthweight
among blacks. The sample was drawn from singleton births to mothers residing in
Massachusetts who identified themselves as either non-Hispanic whites (N=206,358) or
blacks (N=18,715) and delivered from 1987 through 1989. Infants weighing less than 500
grams and infants with unknown birthweights were eliminated. Variables included in the
study were derived from the parent worksheet for the Massachusetts certificate of live
birth. Mother's race was used to classify live births. Several options for both race and
ethnicity were offered on the worksheet and infants whose mothers reported their race as
black were further classified based on the mother's definitions of their own ethnicity.
Substantial variations existed in the distribution of characteristics among the black groups. Certain black ethnic groups (for example Haitian) were more similar to non-Hispanic whites than to black women who report their ethnicity as American. All black groups were found to have significantly elevated risks of low birthweight when compared to the reference group of non-Hispanic whites. The infants of American black women were found to have lower mean birthweights and higher levels of risk than other black ethnic groups. This research is significant in that it demonstrates the importance of investigating ethnicity among all blacks as a means to better understand factors relating to poor pregnancy outcomes. It did not, however, consider the many ethnic/cultural differences among American-born black women.

Wasse, Holt, and Daling (1994) compared birth outcomes of three cohorts of women with singleton live births in Washington State between 1980 and 1991. The sample was composed of Black Ethiopian-born women (n=264), US Black women (n=532) and White women (n=546). Birth certificate data were used to examine demographic differences. The association between maternal birthplace and infant birthweight was calculated with the Mantel-Haenszel pooled estimator of relative risk and Greeland/Robins 95% confidence intervals. Potential confounders (i.e., age, parity, marital status) were considered and those that altered the relative risk by 10% or greater were included as confounders. Ethiopian women were less likely than US-born Blacks to have low-birthweight infants (5.3 vs. 7.6). The Ethiopian women had no greater risk of delivering low birthweight infants than US born White women, despite experiencing difficulties obtaining prenatal care upon entry into the country. Ethiopian women were more likely to be married and have a strong social support system, smoked less than
Black and White women born in the US, and had lower amounts of anemia that US Blacks. It is important to note that during the mid-1980's most Ethiopians that came to the US had refugee status. The investigators suggest that even with a refugee status close in approximation to the socioeconomic status of US Blacks, the mortality rates for Ethiopians were lower.

David and Collins (1997) compared birthweight among infants of US born Blacks, African born Blacks, and US born Whites. Vital records for 1980 to 1995 from Illinois were used to determine the distribution of birth weights of these three groups of women (US born White, N=44,046 infants; US born Black, N=43,322 infants; African-born Black, N=3,135 infants). West African women were selected because most African Americans trace their origins to West Africa. It is estimated that US Blacks derive about three-quarters of their genetic heritage from West African ancestors and the remainder from Europeans. If genetic causes underlie birthweight differences, it would be expected that African-born women would have lower infant birthweights that US born Blacks. This study found that African-born Blacks have infant birthweight patterns that are more closely related to US born Whites than US born Black women. Rosenberg, Desai, and Kan (2002) found similar results.

These studies are important in that they suggest a need to look beyond a genetic basis to maternal environmental factors to explain racial disparities in infant birthweight. Equally important, they indicate the need to separate race from class and ethnicity. It is apparent that more research needs to be conducted that examine ethnic differences among US born Black women. Regional differences based on residence, physical appearance (skin color/hair texture), educational status and race of marriage partner are a few of the
variables that could influence the cultural and ethnic environment and life experiences of black women. For example, one distinct ethnic group of African Americans lives in the coastal areas of South Carolina and Georgia and has retained many African cultural practices and beliefs that could impact maternal child health.

Collins, Derrick, Hilder, and Kempley (1997) conducted research to ascertain the extent to which maternal race was a factor in infant mortality in a developed country socioeconomically comparable to the United States. In a cross-sectional study, a dataset of 1987-1990 birth records from three hospitals in East London, England were analyzed. England has a sizable black minority that emigrated in the 1940's from the Caribbean and, more recently from Africa. The sample size consisted of all live born African (N=3,495), West Indian (N=3,471), and European white (N=20,313) singleton infants born to East London residents. West Indian and African mothers had rates of very low birthweight that were twice those of European white mothers. African mothers, however, had lower infant mortality rates that African Americans in the United States. The differential persisted independently of maternal age, prenatal care, education, or socioeconomic factors. A major implication of this study is that lifetime experiences contribute to the ethnic disparity in infant mortality. Unmeasured factors antecedent to pregnancy must be examined to understand the connection between race and infant mortality.

Several investigators have compared mixed-race infants with single race infants to understand the impact of maternal race on low birthweight. Polednak and King (1998) examined the prevalence of low birthweight among biracial infants of black and white parents by region of the United States. Using the national linked live birth-death infant
file for 1991, low birthweight (<2,500 g) was examined among 50,980 biracial singleton infants according to parental race (black mother-white father vs. white mother-black father). Nationally, the rate of low birthweight was 31% higher in the black mother/white father group. Black maternal race was still a strong predictor of low birthweight. The association between low birthweight and parental race group varies by region of the United States and by mother’s Hispanic origin. Rates for both groups of biracial infants (black mother/white father and white mother/black father) are significantly better than those for infants of all black mothers (the majority of whom have black fathers). In this study, this group of biracial families in the West had a low birthweight rate that was lower than that of all white mothers in 1991. A major issue addressed in this study is the difficulties associated with classifying by race. Infants with a white mother and black father were classified as black by the National Center for Health Statistics prior to 1989. Another important implication is that biracial marriages are accepted differently depending on the region in the US and subsequently impact the maternal environment in different ways.

Similar themes are echoed in other studies that attempt to compare biracial infants to single race infants in understanding the effects of race. These studies conclude that among black mothers, interracial births have lower risks of low birthweight and very low birthweight than single-race black births and that among white mothers interracial infants had higher risks of low birthweight compared to single-race white infants (Collins & David, 1993; Migone, Emanuel, Muller, Daling, & Little, 1991; Parker, 2000). These investigators note that there has been relative improvement in birth outcomes for infants of white mothers and black fathers compared to single-race white births while there has
been no relative improvement for black mothers and white fathers compared to single-race black births.

Studies in this category have several important implications: (1) They indicate that non-genetic unexamined factors contribute to the racial disparity in infant mortality. Several investigators have indicated that the racial identification of African Americans is speculative at best, (2) Mother's race is more strongly related to infant mortality than father's race, (3) Blacks are not a homogeneous group and their ethnicity must be understood from both a historical and cultural context, (4) African American women whose infant's fathers are white may have different experiences relevant to the impact on infant mortality, and (5) It is difficult to study race and will become increasingly more so as traditional racial classifications change.

Socioeconomic Factors and Infant Mortality

Educational level, marital status and the place of residence of the mother are generally associated with socioeconomic status. Both black and white college graduates are considered to represent a group of women who have minimal risk for adverse pregnancy outcomes. Several investigators have attempted to understand the complex relationship between education, race, and infant mortality.

Schoendorf et al. (1992) examined mortality in infants born to college-educated black and white parents. The National Linked Birth and Infant Death Files for 1983-1985 were used to calculate infant mortality rates for a study population of 865,128 white infants and 42,230 black infants. A separate effect of birthweight was assessed by examining mortality rates before and after the exclusion of low birthweight infants. The black infants born to college educated parents had a higher (almost twofold) infant
mortality rate than infants of white college educated parents. In contrast to black infants in the general population, only low birthweight was a causal factor. Unlike the general population, black babies of normal weight born to college educated parents had an equal chance of surviving the first year of life. An explanation given in this study for the racial disparity is that even in the college-educated group, black and white populations are not equal. Another explanation is that intergenerational effects influence pregnancy outcomes in college educated black women. The idea that childhood environment can influence pregnancy outcome is echoed by other investigators (Foster et al., 2000).

Foster and colleagues examined to what extent second-generation high socioeconomic status (SES) women experience improvement in birthweight and gestational age. Former Meharry students were surveyed and a total of 934 births that occurred to children and grandchildren of these students were identified. These infants were compared with a cohort of white mothers from Yale University's School of Public Health. The results are that low birthweight rates were reduced significantly in the third generation of high SES African Americans (from 11.4% in the second generation to 6.9% in the third generation), but was still almost twice the rate of white infants whose rate for low birthweight was 3.3%. Implications are that even among second generation high SES African American women unidentified factors contribute to persistent low birthweight rates that are different than those experienced by white women.

McGrady et al. (1992) investigated black and white female college graduates presumed to have similar socioeconomic status and similar risk profiles with respect to environmental factors. Data were gathered by mail survey from graduates of four Atlanta, Georgia colleges. Three of the colleges had a predominately black enrollment, one had a
predominately white enrollment and two matriculated women only. A survey protocol was adapted from Dillman (1978) and mailed to 6,867 alumnæ. Responses to the mail survey were received from 3,084 (45%) of those sent surveys. Of these alumnæ, 2,743 were eligible to participate. Eligible respondents (those who had completed college and delayed childbearing) had significant differences by age, income, and educational status of parents. White respondents tended to be older, have higher incomes, and have parents who were college educated. Black women were found to have higher rates of both preterm delivery and low birthweight babies. The results of this study suggest that college graduate status does not imply homogeneity in socioeconomic status in terms of race and suggested that race possibly should be seen as a component of social class because of income variances between the two groups. These findings were further supported by research conducted by Din-Dzietham and Hertz-Picciotto (1998), Collins and Butler (1997) and Shumueli and Cullen (2000) who concluded that college educated black women do not necessarily benefit from increased education in the same manner as college educated white women and that a racial disparity is also prevalent among these low-risk women.

Sung et al. (1992) examined the interactive effects of race and marital status on low birthweight. Data from metropolitan Atlanta, Georgia was examined to explain the joint influence of maternal age, marital status and race among groups homogeneous for age and educational attainment. Computerized live birth files (for the years 1980-1987) for five counties in the Atlanta area were analyzed. While 37% of live births were to black mothers during the study period, 56% of low birthweight infants were born to black mothers. White mothers were more likely to be married and have some college education
than black mothers. Infants born to unmarried mothers had the highest risk of being low birthweight, but the impact of being unmarried was strongest for adults, whites, or well educated women who were in the lower risk category. The unmarried to married risk was greater for white women than for black women. Interestingly, married adult black females were found to have a risk for delivering a low birthweight infant that was much higher than an unmarried white teenager. As in other research studies, education did not improve the status for black mothers. The investigators postulated that if marriage is a marker for social stability, then educated black teens and educated married adult black women have social stability equivalent to educated, unmarried adult white women. These are grave implications and further indicate the need to understand the complex relationship of race, African American marriage and social stability in America. This becomes increasingly important given that marriage rates are declining among African Americans and increasing numbers of female-headed households have been linked to infant mortality (Tucker & Mitchell-Kernan, 1995).

LaVeist (1993) examined the effects of segregation, poverty and black political empowerment on infant mortality. Cities were selected that had a population in 1980 at or exceeding 50,000 and at least 10% of the total population was African American. A total of 176 cities and 32 states were represented. Residential segregation is measured using the index of dissimilarity for 1980. The index is a measure of the degree of racial residential segregation based on a scale ranging from 0 (no segregation) to 100 (complete segregation). Poverty is measured by standards set by the US census in the year 1980. Black political power is the ratio of percentage of blacks represented in the City Council to the percentage of African Americans in the voting-age population for 1983-1984.
It was found that there is geographical variation in the degree of black to white disparity in infant mortality. Black infant mortality rates were lower in the West and higher in the South and North Central parts of the U.S. Highly segregated cities have higher black infant mortality and lower white infant mortality rates. Poverty is associated with both black and white infant mortality, but only white poverty is directly related to the differential in black-white infant mortality. In cities where there are high rates of white poverty, the disparity gap decreases between white and black infants. While black infant mortality is lower in cities where blacks have gained political empowerment, it is not significant enough to reduce the disparity. An equally important finding consistent with studies previously mentioned, is that race, more than social class determined where blacks resided. Regardless of economic resources, middle-class blacks continue to live in socioenvironmental conditions not consistent with economic status. Race dictates access to neighborhoods whose resources are commensurate with level of income. This study indicates the importance of examining how city characteristics impact infant mortality. These results are consistent with those of McCord and Freeman (1990) who examined the effects of poverty and segregation in Harlem and other neighborhoods in New York City. They found African American mortality rates at all ages to be similar to Bangladesh, one of the lowest income countries of the world.

Polednak (1996) has conducted a more recent survey of black infant mortality rates in large US metropolitan statistical areas. Findings are consistent that high black infant mortality rates exist and persist in the most-segregated metropolitan areas and are contributing to the disparity between black and white infant mortality rates. These studies
indicate the need for continued research that not only looks at levels of segregation but levels of violence and access to services, including medical care.

Chicago is one of the most segregated cities in America; races are almost totally polarized. Blacks reside in census tracts that are 84% black and whites live in areas that are 90% white (Collins, 1991; Polednak, 1996). Poma and Poma (1999) compared infant mortality rates between large ethnic groups in Chicago from 1989-1996. African Americans contributed to 46.1% of the births and 68.5% of the infant deaths during the study period. Several investigators have examined the relationship between place of residence and pregnancy outcomes in Chicago.

Collins and Hawkes (1997) investigated the extent to which place of residence affects the black to white differential in post-neonatal (28-365 days after birth) mortality. A univariate analysis and multivariate logistic regression was performed using the 1981-1982 Illinois vital records, the Chicago Police violent crime information, and the 1980 US Census income data. Four environmental predictors were examined: (1) median family income of under $10,000 per year, (2) poverty prevalence greater than 50%, (3) violent crimes rates of 11/1000, and (4) limited community access to primary medical care. The results were that the post-neonatal mortality rates for black infants were three times that of white infants. Eighty-seven percent of the black infants tended to have one or more of the predictors present while 64% of the white infants had one or more predictors present. The investigators concluded that the racial disparity in post-neonatal mortality is associated with specific environmental conditions. In a similar study of postneonatal mortality in Chicago, Papacek and colleagues (2002) found that 79% of African American infants lived in impoverished communities compared to 9% of white
infants. African American infants in both impoverished and nonimpoverished neighborhoods were at high risk for postneonatal death.

Roberts (1997) found that certain neighborhood-level indicators predicted low birthweight. Vital records and census data for the Chicago area in 1990 were merged (N=112,327) and a logistic regression model predicting low birthweight was estimated by backward elimination. The associations of nine neighborhood-level indicators were measured. Six indicators were found to predict low birthweight. Community economic hardship and housing costs were positively associated with low birthweight. Community socioeconomic status, crowded housing and high numbers of young and African American residents were negatively associated with low birthweight. The results of this study are supported by findings by Guest, Almgren, and Hussey (1998) who found that community socioeconomic factors account for the variations in infant mortality in Chicago. Similarly, O'Campo, Xue, Wang, and Caughy (1997) conclude that individual risk factors for low birthweight interact differently depending on the neighborhood of residence in Baltimore, Maryland. These studies are important because they stress the need to look beyond individual maternal behaviors or genetic causes to maternal environmental factors to explain racial disparities in infant birthweight.

Access to care is often linked with socioeconomic status and the place of residence. Most often women who have higher socioeconomic levels tend to have greater access to quality health care. Less studied are the reasons why African American women regardless of socioeconomic status or place of residence under-utilize available health care. Murrell et al. (1996) conducted a qualitative study with African American childbearing women (ages 14-42) to examine the relationship between access to health care.
care and experiences of racism. Fourteen African American prenatal and postpartum women were given one to two hour interviews. They were asked to describe their ability to access health care and their experiences of racism. The Perceptions of Racism Scale was administered. Data were coded independently until consensus (95%) was obtained. Three themes emerged: a) the pervasiveness of the stereotype of pregnant African American women; b) care that is indifferent, inaccessible, and undignified; and c) the totality of racism. Similarly, Johnson (1994) identified that the medical system itself is a source of stress to African American women who are often treated by white physicians who display racially motivated actions. These studies indicate the need for more qualitative research that can help make the connection between access to health care, utilization of services, and racism.

Rawlings and Weir (1992) conducted research among a US military population to examine infant mortality rates among black and white women who have equal access to health care. Data were compiled for all live births and infant deaths among dependents of active-duty military personnel at Madigan Army Medical Center, Tacoma, Washington between 1985-1990. Racial designations were designated by parental preferences as noted on the birth certificate. The total number of births during the time period was 15,495 of which 11,740 were white infants and 2,613 were black infants. One hundred forty-four infants died during the study period. The overall infant mortality rate for the year studied was 9.3, similar to the national rate. The black infant mortality rate was 11.1 well below the national rate of 17.9 for all black infants in 1987. In spite of the high incidence of preterm labor, low birthweight and very low birthweight prevalent among black mothers in this study, overall black infant mortality was lower than national rates
and was independent of family income and race. Similarly, Irwin, Savitz, Hertz-Picciotto, and St. Andre' (1994) found that African American women in the Marine Corps had no more risk for pregnancy induced hypertension than white women. Both of these studies indicate that under similar environmental conditions including equal access to health care white-black differentials in health decrease.

Studies in this category also support the need to continue to examine non-genetic factors (neighborhood of residence, level of segregation, access to health care, similarity/dissimilarity of environment) to understand racial differences in infant mortality. Many of these studies have become landmark ones in that they challenge the traditional poverty paradigm in explaining the racial disparity in infant mortality. The investigators conclude that something unexplained, but operating in the lives of low risk (high SES) African American women also make them at risk for increased levels of infant mortality. The disparity is actually greater between low risk white women and low risk black women. It becomes evident that unexamined factors present in the lives of African American women (possibly connected to racism and oppression) is interfering with her ability to gain health benefits from marriage, education and income in the same ways that her white counterparts do.

Prenatal Care and African American Mothers

While prenatal care is seen as the cornerstone of assuring a positive pregnancy outcome (Alexander & Korenbrot, 1995) evidence supporting the association between prenatal care and reduced rates of low birthweight has emerged slowly. The slow pace of research in this area reflects the complexity and variability of this intervention and the difficulties in measuring the adequacy of its use and its content (Alexander & Korenbrot,
1995). Some evidence suggests that adequate prenatal care is associated with reduced rates of low birthweight, but mainly among mature full-term infants (Alexander, Weiss Hulsey, & Papiernik, 1991). A more recent study indicated that augmented prenatal care for African American women increased satisfaction with care, but did not reduce low birthweight (Klerman et al., 2001). Medicaid enhanced prenatal programs have been established in over 80% of US states. These programs provide prenatal expansions to include case management, nutritional and psychosocial counseling, health education, and home visiting (care coordination). Several studies have evaluated many of these programs.

Bradley and Martin (1994) evaluated the impact of home visits on enrollment in pregnancy-related services. As a component of Indiana legislation that provided care coordination for pregnant Medicaid recipients, the Indiana University School of Nursing was contracted to pilot test care coordination both in urban and rural sites to develop standards of care and reimbursement levels. Indianapolis was selected as the urban site as it had experienced the highest black infant mortality rates of a major US city for several years. The Maternity Outreach and Mobilization (MOM) is the urban pilot project that is the focus of Bradley and Martin's (1994) study. Utilizing a team of professional and indigenous workers, this project targeted two primarily black neighborhoods that each had an infant mortality rate of 24.2 in 1987. Secondary data analysis was used to determine the effectiveness in increasing enrollment in pregnancy-related services. Data were collected on 381 participants who gave birth to infants, or were expected to deliver between July 1, 1990, and January 1, 1992. The majority of the women (93.2%) were black, 5.5% were white and 0.3% were Hispanic. Ages ranged
from 12 to 44 years. Most were not married and 85% lived in families at or below the federal poverty level. The McNemar test was used to determine any significant change in the proportion of participants enrolled in each pregnancy-related service before and after enrollment in the MOM project.

This study found that home visits increased enrollment in pregnancy related services in a low income black urban population. While results are mixed for the effectiveness of Medicaid managed prenatal care programs (Piper, Mitchell, & Ray, 1996); the positive findings in this study are consistent with recent studies. Baldwin et al. (1998) evaluated the effect of Washington State's expansion of prenatal services for Medicaid-enrolled women. They found that prenatal enrollment increased and that there was a decrease in low birthweight. Griffin, Hogan, Buechner, and Leddy (1999) evaluated the effect of a Medicaid managed care program on the adequacy of prenatal care utilization in Rhode Island. Similar to the findings from the MOM project and the Baldwin study, these investigators indicated that programs that address organizational and structural barriers to health care have higher rates of positive pregnancy outcomes.

Reichman and Fornio (1995) evaluated the effectiveness of the New Jersey statewide Medicaid Healthy Start initiative. Participants received increased provider reimbursement, case coordination with other social programs, health education and community outreach. The sample size was 24,005 Healthy Start participants and 16,700 non-Healthy Start participants. For black women, participation in the program increased birthweight an average of 258 grams in 1989 and 216 grams in 1990. Newborn hospital costs were consequently reduced by 8.9% in 1989 and 10.1% in 1990. Among black
women each month of late entry into prenatal care reduced low birthweight by 181.5 grams in 1989 and 122.4 grams in 1990. Results were inconclusive for white mothers.

Results from community-based prenatal care programs have not found significant differences in birthweight between study and control groups. Graham, Frank, Zyranski, and Reeb (1992) measured the effectiveness of a home-based intervention for prevention of low birthweight. Black women registered at the MacDonald hospital (1987-1988) in Cleveland, Ohio were eligible to participate. The intervention group consisted of 52 women who received four one-hour home visits from two to four times during their pregnancies (11 received less than four visits). The control group consisted of 58 women. Despite the intervention group receiving more prenatal visits than the control, there were no statistically significant differences in low birthweight between the two groups. Herman and colleagues (1996) evaluated a community-based enriched prenatal intervention (Better Babies Project) serving mostly poor African American women in Washington, D.C. Similar to the Graham study there were no differences in low birthweight rates in the study and control groups. Both studies conclude that the interventions may have been started too late in the woman's life and therefore were not able to overcome a lifetime of disadvantage.

LaViest, Keith, and Gutierrez (1995) examined the difference in prenatal care utilization between blacks and whites. Utilizing secondary data from a survey conducted by the Michigan Department of Public Health, multivariate analysis methods were used to examine the racial differences. Black and white women found no differences in the initiation of prenatal care. Black women were less likely to receive adequate prenatal care or to have as many contacts as white women did. The investigators concluded that future
research should examine the reasons that black women are unwilling or unable to continue to receive prenatal care once it has been initiated. Kogan, Kotelchuck, and Johnson (1993) found similar results in their study that examined racial differences in prenatal visits during the last trimester; black women tended to initiate prenatal care early in the pregnancy, but by the last trimester made fewer visits than white women.

Poma and Poma (1999) found that prenatal care lowered infant mortality rates only when compared with a mother not receiving any prenatal care. Interestingly, infant mortality rates were not influenced when late prenatal care is compared with early prenatal care; early care does not improve infant mortality rates. This suggests that the content of prenatal care versus the timing or number of visits may be responsible for improving birth outcomes. This finding is further supported by the limited number of studies that focus on differences in content of prenatal care based on race. Brett, Schoendorf, and Kiely (1994) found that black women utilized amniocentesis and ultrasonography less, while tocolysis (induction of labor) was utilized more frequently depending on whether or not there was an indication of multiple births. Kogan, Alexandre, Kotelchuck, Nagay, and Jack (1994) found the black women were less likely that white women to receive health behavior advice, but more likely to receive the medical procedures. These investigators suggested that several factors could account for these results: (1) the provider’s perception of the patient, (2) racial variations in provider-patient interactions, and (3) providers lack of training on approaching lifestyle problems with minority women. In a society largely characterized by white providers race may negatively influence the equitable provision of health education. These investigators all conclude that the concept of measuring the adequacy of prenatal care primarily in terms
of utilization is not sufficient to understand the relationship between prenatal care and birth outcomes.

Along with utilization and content of prenatal care, it is necessary to attempt to understand the African American woman's perceived barriers to prenatal care. Reis and colleagues (1992) examined the perspectives of residents of an inner-city Chicago neighborhood on prenatal care and infant health issues. A convenience sample consisting of 380 black adults (231 women and 149 men) was obtained from a neighborhood of approximately 18,000 people. The study was sponsored by the neighborhood community health center that serves a low income, predominately black population with very high infant mortality rates (31.4 out of 1,000 live births). The sample was structured to reflect the percentage of men and women in the community, the percentage of adults employed, and the percent of the community (13%) that received services through the community health center. Participants were recruited at the community health center and other community centers and events. The average age of respondents was 28.6 years. Of the participants, 72% had at least one child in the age range from one to nine.

A multidisciplinary team with extensive prenatal experience designed the questionnaire. Five outreach workers were trained to administer the 70-item questionnaire. A major finding was that one-half of the respondents could not define infant mortality. This indicated that there was a lack of public awareness on infant mortality and the issues related to it. Some sub-groups identified cost of care as a barrier, but financing prenatal care was not seen as sufficient to increase usage. Lack of financial resources in families was the most frequently selected (56% men and 64% women) explanation for the community's high infant mortality rates. Fear of detection of drug
usage was a barrier to care mentioned by most (80%) of the respondents. In general, there was a great concern in the community regarding infants, mothers, and their health status. Prenatal care was seen as important. Studies similar to this one attempt to ensure that education and support are consistent with the cultural needs of individual communities in planning programs to prevent poor pregnancy outcomes. It is important to note that community residents felt that it was more important to increase the family finances in an effort to decrease infant mortality than to finance prenatal care. Similarly, Meikle and colleagues (1995) found that cultural attitudes, not cost of prenatal care, determined if African American women sought early prenatal care. York and colleagues (1999) further support this finding in a study that examined the impact of personal problems on receiving prenatal care. They found that personal problems were the single most often cited reason that low-income African Americans did not seek adequate prenatal care.

There are limited studies that include both women who received prenatal care and those who did not to compare the differences in perceptions of barriers in the two groups. Mikhail (1999) examined perceived impediments to prenatal care among low-income African American women. A convenience sample of 126 African American women who had a child one-year-old or younger was obtained for the study. Women were recruited from a community health center located in an African American neighborhood, two WIC (supplemental nutritional program) offices, and the main welfare office of a city in central California. The ages of the participants ranged from 14 to 44 years. Most of the women were single (81%) and 97% were receiving public assistance. A structured interview and questionnaire was designed by professionals experienced in the field of maternal child health and administered by an African American research assistant.
Adequacy of care was measured by the Kotelchuck Index. This index is based on two dimensions—the adequacy of timing of visits and the adequacy of services received.

The impediments that were most frequently reported by all women as the causes for delay in getting prenatal care were, in order of frequency, transportation, long waiting time, having too many other problems, not having problems with previous pregnancies, afraid of someone discovering substance use, and fear of having a medical examination. Many of the women (30%) indicated that they had too many other problems that made it difficult for them to obtain prenatal care. Significant differences were found between those who received adequate care and those who received inadequate care. Those with inadequate care were afraid that staff would find out about substance use, expressed fear of medical examination, did not feel that prenatal care was needed, and did not have childcare for other children. Similar to findings from the Reis study, the cost of prenatal care was not an impediment to utilization.

Studies in this category indicate the need to examine the adequacy of prenatal care in terms of utilization, content, and quality and, more importantly, to begin to address the perceived impediments to care expressed by African American women. These studies indicate that residents of African American neighborhoods vary in their views and definitions of infant mortality. Many who receive services often have priorities that are different from those who provide services. One documented example is that offering free prenatal care does not increase utilization. It is important to note that women who receive adequate prenatal care share some of the same concerns as those who do not. One of these concerns, waiting time, has been documented for three decades as an impediment to African American women receiving prenatal care (Watkins, 1968) and remains
inadequately addressed. While the research is limited, it is troubling that the results of studies suggest that the content of prenatal care is different between some black and white women. The content of prenatal care is not consistent. Evaluations made of statewide Medicaid enhanced prenatal care programs give promising results regarding increased enrollment and early indications are that low birthweight rates decrease with increased enrollment. In spite of this, the research that connects prenatal care with decreasing low birthweight is limited and the mechanisms through which prenatal care decreases low birthweight remain unexplained.

Maternal Health of Black Women and Infant Mortality

The poor health and economic status of African American women has not happened by chance. Several studies are examining the cumulative effects of a lifetime of racism, oppression and multiple stressors on the health of black women. Green (1990) replicated the Arizmendi and Affonso (1984) study that identified the frequency and intensity of stressors related to childbearing. The original study targeted middle-class white women. A convenience sample of 50 African American women was recruited from the prenatal and postnatal clinics at Highland Hospital, the county hospital for Alameda County in California. Women had to meet eligibility requirements, including the absence of medical complications. This hospital serves the county's poor and disenfranchised.

While in both the Green (1990) and Arizmendi and Affonso (1984) studies, the most frequent stressor was physical symptoms, the events that triggered stress differed between the two studies. In the Arizmendi and Affonso study, events that triggered the most anxiety were anticipatory fears; in Green's study external events such as lack of money and jobs were sources of stress. In 1987, while only 20% of the respondents had less than
a high school education, 70% earned less than $5,000 a year. As in previous studies reviewed, education is not seen as an economic equalizer for African American women. The intensity of the stress related to all events was higher for African American females. While most were unmarried, male partner/spouse issues ranked second under stressful events. Several problems arose in an attempt to repeat a study designed for middle-class white women with poor black women. As an example, two new categories were added to the original scale of stressors. These categories were the desperate need for housing and waiting time in the clinic.

Geronimus (1996) examined whether early health deterioration among young adult African American women contributed to observed increases with maternal age in the black/white disparity in birth outcome. Geronimus (1996) proposes the "weathering hypothesis" to suggest that the health of African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage, a physical consequence of social inequality. Black and white singleton first births in Michigan (N=54,888) were analyzed using data from linked birth and infant death certificates augmented with census-based information. Among blacks, advancing maternal age above age 15 years is associated with increased risks of low birthweight (under 5 lbs. 8oz.) infants and very low birthweight (under 3 lbs. 4 oz.) infants. Among blacks in low-income areas, the odds of low birthweight increased threefold and very low birthweight increased fourfold for maternal ages between 15 and 34 years. These findings suggest that with advancing maternal age, African American women, particularly those in low-income areas, experience worsening health profiles between their teens and young adulthood. This finding is consistent with national health statistics that indicate that until
age 29 black and white women have equal chances of being diagnosed with hypertension. After age 29 black women have a three-fold disadvantage. Collins and Hammond (1996) had similar findings from research that looked at race and risk of preterm, non-low birthweight infants. They also concluded that the African American infant mortality differential is larger at older maternal ages than at younger ages and that a cumulative pattern of racism may explain health outcomes. A more recent study by Shumeuli and Cullen (2000) also found that black women have a progressive decline in birth outcomes with increasing age starting in adolescence.

Ren, Amick, and Williams (1999) conducted research to examine health implications of discrimination. Specifically, they examined how self-perceived unfairness was linked to self-assessed health status. The National Survey of Functional Health (NSFH) was mailed to participants drawn from the 1990 General Social Survey sample, a nationally representative sample of English-speaking persons 18 years or older living in non-institutional arrangements within the United States. The NSFH contains multiple measures of self-perceived health as well as self-reported discrimination. Of 2,474 respondents, 1,819 returned the survey. The response rate was 77% for whites and 64% for African Americans. African Americans reported more incidences of discrimination due to both race and socioeconomic status on a regular basis. Experiences of discrimination had a strong negative association with health and accounted for some racial/ethnic differences in health status. Black middle and upper class respondents reported more experiences of discrimination than lower class blacks. Perhaps they become more aware of discrimination as they matriculate through systems traditionally closed to African Americans. These results are similar to two recent studies. Schulz and
colleagues (2000) found that African American women regardless of where they lived reported more unfair treatment in their daily lives than their white counterparts. Collins and colleagues (2000) found that maternal perception of exposure to racial discrimination may be associated with very low birthweight in their infants. This relationship between discrimination and the social class of African Americans needs further research.

Fiscella (1996) examined the role of urogenital infections in contributing to the high risk of preterm births prevalent in black women. A computer-assisted search of Medline and a manual search were utilized to find published studies in the area. Estimates of the relative risk for preterm birth were extracted from published studies for the following infections: gonorrhea, syphilis, trichomoniasis, chlamydia trachomatis, Group B streptococcal vaginal colonization, asymptotic bacteriuria, genital mycoplasmas, and bacterial vaginosis. Estimates of the prevalence among black and white women were extracted from published research reports. The attributable risk was calculated for selected infections and the impact of the racial disparity in preterm births. Fiscella (1996) found that black women have higher rates of urogenital tract infections than do white women. Reasons for these higher rates are not clear. One explanation is that black women received less prenatal care than white women did allowing infections to go undetected. Bacteria vaginosis and bacteriuria were found to increase the risk of preterm birth. Significantly higher rates of bacteria vaginosis were associated with 30% of the racial gap in preterm birth; bacteriuria was associated with 5% of the racial gap in preterm birth. These findings are limited by the reliability of published estimates of prevalence and relative risk for these infections.
Rey (1997) examined the relationship between mild chronic hypertension (more prevalent in black women than in white women) without confounding factors of disease to the incidence of preeclampsia, neonatal mortality and morbidity among white and black women. A secondary analysis was conducted of a subset of a cohort of women with chronic hypertension. The sample included 208 white women born in Canada and 74 black women born in Haiti. All women delivered infants at Sainte-Justine Hospital in Montreal, Quebec, Canada from 1987-1991. All normotensive white (17,677) and black (2,400) women who delivered at the same hospital during the given time frame were used as a control group. A research nurse recorded maternal and neonatal data. Data were analyzed with SPSS 4.0 software. A two-tailed p<0.05 was considered statistically significant. Black women were older and had had more previous pregnancies. Fewer black women smoked or had good prenatal follow-ups. Black chronic hypertensive women without preeclampsia had significantly more perinatal deaths (p<0.01) and premature deliveries (p<0.05) than black controls and white women with chronic hypertension. Black women also had a significantly greater incidence of preeclampsia and perinatal mortality than chronic hypertensive white women. It is possible that black women have more serious hypertension than white women do. It is not clear whether or not black women from Haiti and US black women share similar lifestyles and health profiles. These findings are not consistent however, with a research study conducted by Irwin and colleagues (1994) who found that US black parous women in a military population had a slightly reduced risk of all pregnancy-induced hypertension. Women in the military tend to be more disease free than the general population of women.
Woolbright and Harshbarger (1995) examined the revised standard certificate of live birth to find out if one of the new items, medical risk factors for this pregnancy, provides useful data. Birth certificate data were analyzed for Alabama residents for the years 1988-1992. A total of 308,573 mothers responded to this question. The most common medical risk factor was pregnancy-associated hypertension. Among other common conditions were anemia, diabetes and a previous preterm infant. There were racial differences among the medical risk factors. Blacks had significantly higher rates of anemia, chronic hypertension, eclampsia, and previous preterm or small for gestational age infants. These data were found to be useful in examining the health of subgroups and populations in regard to the likelihood of a low birthweight infant. These findings are supported by both Kempe and colleagues (1992) and Orr and colleagues (2000) who found that the associations between certain clinical risks and pre-term birth were stronger for African American than White women. They also suggest that attention to clinical risk factors among African American women may be important in improving birth outcomes and that comprehensive strategies are indicated.

Investigators in this category are attempting to connect the effects of a lifetime of racism and disadvantage with the disparate birth outcomes of African American women. An important finding by several investigators is that the health status of black women deteriorates beginning in adolescence. This is consistent with recent data from the NCHS (Mathews et al., 2000) indicating that a black teenager and a black woman in her late twenties and early thirties have the same risk for negative birth outcomes. It will become important to understand the connection between racism and infant mortality more fully. Equally important, some reports indicate that knowing and understanding specific
medical risk factors that black women are more prone to will decrease negative birth outcomes.

Discussion

While overall infant mortality rates decreased during the last decade, powerful racial disparities remain. Singh and Yu (1995) project that in the year 2010, black infants will continue to die at a rate twice that of white infants. The Healthy People 2000 (NCHS, 2001) goal of significantly decreasing the racial disparity in infant mortality has not been met. While this goal remains unmet, the goal of Healthy People 2010 (Keppel et al., 2002) is to eliminate racial disparities in health. Infant mortality is one of the indicated areas. Given the dismal projections by investigators and recent reports from the NCHS, it will take a concerted interdisciplinary effort to define the research agenda and increase theory and knowledge in the area of infant mortality if racial disparities are to be eliminated.

Social science researchers in this new century have a challenging task before them. They must continue to study race, racism and its connection to health, in a country where blacks and whites still tend to live in separate communities, neighborhoods and townships; worship in separate churches and maintain separate professional organizations. In many ways America remains a segregated society. Concurrently, traditional ways of classifying by race are changing. Historically, a child that resulted from the union of parents who were racially different assumed the racial category of the lowest ranked group (the non-white parent). There continues to be little argument about which members of our society are white; there are now many definitions about who is African American and what it means to be African American.
The argument about what race actually is will continue; some will see race as a genetic designation and others see race as a socially constructed term (Mukhopadhyay & Moses, 1997). Medical anthropologists argue that the assumption that blacks, whites, Asians, and Native Americans each constitute a race based on biological ancestry is false. They indicate that this assumption of racial identity (purity) have misled efforts to identify correlations between race and certain diseases and disease proclivities (Anderson, 1996). Race is complex and hard to define but, regardless of what it is, it appears that one's race determines who receives the best health care, who benefits from marriage and education, who lives the longest, who attends the best schools, and whose babies die the most.

The daunting task of addressing race and infant mortality must begin by addressing epistemological issues. According to Rubin and Babbie (2001), epistemology is the science of knowledge. Its subfield, methodology, is the "science of finding out" (p. 5). There are many ways of knowing and research methodologies are selected depending on the aim of inquiry. Disciplined inquiry is guided by paradigms (Guba, 1990). Paradigms organize observations and make sense of them (Rubin & Babbie, 2001). According to Guba (1990), paradigms are characterized by the way three basic questions are answered: Ontological (the nature of the knowable), Epistemological (relationship between the knower and the known) and Methodological (how the investigator finds out knowledge). Various authors use different terminology to define and label paradigms. Rubin and Babbie (2001) indicate that four paradigms currently are the subject of debate about the best way to conduct research in social work and the social sciences. These paradigms are positivism, postpositivism, interpretivism, and critical theory.
The positivist believes the pursuit of science is to control and predict. Under this paradigm reality exists and this reality can be discovered in an objective manner through a methodology that controls for inquirer bias. It is necessary for the inquirer to maintain a distant, impersonal posture. Research questions are stated in advance and are subjected to empirical tests under controlled conditions (Guba, 1990). Similar to the positivist, the postpositivist seeks to verify causality and emphasize objectivity, precision, and generalizability in their inquiries. They too are sure that reality exists, but they are not sure one can know when it is uncovered; objective reality is seen as intangible. Research is seen as a never-ending and self-correcting search for knowledge that requires the replication of findings by different investigators. Investigators believe it is possible to use logical techniques and arrangements that will reduce the influence of personal values on the findings (Rubin & Babbie, 2001), but feel it is impossible to be objective in the absolute sense (Guba, 1990). Both quantitative and qualitative research methods are utilized by the postpositivist (Guba, 1990).

Interpretive researchers do not seek to discover causes and make generalizations. They attempt to understand how people feel and interpret the everyday experiences that people have. These investigators interact with people in their natural environment and develop an in-depth subjective understanding of the group studied. The methods used are flexible and do not rely on objective measurement tools. Social reality is not seen as being complete without understanding how the group studied perceives the world and creates their own reality (Rubin & Babbie, 2001).

The aim of inquiry in critical theory is to raise oppressed groups to a new level of consciousness (Guba, 1990). Both highly structured and flexible methods are used;
however, it is the way the findings are interpreted that distinguishes this paradigm. Critical theorists interpret findings through political and advocacy filters (Rubin & Babbie, 2001). Paradigms are not good or bad; however, findings are influenced by the methodology selected.

Given the above definitions, it appears that postpositivism has been the overarching paradigm that has guided the inquiry of African American infant mortality. As a result of my literature review I conclude that knowledge production and dissemination in the area of African American infant mortality is at a crossroads. The major focus of research in this area has been to determine the causes of low birthweight and predict which women are more at risk for adverse outcomes. When it was identified that African American women were at higher risk, numerous studies were conducted and replicated. These studies have been largely quantitative and samples have been drawn from a variety of numerical data sets. The principal investigators have tended to come from the medical and public health communities. Prior to 1990, most studies examined individual health behaviors of pregnant women and the utilization of prenatal care. During the 1990's several investigators examined areas previously unexplored that linked the maternal environment to infant mortality. Yet, there was no defined research agenda in the area of black infant mortality and even in these studies, the mechanism or the processes through with these factors influence pregnancy outcomes remain unexplained.

The focus of the research should and is changing. Should the paradigm also change? Traditional infant mortality studies have not sought to find out the worldview of African American women, but instead how her behavior could be modified to come close to that of 'an ideal pregnant woman.' Even studies that suggest that oppression and racism
have compromised the health and childbearing abilities of African American women
have done so without their collaboration. Thus, the black woman remains an enigma in
most studies. While it is clear that race is a risk factor for low birthweight and infant
mortality, the specific aspects of race which account for this relationship are largely
unknown. While race has long been and continues to be a major stratifying agent in
America, it is unclear what it is about being an African American woman that leads to her
increased risk of infant mortality. To advance the study of this complex relationship
between race and infant mortality will require additional paradigms to validate and
include the perspective of African American women.

How valuable is knowledge obtained without the collaboration and input of the
group studied? Should African American women have epistemic privilege under a new
paradigm? Narayan (1994) makes several observations about epistemic privilege
applicable to this question. Epistemic privilege is the claim that members of an oppressed
group have a more subtle, critical knowledge of their oppression than non-members
(Narayan, 1994). According to Narayan (1994), the oppressed can be said to have
epistemic privilege when it comes to the knowledge of the lived experiences of everyday
life under oppression—how it defines and affects their lives. Narayan (1994) states that,
"No explanation of a form of oppression can be adequate that totally fails to account for
the way it is experienced and described by the oppressed; questions that the oppressed
raise have assumptions that are theory-laden and may serve to shatter the neat
explanatory paradigms of outsiders" (p. 180). Without the collaboration of African
American women and the historical context of their health and sexuality in America, the
knowledge of infant mortality remains incomplete.
Incomplete knowledge can be harmful. It could be argued that the very knowledge that has been generated to help African American women have better pregnancy outcomes has inadvertently had adverse effects on her already negative stereotype. In the majority of studies there is an absence of historical and political frameworks. In a group that has been as marginalized as African American women, the absence of these frameworks leaves them to be seen as misled women who need to be taught how to be good pregnant women, if indeed they must have one more child. According to Rowley (1994), a relatively small percentage of adverse birth outcomes in African American women can be attributed to unwise behavior of the mother. Yet, African American women are often portrayed as contributing to the disparity by using drugs and not seeking prenatal care. They are not given any acknowledgement for survival and resilience in the perilous situations that disadvantaged women often find themselves. Historically, black women have not been sent messages by American society that they are worthy or should take care of themselves, only that they are to take care of others. Even if a 30-35 year-old African American woman has not performed tedious domestic work or some other menial task, odds are that she knows of one of her female relatives who has. Many black women of childbearing age, particularly those who lived under the remnants of the Jim Crow laws in the South, were denied adequate medical care as children. Relatively speaking, this notion of promoting the health and well being of black women is a new one and should be understood as such.

In social work the following controversial question has been raised: Are some research methods biased against people of color? Song (1994) argues that traditional empirical research methods are biased against people of color.
Research that documents only differences between races offers no understanding of why those differences exist or how such differences may be attenuated; and therefore, it tends to reinforce (or create) any negative stereotypes. Furthermore, this approach implicitly promotes an understanding of minority issues as residing within individuals, despite social work's commitment to a "person-in-environment" approach...This frame of reference, bolstered by "scientific" findings, has a kind of institutionalized legitimacy that may discredit minority views and disempower minority communities. (p. 24)

Investigators also have voiced their frustration with the state of the current research as they indicate the need to find new ways and methods to enhance the current understanding of African American infant mortality. Perhaps the following statement from Collins and Hammond (1996) best sums up the current research paradigm crisis:

Clearly, a broader research paradigm is warranted. It should take into account the heterogeneity of experience in the African-American population especially as it relates to the political, economic, and historical reality of the color line drawn by institutional racism. Novel risk factors amenable to intervention may emerge from such a research agenda. (p. 336)

While it is obvious that a paradigm shift is needed to advance knowledge in the area of African American infant mortality, it is possible that no one paradigm can operate alone to discover new knowledge about this complex issue. I argue that a paradigm shift is needed, but only in the sense that alternative paradigms operate along with the traditional ones to advance knowledge. It would indeed be a new and creative way of thinking if multiple ways of knowing (Hartman, 1990) could be validated without any one of them seeking hegemony. There is nothing wrong with attempting to control and predict infant mortality. It appears that without this type of knowledge, we would not know with certainty that the racial disparity exists. It also appears that without additional ways to obtain knowledge, we will only know that the disparity exists; currently

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knowledge in this area appears to be paradigm-locked. Wise and Pursely (1992), two
highly respected investigators in the area of infant mortality, echo my concerns:

Despite the fact that the issue of racial differences in infant mortality has been identified as a research priority, there is still a
high degree of tolerance for repetitious investigation and a
profound lack of strategic coherence in the national research
efforts in this area. The fact that the poor outcome of black
infants is in some measure a legacy of the poor state of black
women's health in general remains unaddressed. (p. 1559)

Most of the current knowledge regarding infant mortality is generated and
disseminated by groups of medical professionals. Much of the knowledge appears to
remain in these professional communities. It is unclear to what extent most African
Americans are aware of the disparity in infant mortality. Many of the prenatal programs
utilize staff representative of the African American community as outreach workers;
these workers tend not to have been included in developing the programs. They tend to be
hired after the program has been designed and the innate knowledge that community
members have is not included in the intervention process. Thus a paradigm shift that
includes the collaboration with and perspective of African American women is important
not only for obtaining knowledge, but utilizing knowledge also.

It is apparent from the literature that there is a lack of theoretical knowledge about
the lives of African American women. Paradigm-locked questions appear to have limited
what is known about African American women, yet, one of her most intimate human
functions, childbearing is being studied. African American women know so much more
than the current paradigm encourages investigators to even consider asking. As an
example, what does a black pregnant woman think and feel when she turns on the news
and hears that a 21-year-old black male has been shot by police 41 times? Questions like
these help build theory about the way some African American women cope and organize their lives. Theoretical frameworks should direct the application of interventions that attempt to decrease infant mortality. As can be seen from the literature review, results of interventions tend to be mixed at best.

Alternative paradigms tend to have a broader view of knowledge and allow for multiple ways of knowing. Sources of knowledge could include a group's folkways, folklore, art, stories and music. Methods could be structured or flexible and include ethnography and case studies (Eisner, 1990; Schiele, 1996). If the knowledge generated is to be adequately utilized in a country as diverse as the United States, then one cultural group can no longer have hegemony over knowledge and knowledge rights. African American women must be seen as having valid knowledge, not primitive mother wit. This tangible knowledge has led to the survival of a group of women who at one point in their histories were treated as field animals as they bore children and cared for multiple families, including their own. African American women have valid knowledge from the layers upon layers of painful experiences in America, the weight and depth of which has not been adequately explored under traditional paradigms.

The Afrocentric paradigm is an emerging alternative paradigm that offers social workers and other professionals the opportunity to learn cultural knowledge of African American women and understand different worldviews that exist in the African American community. This paradigm does not claim hegemony and is grounded in contemporary African American and traditional African philosophy (Schiele, 1996). The crucial role attributed to the African social and cultural experience as a point of reference defines this paradigm and distinguishes it from other bodies of thought (Mazama, 2001). African
Americans have retained some components of African culture (Leashore, 1995). This retention is particularly evident in African American churches, clubs and societies and other structures that have not historically included white members.

Methodological principles are informed by a particular paradigm. Mazama (2001) indicates that Afriocological methodological principles that inform research are: (1) the research problem must be centered in the experiences of African American people, (2) the spiritual is important and must be given its place, (3) cultural and social immersion in the subject is necessary, (4) holism is a must, (5) intuition must be relied upon, (6) not everything is measurable because not everything that is significant is material, and (7) the knowledge generated from the research must be liberating. Methods vary depending on the topic of study, however; they are informed by these principles (Mazama, 2001).

Learning how to understand and incorporate different worldviews could enable researchers to gain valuable knowledge about the mechanisms of racism, race and health that could inform and enrich the findings from numerous studies. One tenet of the Afrocentric paradigm in particular allows for a wealth of knowledge production. This tenet states that the affective approach to knowledge is epistemologically valid, meaning that feelings or emotions are seen as valid sources of knowledge (Schiele, 1996).

The Aim and Justification of the Study

The cultural knowledge of African American women is needed to generate new knowledge and to further interpret the findings of the many studies that have been conducted. Innovative and creative questions must be asked. After completing the literature review, I formulated the following analogy to describe the current state of knowledge about African American infant mortality:
We have a patchwork top (numerous studies indicating the unexplained disparity); we have the batting (these studies have been replicated by numerous investigators); we have the backing (some interventions do lead to better infant health), but we still do not have a completed quilt. It will not become a quilt until African American women are invited to sit at the quilt frame with their thread (knowledge) and along with investigators make all those tiny, intricate stitches that will hold this fabric of knowledge together. An incomplete quilt provides no warmth or protection. In a similar fashion, incomplete knowledge will not enable us as a society to develop strategies to decrease African American infant mortality.

I want to begin to understand the lived experiences of African American women in relationship to the 'black gap' in infant mortality. What is going on in the lives of African American women that increase their risk of infant mortality regardless of income, education, or marital status? The historical, social and political forces that shape the life experiences of African American women are complicated and are deeply embedded in American society. Because of this, I am convinced that greater usage of qualitative approaches would help investigators to unravel and understand the mechanisms by which the life experiences of African American women affect pregnancy outcomes. This partnership would allow research questions to be developed that are grounded in cultural knowledge. In addition, qualitative methods would allow black women to become collaborators in seeking the solution to this perplexing social problem.

The study is congruent with the research agenda proposed by the Office of Behavioral and Social Sciences Research Division of the National Institutes of Health (NIH, 2001). While several summary recommendations apply to this study, the following is cited:

Expand research on social and interpersonal factors that influence health, including racism and other forms of discrimination; social interactions and social networks; social integration, social
cohesion, and social capital; and religion and spirituality. Study the ways in which these factors intersect and the cultural, social, and biological mechanisms through which they affect health. (NIH, 2001, p. 2)

Further support for increased qualitative studies in the area of African American infant mortality comes from the CDC. Recently researchers at the Division of Reproductive Health at the CDC (Rowley, 2001) have proposed that study of the causes of the racial disparity in infant mortality requires a multidisciplinary approach to examine the social and political impact of being an African American woman in the United States. They suggest that racism, and the combined effects of racism, gender and social position be considered as unmeasured etiologic factors that contribute to the gap. Hogan and Ferre' (2001) of the Pregnancy and Infant Health Branch of the CDC further state that, "eliminating health disparities requires a greater understanding of the factors that contribute to their development" (p. 67). In order to move towards accomplishing this goal, the CDC has funded and participated in qualitative studies that seek to understand the social context of being an African American woman. While limited in number, these studies have produced significant findings. Two of these studies are described below.

Mullings and colleagues (2001) conducted the Harlem Birth Right Project from 1993-1997 to improve the understanding of interacting social forces and African American infant mortality. This four-year qualitative study was guided by participatory action research and utilized an ethnographic research design with four components: participant observation, longitudinal case studies, focus groups, and an ethnographic questionnaire. Participant observation was conducted at 10 sites (work/neighborhood). A total of 22 women (11 pregnant) participated in the longitudinal case studies. Eleven focus groups were held (5-10 members in each group), and 83 participants completed the
ethnographic questionnaire. Using community partnership and qualitative methods uncovered important aspects of the social context of the lives of African American women that tend not to emerge through traditional epidemiological research.

Findings indicate that the effects of economic conditions are not clearly distinguishable from the social and political conditions. Low-income women and middle-income black women acknowledged the stress and strain associated with generating income. While low-income women experienced stress associated with relying on a number of sources for income and benefits, middle-income black women, over-represented in the public sector, felt lack of job security due to cuts in Federal and state funding. In the context of constant strain, pregnancy appears to increase the magnitude of the actual and perceived stress as women attempt to access adequate income, find quality health care, and in general, provide for themselves and their families.

Another important finding has implications for prenatal care. Data from the longitudinal sample indicated that bureaucratic procedures for obtaining insurance and enrolling in prenatal care programs could delay the start of care for up to four weeks, particularly for the working low-income woman who is not provided health insurance through employment and is just above Medicaid limits. In addition, the attitudes of health care providers may be shaped by assumptions that individual behaviors, including high-risk behaviors, can be isolated and treated separately from wider social conditions. For the women in the study, medical care was placed in the larger context of all self-care efforts. Equally important, women varied in levels of distrust and engagement in the medical system. African American women with more than a high school education
tended to seek alternative treatment when concerned about quality of care, while women
with less than a high school education tended not to be compliant.

Jackson and colleagues (2001) examined how college-educated African American
women experience racism and what possible implications these experiences had for
pregnancy outcomes. Four hundred seventy-four African American women collaborated
in a study that included focus groups, interviews, and the administration of a pilot stress
instrument developed from the qualitative data. Women's narratives indicated that
African American women experienced significant stress from two major sources: the
obligation to protect all black children from racism and racism encountered in the
workplace. In particular, the historical role of African American women protecting and
nurturing children was a stressor associated with burden. Responding to the needs of
black children in schools, communities and other settings is a significant component of
how the women in this study experienced racism. These investigators ask two crucial
questions: What does having an already full plate mean for the health and well-being of
individuals who are both African American and female? If African American women are
taxed with concerns for the well being of children before pregnancy, what happens during
and after pregnancy? It was concluded that heavily burdened college-educated women, as
a consequence of gendered racism and other forms of stress might be at an increased risk
for poor pregnancy outcomes.

Both of these studies demonstrate the importance of research that attempts to
understand and examine how race and gender are lived and experienced when attempting
to understand the factors involved in the racial gap in infant mortality. Deconstructing the
lived experiences of African American women and relating the mechanisms by which
social realities affect infant mortality cannot be accomplished in a single study. In this study, I used the phenomenological approach to begin to understand the lived experiences of African American women, build inductive theory, and generate additional research questions that need to be addressed in the area of infant mortality. Interpretive phenomenology was selected as the approach to guide this study because it seeks to discover how people make sense of their everyday experiences and how people understand their lives, yet equally as important the researcher seeks to understand the process of understanding (Rubin & Babbie, 2001). It was expected that this method would allow a 'fresh look' at and add new understandings to this well-studied area that remains shadowed and unclear. A discussion of the rationale for selecting the phenomenological approach can be found in the Methods section.

Significance

This study is significant for several reasons. First, the overall objective of Healthy People 2010 is to eliminate, not reduce racial disparities in health. Infant mortality is one of the indicated areas to be addressed. Findings from a study by Levine and colleagues (2001) give dire implications. They conclude that since 1945 there has been no sustained decrease in the black-white inequalities in age-adjusted mortality of life expectancy at birth. Findings like these strongly suggest that it will take a concerted interdisciplinary effort by investigators to begin to define the research agenda and increase theory and knowledge in the area of African American infant mortality if this goal is to be met. The study builds inductive theory in this area and is possibly the first to develop a research agenda crafted by African American women. Second, there are national efforts to have churches, faith communities, and community-based organizations acquire a greater role
in providing needed services to constituencies. African American churches have a history of enhancing the social and physical well being of black families (Billingsley & Caldwell, 1991; Moore & Collins, 2002) and as such is congruent with the mission of the black church. The African American women in this study suggested roles that the African American churches may adopt in addressing infant mortality. Third, historically, there has been a sense of distrust between the African American community and the research community. Most African Americans are familiar with unethical studies, one of the most cited is the Tuskegee Syphilis experiment (Jones, 1993). Similar studies and conspiracy theories have resulted in lack of trust and of participation in medical research by the African American community (Moore & Collins, 2002). This study demonstrates that culturally sensitive medical research can be used to increase the dialogue between these two communities. Finally, and perhaps most importantly, the literature review indicates that with the exception of a few studies, the voice and knowledge of African American women is absent in infant mortality studies. This study is one of a handful at present that allows African American women the opportunity to play a vital role in increasing our understanding of the complexities associated with infant mortality.

Evolution of the Study

I am very interested in understanding more fully the racial gap in infant mortality. While conducting this study I moved closer to understanding how the lived experiences of African American women are possibly related to infant mortality. While an extensive literature review indicated the need for this study, many other significant factors influenced the questions that I have as a researcher and they have evolved over a lifetime. These factors include the knowledge that I have gained as the result of growing up black
and female in the coastal area of South Carolina and Georgia, my experiences as a nurse and a social worker, and my experiences as an African American woman who has given birth to and parented three children.

Always curious I learned how to eavesdrop on the conversations of adult black women at a very early age. As a child listening to their conversations, several things struck me about my black female elders. These women had a secret world that they were in charge of and it was theirs alone. They seemed to know everything and appeared to be able to do almost anything. Many of them wore uniforms almost every day of the week, whether for domestic work or a church organization. When the uniforms came off, their behavior and language were different. I later learned that this symbolic 'shedding of the uniform' would become important in my socialization as an African American female. I too would learn how to look one way on the outside and feel another way on the inside as a way to survive in a society where my skin color made me 'less than' people who were white. I would also learn to know, understand and question phenomenon in the world through various methods including intuition...In some sense my experience as a black woman made me develop skills similar to those needed as a researcher.

My initial knowledge of culture, race and infant mortality came as I listened to my female relatives discuss their dead babies. They often spoke of how old this or that child would be if they had lived. While my family would have been classified as black middle-class during my childhood years, several of my female relatives experienced infant mortality. Even as a child, I wondered why so many babies were dying. One thing I was very sure of as a child was that everything for African Americans, including infants, was inferior. This included health care. Doctor's offices were segregated from the
very entrance labeled 'white and colored.' In addition, the waiting rooms, treatment rooms and medical care itself differed depending on one's race. Most black people I grew up with used home remedies for most complaints and sought segregated medical care for emergencies. This system of poor health care extended to maternity care as well.

The majority of black women gave birth at home and this was most often not by choice. My generation was the first to be born in hospitals in my family; even then my mother had to drive fifty miles to reach a hospital that would provide adequate services to black women. As a result, my brother was almost born in the car. Two of my mother's sisters gave birth to babies born several years after I was born. Both of these apparently healthy infants died shortly after birth. We always felt that if they had received adequate care and monitoring after birth, they would have survived.

My pursuit of knowledge in the area of race and health continued as I pursued careers as a nurse and a social worker during the late 1970's. I saw and experienced many inequities in the medical system as a result of my race. Concurrently, I became aware of racial bias and unethical practices in medical and social research. Very little research was done to elevate the health status of African Americans and most often blacks were portrayed in a negative manner. I was keenly aware of the need for culturally informed research that benefited the group studied.

With each of my pregnancies I became more aware that societal forces exert strong pressures that negatively influence the pregnancy experiences of African American women. My hunch is that something very subtle, yet very real is occurring that negatively affects pregnancy outcomes in black women. One way that this 'something'
can be discovered is to have black women begin to think about the world and their related actions and what it means in relationship to their increased risks for infant mortality.
CHAPTER 3: METHODS

Methods of Inquiry: General

I considered several factors in selecting an overarching method to guide this study. My first consideration was the aim of the study. This study focuses on people and how they make sense of their lives. Another consideration is that both the participants and the researcher in this study are female and African American. This study has overtones of Afrocentricity and issues related to gender. The philosophical underpinnings of the study method would have to be compatible with those of the Afrocentric and feminist perspectives. I have the advantages that come with group membership and shared cultural knowledge. Consequently, I wanted a method that would allow me to state my own biases and assumptions and use this as strength in the process of data analysis. Equally as important, I wanted a method that would enable me to step back and discover tacit knowledge that my biases and group membership could cause me to neglect.

Given the aim of the study and the above-identified needs, I selected interpretive phenomenology as the overarching research perspective to guide this study. As a doctoral student I took an independent study course which focused on interpretive phenomenology. In completing the research project for this course I found that this research perspective not only allowed for an in-depth understanding of lived experience, but that it required that I dig deep within and seek knowledge of myself as part of the research process. Additionally, I have pursued a graduate minor in medical anthropology. Understanding how the social and cultural experiences of black women impact pregnancy is congruent with the objectives of medical anthropology.
Phenomenology is the study of the individual's life world as experienced rather than as conceptualized, categorized, or theorized. The aim of phenomenology is to gain a deeper understanding of the nature or meaning of everyday experiences and while doing so to become more human (Munhall, 1994).

The German philosopher and mathematician, Edmund Husserl, is considered the founder of modern phenomenology. During the early 1900's Husserl sought to understand how consciousness worked in order to understand human experience; however, he was concerned with human experience from an epistemological stance (how knowledge is generated). From this stance, Husserl felt that everything one knows about reality derives from consciousness (Munhall, 1994).

Husserl's student, Martin Heidegger, expanded Husserl's work and argued for a shift from epistemology to a focus on ontology (what does it mean to be a person and how is the world intelligible to us) (Leonard, 1994). Hermeneutics is a method for studying humans that is consistent with the Heideggerian view of the person (Leonard, 1994) and is often interchanged with the term interpretive (Benner, 1994). Key concepts of the Heideggerian view of the person outlined by Leonard (1994) are as follows:

- The person has a world. Within the phenomenological perspective world is the meaningful set of practices, language and relationships that are derived from being born into a culture. World can define a person's possibilities and opportunities. In our world the ready-to-hand mode (everyday taken-for-granted practices) is presupposed by present-at-hand (theoretical knowing). Theoretical knowing can cause the meaning of taken-for-granted everyday experiences to be
missed. It is often through a breakdown in function that everyday practices are best understood.

- The person is a being for whom things have significance and value. One's concerns are based on culture, language and individual situations. To understand a person's behavior, the person must be studied in context. Values and significance only show up in context.

- The person is self-interpreting. People are engaged in and constituted by an interpretive understanding based on particular backgrounds.

- The person is embodied. The body moves with intention in the world and the physical and mental components relate.

- The person in time. This is different from linear time and refers to temporality. Temporality includes how one understands themselves both in terms of the past and projection into the future.

These elements are essential to the particular qualitative approach used in this study. The philosophical underpinnings take into account the connection between the physical body and the mind, the influence of the past, that people interpret the world based on culture, traditions and spirituality, and most important that it is crucial to uncover the meanings behind taken-for-granted everyday experiences when seeking to understand a phenomenon.

Method of Inquiry: Applied

Site and Participants

The study took place in the towns of Blacksburg and Christiansburg, Virginia. These municipalities are located in the New River Valley, an area in southwestern
Virginia, surrounded by the Blue Ridge Mountains. Study informants met the inclusion criteria: self identified as African American (one participant is of Caribbean descent) and at least 21 years old. They were involved in either the focus group or extended interviews. Women were recruited through verbal and written announcements in two churches (Asbury United Methodist Church and St. Paul African Methodist Episcopal Church) and listservs for African American faculty, staff and students at Virginia Polytechnic Institute and State University (Virginia Tech), and Radford University.

A total of 13 women participated during the three-month period of data collection of April-June 2003. Informants could choose to be a member of the focus group, to have an extended interview, or to participate in both the focus group and have an extended interview. None of the informants elected to be in both the focus group and to have an extended interview. Seven informants initially arrived to participate in the focus group; however, two had to leave due to an emergency involving the pastor of the church before they were able to contribute. This emergency was related to the pastor's deteriorating medical condition at the time that the focus group met. Sadly, the church pastor passed away several days after the focus group met. These two informants were not included in the total study number. The five remaining women participated in the focus group. A total of eight women agreed to participate in extended interviews. Four of the interviews were conducted in the homes of the informants and four interviews were conducted in my home.

The age of the informants ranged from the early thirties to the mid-sixties. The majority of the women were of childbearing age. Of the thirteen participants, three had experienced a loss as the result of a miscarriage. Nine of the thirteen participants were
married at the time of the study. Of the thirteen participants, ten had experienced at least one pregnancy. The informants in the study were highly educated. All of the women were college graduates. Two women were doctoral students and five women had doctoral or advanced degrees. At the time of the study, most of the informants were employed at either Virginia Tech or Radford University and would be considered middle to upper class based on occupation and education. A unique feature of this study is the opportunity to hear from middle to upper class African American women. Infant mortality has most often been studied within the parameter of poverty (and the connection between poverty and infant mortality appears to be understood), yet all black women are at risk. This provided a platform to examine other factors besides poverty that impact infant mortality. The women in this study included authors and researchers who moved to the area to obtain employment with one of the two universities and native black Appalachian women whose families have resided in this area for one or more generations.

Data Collection

The focus group met at Asbury United Methodist Church on April 26, 2003. I was a new member of Asbury United Methodist Church at the time of the study and had access to the formal mechanisms that the church uses for decision-making. Asbury has an administrative council that includes the pastor and selected church members. Any member can attend the regular council meetings and present an item to be included on the agenda. I attended a council meeting and presented information regarding the purpose of the study and shared pertinent information (confidentiality and consent forms and appropriate materials verifying that Indiana University has approved the study). The pastor and the council members expressed great concern about the prevalence of health
disparities and were very excited to be partners in this study. Participating in this study was seen as congruent with the church's desire to increase its outreach to the community in the area of health promotion.

The African American church has several characteristics that make it an appropriate site for a qualitative study. According to Moore and Collins (2002), the black church is a major player in significant community events and should be used to increase African American participation in public health research. Additionally,

- Black churches represent a heterogeneous social-class structure. Members are not excluded because of economic differences (Moore & Collins, 2002).

- Black churches are centers of community activities—both social and political. It is a natural gathering place for black people. Church membership is not a prerequisite to participation in the church itself or activities held at the church (Billingsley & Caldwell, 1991).

- African culture has been retained in African American churches (Leashore, 1995).

- Most African Americans feel comfortable with research sanctioned by African American churches. The church can assist with engaging the community to participate in medical research (Moore & Collins, 2002).

- Black churches are seen as supportive of family life and activities that enhance family functioning (Billingsley & Caldwell, 1991).

The oral announcement made in the churches indicated that interested persons could contact me in person after church, or by utilizing the church directory (as was the case in my church of membership). Similar information was also printed in the church programs. Additionally, a female church member of St. Paul African Methodist Church
agreed to assist me with recruitment at her church. The majority of the informants came up to me after services and we exchanged phone numbers and email addresses. Of the thirteen informants, eight were members of my church, Asbury United Methodist Church. I called each informant and arranged a time and place to meet. They were reminded by phone and email one week before the interview was scheduled. Informants who chose to be part of the focus group jointly decided on the best day and time that the majority of women could meet.

The initial phase of data collection began with the meeting of the focus group. Focus group interviewing is being used increasingly in social science research (Morgan, 2002) and has several benefits that make it appropriate for this study. These benefits as outlined by Berg (1995) include:

- Often participants gain insights and there is opportunity for social construction versus individual construction of experiences. A larger number of ideas and solutions are available when compared with individual interviews.
- There is the opportunity to observe interaction. Often interaction gives greater amounts of information on experience and attitudes. The researcher has the opportunity to learn how participants discuss issues among themselves.
- Focus groups allow text for phenomenological bracketing. Bracketing is a process of setting aside one's own beliefs in order to be undisturbed by one's knowing.

This group met at Asbury United Methodist Church in the gathering room on April 26, 2003 for two and one half-hours. Consent forms were read and signed by participants before beginning and the entire session was audiotaped. Informants were asked to put their age group and educational level on a slip of paper and place them along
with the consent forms in a large envelope. Most of the informants knew each other and were given fictional names written on large name cards to use during the meeting in an effort to protect identities on the audiotape. Because the women knew each other there was an immediate sense of trust and security, and they appeared to feel comfortable. These women tend to be in situations where they have to maintain a professional demeanor in all aspects, including speech. In this situation with a same sex-gender investigator they felt free to speak in a more relaxed manner--sentence structure did not matter and accents were unimportant. I transcribed the tapes using the language that was spoken. Women were excited to be in a study in which their input would help provide information about a subject matter that they were very concerned about and saw as a problem--the health of black women and infant death. We developed group rules that included: One person would speak at a time, disagreements were allowed, there were no expectations with regards to answers--there could be no right or wrong answers, they were only to share what was comfortable, and silence was okay. We sat around a table with breakfast snacks and in this small, comfortable setting women spoke collectively and individually about experiences affecting the health and well-being of African American women and the possible impact on their pregnancy outcomes. Five grand tour questions guided the focus group discussion:

- What do you believe are the factors most responsible for the higher rate of infant mortality among all African American mothers?
- What is your everyday life like?
- Talk to me about your pregnancy experience or of your knowledge of other people's pregnancies.
• Talk to me about churches and infant mortality.

• What should we be considering in conducting research in the area of African American infant mortality?

The pastor of our church died one week after the focus group met. The entire community was affected by the loss of this great leader. I decided to wait and allow healing and regrouping before continuing with the study. I called the study informants and we all agreed to continue in a couple of weeks. During this period I transcribed the data from the focus group and used it to inform the next phase of data collection, the extended interviews.

Extended interviews used in conjunction with focus groups presented the opportunity to explore in-depth information on selected segments of group data. A major strength of using extended interviews is the flexibility that it gives the researcher. Most often researchers are given information not anticipated and new questions and responses are formulated (Berg, 1995; Rubin & Babbie, 2001). The women in the focus group found it difficult to put the many feelings they had into words unless it was through reliving an experience, or telling a story. As one informant noted, "On top of everything else, our babies die more often, I am having a hard time just wrapping myself around all of this." Women's experiences were so highly interwoven that the discussion seldom focused solely on pregnancy as a discrete element of their lives. Rather pregnancy was seen as occurring in the context of multiple events shaped by current and historical circumstances. Early in the focus group I realized the need to allow the women to communicate in a manner that enabled them to discuss everyday events in their lives. To accomplish this, I added a grand tour question, "What is your everyday life like?" This
approach of allowing women to tell their stories and construct their lives in their own way is consistent with the methodology that I chose to guide the study and was continued in the extended interviews. Therefore, I did not use data from the focus groups to shape grand tour questions as I initially planned, but used some of the information to shape probes only after women told me about their lives and experiences.

Extended interviews were conducted during the months of May and June 2003. Before beginning each extended interview, the informants signed consent forms and I answered any questions about the study. All interviews were audiotaped and the majority of the interviews lasted one and one half-hours. Whether in my home or the homes of the informants, we immediately established rapport. Women were excited about the study and wanted to be a part of it. I began the interviews with one of the two opening statements: "Walk me in your shoes...tell me about being you," or "Use your life experiences to help me understand the black woman's risk for infant mortality. You may start at any point in your life that you would like to." The use of specific probes was varied depending on the content of the interview, but many of them dealt with pregnancy, health care and racism. We sat around tables, on floors, and on steps with cups of tea, food and flowers and had conversations about the lived experiences of black women and the impact of these experiences on pregnancy outcomes.

Before I began the initial phase of the data collection, a major task for me was to temporarily let go of as much of my own theoretical knowledge of the black female experience as possible. I used various techniques to help me with this. Visually, I saw myself carrying the burden of black female experience on my back. This burden was heavy and real, yet it had been carried for so long that the contents were now unknown to
me. Carrying this load left me feeling angry, tired, and frustrated. I challenged myself to lay down this burden so that I would have the energy and insight to ask probing questions that would elicit tacit knowledge and decrease the chance that my own theoretical knowledge would impede the data collection process. I gave up knowing; I no longer focused on what I thought it meant to be a black woman. I was not so sure anymore. Rather than knowing, I questioned others and myself. In a sense, it was a relief not to have this burden, in another way it was frightening because I could really understand how vulnerable I would be as a black female in America without my cloak of knowledge to protect me.

This process of not knowing became a continuous process as I listened to the stories of the informants. In one sense the ability to switch selves was consistent with my life and survival as an African American woman. This experience was different because I pushed self-knowledge aside in order to learn. By not knowing, I helped the participants explore their experiences more fully because I had no set expectations (based on my experiences) for their responses. I asked taken-for-granted questions that were seen in a new light when asked in reference to infant mortality. Conversations became tense at times as participants connected everyday experiences with increased risk for infant mortality. There were pauses as experiences were recalled and thought about in the context of infant death. Informants often said, "I never really thought about it like this before you asked me." A few informants needed probes because they appeared not to be aware of their day-to-day experiences; however, most women began with their pregnancies.
Data Analysis

Data analysis was a fluid part of the entire research process and was not seen as a separate step from data collection. As I collected the data I thought about the lived experiences of the informants and my own experiences and wrote my thoughts, questions, and impressions in a journal. I thought about my life, their lives, and the lives of other black women. I paid attention to everything around me that related to black women and these observations helped me to interpret and tell the story of the participants. For example, Ms. Jessica Lynch was selected as the symbol of a POW from the Iraq war and given high media coverage, a book contract, and a movie deal. Ms. ShoShana Johnson, her black peer, also a POW seized at the same time, was paid very little attention and is struggling financially. While Ms. Lynch was disappointed by the lack of attention given to Ms. Johnson, she still benefited (Arinde, 2003). The black community was outraged, and felt even war could not close the racial divide (Hutchinson, 2003). A white journalist commenting on this said he could understand the feelings within the black community; however Ms. Lynch was blond, fragile, and beautiful and in this society that is who is thought to need protection; she is the one that the media would be drawn to. He simply shrugged his shoulders. Incidents similar to this one along with fiction and non-fiction writings of black female authors aided in my interpretation.

As I continued to become totally immersed in the data, one of the first issues that I contemplated in my journal was that of role strain and black women. This was a natural choice because the role strain of my informants impacted my study. These were extremely busy women. As a result, while the interest in the study was great, it was really difficult to schedule time. Dorothy Height, former President of the National Council of
Negro Women, recently was the recipient of a prestigious national award presented to her by President Bush. Her brief acceptance remarks were "Black women rarely do what they want to do, but they always do what they have to do." These were her feelings after living for more than 90 years in the United States of America. I asked myself what was it that black women have always had to do and wrote some reflections in my journal. The majority of the study informants played major roles in both the black and white communities. These women were the backbones of the black community and at the same time they were the ones that the white community recognized as competent, articulate and who were solicited when African American representation was needed. There were no choices; these women felt they had to meet the heavy demands of two separate communities. I thought about historical and current role strain and the dual community demands on African American women and the particular implications that this has for their health. I also thought about the similarities between middle-class women in this dual role and black women who in a domestic role had the responsibility for their families and the white families they worked for.

Two methods of data analysis were utilized. Inductive content analysis (Berg, 1995) was used with the text from the focus groups interviews and extended interviews as a method of data organization and I followed the method for interpretive analysis as outlined by Benner (1994) to understand the data. Content analysis is defined as a method for transforming the symbolic content of a document (words, or images) from an unsystematic form into a systematic form (Monette, Sullivan, & DeJong, 1994). This analysis uses qualitative data and deductive or inductive techniques (or some combination of both) to develop categories and coding frames. I read and reread the data
many times, including during the many weeks of transcription. Narratives from the interviews were independently coded by hand and I did not use a code list. As a result I had many different key words and phrases after this process. While this process helped me to organize the data and was a good starting point, I felt I was losing the meanings of the stories. In some sense the whole seemed more important than the parts. I could see the components of the lives of the participants, but I did not know the story that their lives told. The data begged not to be chopped up and analyzed in this method, but to be told as a collective narrative of the lives of these participants. I continued to read the data and my journal notes and primarily followed the method for interpretive analysis as outlined by Benner (1994).

The transcribed focus group interviews, in-depth interview data, and field/observational notes were treated as text. Benner (1994) describes three narrative approaches for understanding socially imbedded knowledge: paradigm cases, thematic analysis, and exemplars. According to Benner, the researcher usually enters the world of the participant through finding a paradigm case. Paradigm cases are instances of ways that the participant 'is' in the world; they embody thick descriptions (Denzin, 1988) necessary for understanding how actions and understanding emerge from social context. The entire text is read for global understanding. Events, issues, or concerns are selected for further interpretation. The interpreter will articulate the language, traditions, socially organized practices and other experiences that are components of culture and community. Various paradigm cases are then examined in their own terms and compared and contrasted with other cases for similarities and differences. A thematic analysis is also done to understand similarities and distinctions across cases, but the focus is on finding
meaningful patterns that form themes across the text. These themes are not expected to be consistent; most often people's lives have gaps between what is practiced and what is felt. Exemplars are stories or vignettes that capture meaning and can communicate aspects of a paradigm case or a thematic analysis. The selection of exemplars is central to the researcher's ability to see a growth in his or her understanding of qualitative differences.

All of the informants drew me into their worlds, but two in particular gave colorful, vivid narratives that compelled me to question what I knew about culture, race, gender and health. These two narratives as defined by Benner (1994) became the paradigm cases that were used as entry points in beginning my interpretation. In many ways these two informants were opposite from each other and I found it extremely helpful to compare and contrast the two cases. A segment and discussion of the first paradigm case that I selected is included in the findings. I read both interviews many times and compared and contrasted them with each other and eventually with other cases. I made a list of similarities and differences between these cases and others. Additionally, I made note of what the participants did not discuss. Information that they excluded was as important as what they included in understanding their lives. As an example, all of the participants spoke of painful racial incidents growing up, but several did not mention their marriages.

Utilizing the two paradigm cases as starting points, I cut the transcripts apart and clumped them back together in a manner that formed meaningful patterns. For example, one pattern was that of negative stereotyping. I now had one long transcript and all data were included at this point. I read through it again and pondered how to organize what I considered to be very complex information. I assigned each group of exemplars a broad
theme that came from my understanding of the data. The next task was to select exemplars that would best convey to the reader how the participants lived in their worlds. This was difficult; I felt each line of each story was important. As I selected these exemplars, I increased my understanding of the data. The exemplars/vignettes that I selected from the study data are included in the findings. I spoke as the voice of the participants by formulating a broad theme in the form of a sentence based on my increased understandings of how these individual experiences formed a collective story. Specific vignettes were placed under these themes. For example, one theme I formulated was "Our pain is often swept under the rug." The findings from the study are written in a narrative form that reflects my interpretation of what participants shared with me.

**Validity and Reliability**

As a qualitative study, the intent is not to generalize the findings to all African American women. Rather through written, rich, thick, detailed narratives (observations, quotations) I have interpreted what informants told me to enable the reader to feel, experience and understand the everyday life events that the black women in this study feel impact infant mortality. The informants invited me to open a door and have the reader to walk with them in their shoes, to view the world from their eyes, and to learn from their experiences as they see and understand them. Due to the qualitative focus of this study, the terms trustworthiness and accuracy were used to achieve rigor (Cohen, Kahn, & Steeves, 2000). A major test of the trustworthiness of this study is receiving the "phenomenological nod" (Munhall, 1994, p. 189) from the participants. This indicates that the participants nod in agreement that I have captured their meaning in my interpretation. This procedure is also termed member checks by Creswell (1994) and
Rubin and Babbie (2001) and involves having participants read the data for accuracy. Two informants and three peer debriefers verified the data. I asked the two informants (Hallie and Jossie) whose narratives were initial paradigm cases to verify the data. They were mailed copies of the findings and we discussed them by telephone. These conversations were approximately one hour in duration. The two informants confirmed the validity of study interpretations. Frequent responses were: "This is so true!" "You will never meet a woman better than a black woman." "We have struggled so! I see the struggle and I live the struggle."

I selected three peer debriefers from African American women that I was acquainted with who expressed an interest in the study. They had similar socioeconomic characteristics as the study informants. The debriefers were middle-aged professionals who had some experience with childbirth. Lin is a registered nurse specializing in maternal child health. Dee is a doctoral student who teaches African American history. Corine is an elementary school principal in the Sea Islands of South Carolina. They were given the findings to read and we met in person for our discussions. They verified the data with the following responses (other comments are included in the findings and in the discussion): "Oh my God, this is my life, this is my story." "This is so true. When you live it, you know it, I am not talking about what I heard or about what I think, and I am talking about what I know." "This is the way that it is."

The following exemplar is presented to give an example of the process I used to make interpretations:

Some people think black women are big boned, strong as an ox and just can take anything. When I was going through menopause and was being seen at a clinic they just laughed and said you are big boned and can take a strong dose of medicine if you want
to...But I did not want all this stuff going through my system... they look at us like they did during slavery. There is an area not too far from here where they used to have a place just for inbreeding slaves to produce, like you breed horses, you breed slave children. They think we are big, robust and big boned...we are like oxen and the mentality is that we can withstand a lot being black...that we can withstand most things that a person who is white, so fragile, so glasslike can't withstand and that is the difference. If they can break away from that mindset that just because someone is white, fragile and thin that they have to go that extra mile to take care of her...although we are big-boned you still have to go that extra mile to make sure that the black race will continue... that our generation will continue...we should have measures to nurture ourselves and pass that information on to other generations. In the white world they are going to use everything they can to ensure that their generation will survive, as far as they are concerned we can just die off.

This exemplar overlaps many areas, but what I heard very clearly was "There are pervasive negative stereotypes about us." I used a historical framework to understand this informant's perspective. Historically, the black woman was not seen as needing the protection and care that white women received medically or socially. White men could openly rape black women; however, black men were killed if they were suspected of raping a white woman. I noted the words that the informant used to describe how she felt black and white women were viewed by society. The informant used the words "big-boned," "strong as an ox," and "robust" to describe how society viewed black women. She used the words "fragile" and "glasslike" to describe how white women are viewed by society. Additionally, she used the words "slavery" and "breeding." Generally breeding implies that there is a profit to be made from the production and sale of a superb, strong being, usually an animal. This informant referred to animals in the same breath as she did slaves. She is aware of a site where slave children were once bred. The historical past combined with her current experience make it difficult for her to believe that most whites
really care if blacks live or die. She expresses that black women must begin to nurture themselves and pass this knowledge on to future generations. Holding in pain and putting self last is seen as a negative coping pattern that has been passed from one generation of black women to another. She wants this to stop. In my understanding, although being seen as strong is generally thought of as a positive trait, it is also a negative stereotype because the historical myth of the black woman's strength strips her of her humanity. This informant did not feel that she was seen as needing the same care and protection as a white woman. A group of women, who are descendents of a people bred to be sturdy and strong, have on some level been seen as a type of super being having a supernatural capacity to go through extraordinary pain and suffering without negative consequences. Pain is held in. They can take anything, give everything, create with nothing, and this just makes them stronger and stronger. I understood this informant as saying that this myth of strength is in itself a pervasive negative stereotype that is very harmful to black women in regards to their health and ultimately to their ability to have healthy pregnancy outcomes. Thus, one of the issues for African American women is the internalization of racism with one consequence being the creation of cultural myths. Many harmful stereotypes and myths abound regarding the black woman.

Triangulation is another procedure that has been identified (Creswell, 1994; Padgett, 1998; Rubin & Babbie, 2001) as a way to ensure the validity of a study by using two methods to collect and interpret data. In this study I used several methods to collect data: focus groups, in-depth interviews, personal observations, and field notes and two methods of data analysis: interpretive phenomenology and content analysis. Thus, I
sought convergence between these data sources and analytic methods as a means of triangulation.

This is very likely the first study to use a phenomenological approach to focus on infant mortality with African American females. Phenomenology is a method that requires rigor and should be utilized to further explore infant mortality with African American women. Munhall (1994) has identified several concepts that measure rigor in a phenomenological study; these concepts provided a foundation for this study:

- **Resonancy.** The written interpretation (or at least a part of it) explains a puzzle; it prompts familiar feelings or thoughts.

- **Reasonableness.** The interpretation and the actions taken by the researcher are rational upon evaluation of the study.

- **Representativeness.** The material concerning the phenomenon should represent the various dimensions of the lived experience and add a deeper understanding.

- **Raised Consciousness.** The study helps the reader to understand more fully what it means to be human, to become more conscious of the taken-for-granted experiences.

- **Readability.** The study is readable not only by professionals, but also by the general population.

- **Relevance.** The research is relevant to both the researcher and the field of human science.

- **Responsiveness.** As a result of the study both participants and colleagues are moved to think through preconceptions and possibly change actions in response.
Ethics

Munhall (1994) states "perhaps the most critical, ethical obligation that phenomenological researchers have is to describe the experiences of others as faithfully as possible" (p. 153). This statement formed the ethical heart of this study. This study revealed some of the feelings and experiences of black women that are not generally shared with mainstream society and as such this study was written in a manner that is culturally sensitive and reflective of the truth as seen by the participants. I expected ethical dilemmas to arise as a result of this.

Much of the history of the United States has dark corners of pain, guilt and shame. One cannot think about the founding of the United States without contemplating the plight of the American Indian. While I am an avid quilter who loves fabric, I never look at cotton fabric without understanding the pain that my foremothers and forefathers suffered over greed and the cotton plant. I respect and honor their labor and I stitch it into my quilts. Looking back and processing is a very painful event for many African Americans. My mother once told me that the slave ancestors in my family decided to never look on those days anymore. The horrors of slavery would not be spoken. In order to survive many African Americans have tucked away horrible memories and pain. On another level this pain and these memories allow African Americans to have something that cannot be taken away because it is hidden. In some ways marginalized groups maintain a type of power when the dominant group does not know certain hidden feelings and thoughts. I was asking these women to reveal some of these types of feelings to me and I was ambivalent about doing so. There were times when I did not want to hear what they were telling me.
Part of my criteria for selecting members for my doctoral committee were that they be people I felt were culturally aware and sensitive. In spite of this, there were times when I wanted to omit material in the section on study findings and thereby soften what informants shared with me. Initially, in the first draft of my findings, I wanted to leave out excerpts that I felt would offend some white readers. Also as a black woman a number of these excerpts evoked strong feelings within me. I wanted to finish the process of writing my dissertation and be politically correct while doing so. In one sense, I had to decide how to be a black woman presenting a study focused on race and gender to a largely white audience. I did not want the anger, pain, and hurt that I felt at times during the data analysis process to influence my interpretation and presentation of the findings. It was during this struggle that I realized the inherent validity of the study findings. This study was intended to identify the perspectives of black women, not to make people feel comfortable. There is nothing comfortable about unexplained infant mortality. In this fashion, throughout the study I strove to faithfully gather and reflect the thoughts, feelings, and lived experiences of the participants and myself (where relevant regarding the research questions).

All members signed an informed consent form (Appendix A) that included information about the study, the voluntary nature of participation, confidentiality, and how the results would be utilized. Munhall (1994) indicates that in phenomenological research informed consent is an ongoing process due to the need to renegotiate as unexpected events arise. Glesne and Peshkin (1992) also support the need for this type of flexibility regarding informed consent in qualitative research. There was no indicated need for renegotiations during the course of the study. I adhered to professional ethical
codes governing research from the National Association of Social Workers and the Council of the American Anthropological Association, both of which indicate that the rights and safety of participants are of utmost importance and are to be considered first should there be a conflict of interest. I appreciate the opportunity that I was given to conduct this study in a scholarly, creative manner that honored the dignity and the knowledge of the participants.
CHAPTER 4: FINDINGS

Walk with us in our Shoes

When African American women are not at the table, we lose a sophisticated examination of the concept of race...we just kind of skip over the concept of race. I was on a conference call the other week and we were looking at racial disparity and I asked, Well how did you collect race, what were the variables...did the person self-identify? They said, "Well you know we never really thought about that." Well if race is the focus you need to start with the independent variable, you need to start with the concept. I just threw that out there for all of the studies that unpack the term race. Maya, mother of one.

What is it like to be a black female? How can knowledge of black women's experiences help us to better understand their increased risk for infant mortality?

First this knowledge provides us with a platform to further understand the concept of race, as well as racism and its impact on well being. Secondly, it moves us beyond the narrow view that good health during pregnancy occurs in a vacuum dictated by proper diet and prenatal care alone. The problem of infant mortality should not be viewed as distinct from the contemporary problems of black women and their families. This is best illustrated by a response from Jade, an informant in her early 30's:

The first thing that comes to mind is finances...I don't know, even though they (black women) are in the same class (as white women), maybe they just got there, or they have more debt, or they don't have old money like the white family, or maybe they are the first generation to have this money and get on a different path and they have stresses that the white family is not going to have and so yeah you can be in your 30's and 40's and well educated and still have infant mortality. I think black families have other factors that white families don't have.

The women in this study could not discuss infant mortality in isolation from their lives and life experiences. Reproduction, birth and its aftermath are seen as occurring in the midst of historical and current stressors and factors. They spoke of these stressors and
factors. These informants allowed me into their worlds and often shared incidents that they have not had the opportunity to share with others. They searched deep inside of themselves and shared their insights because they saw the issue of black infant mortality as one that was paramount to them and interwoven into their histories, their struggles and their futures. Perhaps Hallie in her late 30's captures these feelings in this response:

I think about my grandmother and my great-grandmother and what they went through...I just look back. My great-grandmother, I just have the pictures of her, but my grandmother I remember her very well. And I remember what she did to get me where I am and if it had not been for her pushing me to be all that I could be, I would not be where I am now. I don't hope for a lot of changes now in my generation because time is swiftly passing, but I hope that my grandchildren will say that my grandmother made a difference, because she spoke up on certain issues. She was the one that said we are going to change the path of our families and we are going to send our family on this road now, and maybe this will help to decide where my grandchildren will go in life. My road had been a good one, but it has been so hard, so maybe I can help my grandchildren to have an easier road. Look at what the slaves did for us so that we could have freedom that we could stand here and work the jobs that we work, so even though I get tired, I want to make a difference. Maybe my grandchildren will say, look at not only my grandmother, but all the women during my grandmother's era of time that were researchers, were women who were determined to make sure that black women successfully carried, delivered and raised her children and were able to have a strong bond and a strong generation. And like I said, it doesn't change in this generation, it will be those yet to come that will look back and say, well she made a difference. It doesn't always take a lot of difference, it can be a wee bit of difference, but it kept that chain connected, made it even stronger.

Because of the complexity in which African American women have come to know, understand and experience the world, I used an interpretive strategy of grouping the themes and exemplars in the chronological order in which I understood them to occur in the lives of the women. I looked to the past, present and future to understand the lived
experiences of the study participants. While the overarching themes were the constancy of stress and the constancy of racism, I am presenting several broad themes in the form of a sentence that reflects my understanding of the data and to present a collective story. There is some overlap between them. I think that this approach opens up the research window to the many types of experiences that black women feel impact infant mortality. It discourages us as researchers from attempting to put the lives of women in little contained boxes as we consider what impacts pregnancy, but rather it forces us to think about who women really are and how they grew up to become this pregnant woman in the first place. Women are not born pregnant, they grow up to become women and then they become pregnant. Even those who become pregnant as children bring experiences with them. Pregnancy itself is the end result of a very intimate act that is dictated by prior events and experiences in a woman's life—choices she made, choices she was not allowed to make, and choices she did not know that she could make. To begin to understand what African American women bring to the pregnancy experience is in itself a step towards understanding pregnancy outcomes. I have selected exemplars from the data to attempt to help the reader begin to weave together what many African American women bring with them to the pregnancy experience. When names are used in the study, they are fictional.

Thirteen women participated as co-researchers in this study. The African American community in which the study took place is small and close-knit. Given this, I will introduce the reader to each informant presenting very limited information to protect her identity. Meet the informants:

- Hallie is married and the mother of two children. She is college educated and is in her late thirties.
• Jade is an unmarried woman in her early thirties. She is a doctoral student and has experienced an infant loss.

• Maya is married and the mother of one child. She has advanced educational degrees and is in her mid-thirties.

• Thea is married and the mother of three children. She has advanced educational degrees and is in her late forties.

• Ruth is married and the mother of two children. She has advanced educational degrees and is in her late thirties. She has experienced an infant loss.

• Iris is married and the mother of three children. She is college educated and is in her mid-sixties.

• Jean is married and the mother of three children. She is college educated and is in her mid-thirties.

• Cinna is unmarried and does not have children. She is a doctoral student in her early forties.

• Jossie is divorced and the mother of one child. She is college educated and in her late forties. She has experienced an infant loss.

• Bea is married and the mother of three children. She has advanced educational degrees and is in her early sixties.

• Lu is married and the mother of two children. She is college educated and in her mid-sixties.

• Bev is unmarried and does not have children. She has advanced degrees and is in her late fifties.
• May is married and does not have children. She is college educated and is in her early sixties.

I begin the presentation of the findings with a portion of the first paradigm case that I selected during the initial phase of my interpretation. I selected this narrative as my paradigm case because this informant's lived experiences provided an excellent starting point in which to examine the complex relationship between race, gender, and health. Her life story made me think and formulate questions. This participant grew up in a very segregated area where she experienced the negative physical and psychological trauma of racism. To this date, her hometown is one that has limited opportunities for African Americans and unfortunately is among many such areas in this country. This interview took place at my home one late afternoon in June 2003. This informant is the mother of two, college educated, married, and a health care professional. Her fictional name is Hallie and I have entitled her interview as 'An Elderly Woman Told Me I Was Pregnant'.

Paradigm Case

An Elderly Woman Told Me I Was Pregnant

In this segment of the interview Hallie describes what health care was like for black women in her community less than twenty years ago. She received inadequate health information, but had been socialized to not question the white doctor. She took the information given as the truth. African Americans living in rural white communities saw outward obedience as one method of survival. In this instance she was given potentially devastating information suggesting that she was infertile. Not only was the information inadequate, but also was presented to her in a very insensitive manner. This misleading information almost cost her her life. An older black woman knew what she herself did
not...that she was pregnant. Interestingly, an older black woman informed me that I was pregnant before taking a pregnancy test. From a historical perspective black women once played a significant role as midwives and knowledge providers in their communities.

I: Thank you for agreeing to participate in this study, I am excited to find out what your thoughts and feelings are on African American infant mortality...Why do more babies born to black mothers die more often than those born to other mothers? Using your life experiences please help me understand this. You may start with any experience, or at any point.

P: Well, I find it easier to talk about my pregnancies. I know what I went through when I was pregnant with my two children and inevitably did not deliver vaginally, but had C-sections due to complications. I will focus on my first pregnancy. Growing up young girls should always see a gynecologist for their pap smears just to see what the doctor says and what it is like and I don't remember doing that. I was of age and went to the doctor to have my first pap smear. At that time the doctor told me I would never have children due to the placement of my cervix. He was an older white doctor and did not spend much time with me, just said you are fine right now and you will probably never be able to have children. So I took that with a grain of salt and went out thinking well he has told me that so that is what I am supposed to believe. Many years later I met my husband and told him I could not have children and he accepted that as a fact. We decided that that was okay and maybe eventually we would adopt. Therein we figured out pretty soon that the doctor was wrong and I was almost into my fourth month of pregnancy before I knew I was pregnant simply because I did not expect to become pregnant. I had the typical signs, the nausea, the weight gain and whatever, of course you put it off to well I am

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gaining weight because I am married and that's typical for new couples, or having a virus. I got really, really sick one day to the point that I thought I was going to pass out and I thought I was dying, so I asked my husband to take me home to my parents, that's how bad I felt. When we got to the doctor an elderly lady that worked in the office asked me when was my baby due and I told her I was not pregnant just sick and she told me, no you are pregnant, I can tell you are pregnant. And the doctor came in and they did a pregnancy test and sure enough I was pregnant. Well four months has passed and I had no prenatal care. I did not drink or smoke and I felt my diet was pretty good so I thought things wouldn't be that bad... only to find out that I was a diabetic and was hypertensive. My pregnancy was not the smoothest one, but I think a lot of women think that if they eat well and do well that will take care of it, but it's a lot of things that women, especially black women do not get that they should.

I: Please elaborate on what black women don't get, spell it out for me.

P: Well, the doctor did not elaborate on the fact...it wasn't that I couldn't carry a child or conceive a child, it was simply that my uterus was tilted backwards, or tilted somewhat to the back which makes getting pregnant harder, but it doesn't mean that you can't conceive.

I: So you found out later that you could conceive, but that it would be more difficult to do so?

P: Yes and I think that happens with a lot of women. You tend not to question the doctor and particularly in the area that I was raised in. We just go in and they kind of see you and slide you on and see the next person.
In this segment Hallie explains that healthcare was not always available for blacks in her hometown. When available, healthcare was inadequate for blacks. She provides several themes to describe the racist behaviors displayed by white doctors. These include dishonesty, disinterest and providing a false or incomplete diagnosis. I could not help but think of how vulnerable a sick pregnant black woman could be on a day when the white doctor would not see a black patient. This segment raised two issues for me: 1) Hallie shared that she felt diabetes and hypertension are hereditary in black families. I wondered if black families inherit these medical disorders, or do they inherit the life conditions and circumstances that lead to these disorders. 2) In a study focused of adequacy of prenatal care, the reasons that Hallie gave for not having care that started in the first trimester could easily be misinterpreted without knowledge of her history. Given Hallie’s experiences I wondered how much data in this area has been misunderstood? Hallie eventually left her hometown after marriage. The words "slide through" and "in and out fast" describe care from her white doctor. The words "took time" and "explained medical condition" are used to describe medical care received from her black doctor.

An elderly woman who worked in his office told her she was pregnant. This wisdom that was shared with her by the elderly black woman reinforces the obligation that she feels that black adult women owe to young girls. Hallie shares that this historical role of giving advice and teaching young girls about their bodies, sexuality, asking the right questions and making good choices will positively impact infant mortality. She provides themes that describe what happens when this is not done. Themes identified include having babies for paychecks, having babies for someone to love, misinformation, inadequate preparation, and not seeking medical care.
I: Why in the area that you were raised in?

P: Because there was a lot of racism in that area and you had no black doctors and there were only one or two white doctors that would choose to see black patients...

I: Even in your day?

P: Even in my day and they were very selective of how they would do that...they may say I am not seeing patients today or I have a full patient load, things of that nature...so they were very selective of how they would present that little racism. When they saw you they would quickly move you through the office so you didn't question it, you just did what you had to do and whatever they said you kind of accepted it and of course being young you don't know to question those things. As you get older you see things differently, but by that time I had left the area. Of course with this pregnancy, I had a black doctor who took a lot of time with me and he told me I was fine, and there was no reason why I couldn't conceive and no reason why I couldn't carry a pregnancy. It was just that the uterus was tilted back and no reason that I couldn't have a pregnancy with that. I did end up with gestational diabetes and high blood pressure due to the pregnancy and I think that is hereditary pretty much in the black family, but things were controlled with diet and a lot of things I had to give up, but I did have my baby. I grew a very large baby and that is the reason I couldn't deliver him...he was at 10 lbs. and I am a tiny woman. I was wearing a size eight when I conceived and a twenty-two at the end of the pregnancy, and it was a long pregnancy and I was sick, but I never had to be hospitalized. I think a lot of women don't seek medical care because they just don't know and I think if we educate our young black women at the age of menses when they start their period we prepare them and educate and teach them and that will save them. When they hear it so
many times they will understand, this is what it is and this is how it works and this is what I need to look out for. If given correct information, I would have realized I was pregnant, but I didn't...it took an elderly woman to tell me I was pregnant, not a pregnancy test. It all comes back to education and I think our young girls are not being taught the things they need to be taught otherwise our young girls wouldn't be out having sex unprotected and conceiving these babies they are not ready to carry simply because their bodies haven't matured enough to carry these pregnancies. Even though I did not lose my pregnancy, I was able to carry it because I got medical care in time. Had I not, you know when I in, my blood sugars were 400 and had I not gone in at that time I could have lost the pregnancy. As young women we are told things and we are not questioning it and I think if our young girls are taught about their bodies, then they will learn, know and seek medical care. When you are pregnant you have to have the extra vitamins, proper rest, nutrition and stress free environments and that is hard in this day and time to do that. Girls are going to have to learn if I am having this baby it is not just to get another check from the government it is to nurture this life that I carry and to raise it and they don't see this because they are in environments where they want the check and they also want someone to love.

In the final segment presented, Hallie describes a destructive cycle that some black girls have learned in order to survive. Additionally, she shares experiences that reflect the negative stereotypes held by society regarding black women. These stereotypes (too young, uneducated, unmarried, poor) were a challenge to her while pregnant and were a source of additional stress for her. Equally importantly, she indicates what she did to prepare for motherhood, all of which contradict commonly held
stereotypes. It is no longer possible for women to receive financial assistance for giving
birth to a child; however, as indicated by this informant people still believe that this is the
way that the welfare system works.
I: Okay you mentioned them wanting the check and being in an environment...how did
this happen where black women want a pregnancy to get a check?
P: They have watched their mothers do this and it is a vicious cycle and when you see
children that live in poverty stricken areas or section 8 areas you see them playing the
system and girls 14 and 15 years old are not physically or mentally ready, but they want
that check and these children are not getting the medical care that they need and they
need mental health care because these children are not ready for the pain that comes with
delivery or the post-partum things that happen because they don't know themselves less
than the change that will occur....but back to myself I did make it through the pregnancy
but the next time when I conceived I knew right away and I knew how I felt and how my
body felt...I took a pregnancy test and it was positive and I immediately made the
appointment, I knew because I had been there before and knew what to expect and the
second was a lot easier even though he was a bigger baby than the first..10 lbs. 2 oz. And
he was 23 ½ inches long...I am 4'11 and I was baby from here to there. With the first and
second pregnancy I did look like a child because I was a small woman and a lot of people
thought I was a child and I got snide remarks like why are you having a baby at your age
and I found myself telling people that I was an adult.
I: How did it feel to be perceived as a young black teenager having a baby?
P: It was kind of hurtful because I knew all my life I had not been that kind of person and
I did not want people who met me for the first time to perceive me as that kind of person.
I wanted people to see me as a young black woman with a good job and a husband, I owned my home, I owned my cars and I was making a good life for my children, not just having babies for the system, but people tend to look at you right away for that before they spoke to you and understood you for who you were...they just said, oh I thought you were a teenager having a baby and they did not look at you as who you were just here you are another black girl that was pregnant. They never thought that I had put my time in and graduated from college and I had gone through the whole nine yards to be who I am and where I was and where I was in life. And I said I am not a child, but an adult and probably older than them at the time. That was a big, big challenge for me during my pregnancies.

Themes and Exemplars

*Once Upon a Time Life Was Not So Pretty for Little Black Girls*

Whether the women were 60 or 30 years old, most told of negative experiences that involved race while growing up. For black women childhood does not provide a grace period, rather it represents a time when they are given subtle messages indicating their inferior status. These negative experiences involved being told they were not as smart, or pretty as white girls, being physically hurt as they integrated public schools, and learning that black girls weren't expected to be smart. Ruth, a mother of two, in her late 30's tells of white privilege, low expectations, and the limitations that can result:

Well in elementary school I did have wonderful white girlfriends who would come over and play...I grew up in Kansas. But things changed...after elementary school, life happened. Privilege kicked in...they started getting better grades, not because of their academic abilities...but who they were...I was always smart. I was placed in all upper level courses in 7th grade, my teacher knew my abilities, but I did not do well. I remember feeling so uncomfortable and so alone and some of the teachers in 7th grade
had low expectations of me...I remember that well. And I think those kinds of things kick in when we get older. Those kinds of external expectations, which limit what, we are able to do.

Some experiences recounted involved physical trauma as illustrated by Hallie, a mother of two in her late thirties who tells what her daily life was like as she rode the bus to school. Hallie uses the word protection many times in this excerpt. From a cultural perspective the need for protection operates in a circular manner. Older members of the community are to protect younger members; these younger members must then extend the same role to others. This obligation to protect is often keenly felt by African American women:

You know growing up I went through integration and I had to ride the bus and it was just my sister and I and we were the only two black kids on the bus and they spit on us, they took our coats, they made us stand up and this was a daily situation, not just one day, it was an everyday thing, we had to deal with it on a daily basis and when you got on the bus you just prepared yourself because you knew before you got off that bus you were going to get spit on, you were going to be hit. Finally it got to the point where other black kids were riding the bus and they were older black kids, and they would protect you and so you looked to those kids to protect you and that's why I look at these young girls that are putting themselves in harms way by having sex, unprotected sex and getting pregnant and we as young adults or we as women should try to protect these children even if their parents don't, cause a lot of them don't have parents to protect them and we should tell them that they shouldn't be doing this cause a lot of them don't know that they shouldn't be doing this.

May in her early 60's recalls a time when as a little girl she witnessed a little baby die because of lack of access to medical care that was a direct result of racism:

I can remember one time when I was a little girl in the country, and my stepmother lived in the city, and I was in the city at this particular time, and this little baby was sick. Very sick. And they were trying to get a doctor to take care of the baby. But that was on a Sunday, and no doctors would go to black families, and they couldn't get a doctor to take care of the baby and the baby died.
So that was part of not getting what we need to take care of our children, and stuff like that.

These types of experiences become the foundations for which many African American women learn to view the world.

*We Navigate Between Two Worlds*

Often African American women learn as children that the black and white worlds are separate, yet they would have to learn to live in both to survive. While this process begins during childhood, it is seen as continuing throughout the lives of black women. May, gives a detailed description of the process by which she learned about these two worlds. She speaks of subtle differences, class differences between blacks and whites, and lack of resources in the black community:

I went to preschool and was probably the first black child to go there along with another little black girl. I was born in 1968 and this would have been around 1972. Integration was being resisted. We were treated fine, but it was the small subtle differences, you start to live in two worlds, the things that you do and say at home and among your friends and stuff, that you couldn't say in that environment. One time we went to one of the mom's houses and the house was huge and I thought it was like an amusement park, they had little doll houses and stuff and I was like do people really live like this. There was a little boy that I liked and I remember some kid saying he could never be your boyfriend because he is white. Now at four it wasn't serious or anything, but it was there that I realized that I lived in an all black community, we were middleclass and my father was an educator so we were better off than most other black families, but in that particular neighborhood it was still all black and most people were working in the factory making ends meet. In our community we were seen as the family that had a lot, we got central air first, but when you looked at the larger community we were just run-of-the-mill, the black area was really poor... everything came to us last, the snow removal, the mail did not come until late, we were on the back end of the receiving end of everything, I think it was then in preschool that I realized that I was African American and then it began to get reinforced, you knew that when you turned down a particular street, the world became white.
Once this process begins in childhood, it seems to continue into adulthood. She speaks of internalized racism and the process that many blacks go through to become a person who can be accepted by whites, only to realize that the problem itself is not one's behavior, but a color-caste system:

You always feel like you are navigating between two worlds... You became aware at an early age of this. It has varied at different times in my life. There was a time early on when I thought the more white acting you were the more accepted you would be by whites, so if you would be able to say ...distance yourself from the image of a black person, I am well educated, my parents are well educated and subject-verb agreement is not a problem, you know whatever the issue is you knew white history, European history, whatever and you down played race, then you thought well maybe that is the approach that I should take...and I took that approach in college, you know I had white friends, and I said well maybe race isn't that important, but then as I matured you know I realized more and through reading and my eyes opened and I realized that the problem was not with me, but with society and the color caste system that we have in society and so I know that if a white person...I think primarily white people view black people as all the same and we kind of think that we can escape and be viewed differently, but it is always that that person is the exception, but the race or the view of the race is the same, it's like S------ is not like that, or Glenna, is not like that, or Crystal is not like that black person...you can never change the image of the race and that is a problem. And another thing I have seen quite frankly is that if somebody wants a white person for the job, they are going to hire a white person and I don't care how you wear your hair or how you present yourself, you can be as conservative as you want to be.

She continued to elaborate on the politics of skin color within the black community. In some facets of the African American community lighter skin and eye color are highly desired because racism has been internalized. Historically having extremely light skin gave African Americans the opportunity for "passing," or being easily accepted in some aspects of mainstream society. In her community African
Americans tend to have lighter complexions. One's skin color is not important in such a community and all blacks have very limited opportunities to this date.

There were always two worlds... in the black race and you kind of figured it out, even at family reunions, people would talk. You always knew that good hair was better than bad hair or kinky hair, that light skin was better than dark skin...but the big thing in my hometown was whether or not you had you had light eyes. Light skin was a dime a dozen there, almost everyone had light skin. If you had blue or light eyes then that put you up at the top of the beauty scale. This did not apply to the white community of my hometown. In the white community of my hometown, if you black, you black. Light skin did not matter, light skin was a dime a dozen. That has always been the way. Opportunities were always so few for blacks in that area and continue to be so. I doubt if I could go back there now and get a job other than if I went to the community college to get a job. If I were to go to the private sector and apply for a professional administrative position within a large company there... the opportunity would not exist. You really felt if you were black it wasn't there. This had a very negative impact on education because it was really discouraging for blacks who went away and got a college degree to come back to scan furniture along side someone who had dropped out of high school. The community would ask why are we wasting our money sending someone to college when all you have done is amassed a big debt and you are worse off than the person who did not...people began to think that education was not a worthwhile investment... And I think the return investment was not worth it under those circumstances. My parents kept telling me you have got to be prepared to leave this area... the opportunities are few and far between and continue to be.

She gave an example of how learning to live in two worlds extends to most aspects of one's life, including motherhood. She speaks of a dual system resulting in a cultural disconnection between the African American patient and the white medical community:

In my hometown you have a dual system operating and I see this happening in many places and particularly among African American women. We know what the rule book, or what the doctor says. As an example, when to introduce cereal or whatever, but then you got great grandma or aunt such and such
that says "if you want that baby to sleep you need to put some cereal in that bottle and stretch the nipple" and then what do we do? We go right into the doctor's office and when the doctor asked what we have been feeding them, we tell a boldfaced lie and tell them all we been feeding them has been formula, or breastmilk. The medical community bears some responsibility too, because we get chastised so much by telling them if we have been doing anything different, that it makes you reluctant to be forthcoming with what you are doing.

Ruth, a participant in her late thirties feels that both black and white girls are given messages that must live in two separate worlds. That white girls are to have privilege is seen as an early message black girls receive:

We saw other people enjoying the privilege, they (white girls) were the cheerleaders and it wasn't because they were the most athletic, or that they could dance better, they were just given the spot. There should have been more black cheerleaders even at a predominately white school. Who was the prom queens, leaders of clubs, and those kinds of things? We were members, but they were the leaders. Well, it was happening to them too. People were giving them messages that they couldn't be best friends with a black girl...so we grew into our different worlds. Currently all of my daughter's girlfriends have been white...she has been to private school all of her life.

There Are Pervasive Negative Stereotypes About Us

Several participants said that the negative stereotype of black women impacts everyday life experiences. Jean recounts a time in her life when she was left by her husband with a toddler and was faced with having to apply for welfare. She tells of the stigma that she perceived being seen as a black woman on welfare:

My whole world had been ripped from under me. It took me a good while to get back to...you can do this, your son is depending on you and you don't have time to waste and that was the beginning of the lowest point of my life...going to apply for welfare and when they see a black person walk in there and they roll their eyes and you know there is the stigma, I was educated and married, I did not just have this baby out of wedlock and all the stereotypes were there and I was in that office for five hours
and they denied me because his father refused to sign some papers and I had to...I had $300.00 when he left and I had to pay for food and I was riding the city bus and couldn't even get an apartment...At that time I was living in a garage and it was summer and I slept on two big shipment boxes and my son slept on a cot. When you think of welfare, you think black women, but from what I know and what I saw while I was on it, it wasn't even close to being the case. They just assumed things about me.

Lisa, a mother of two students who excel in school told of a teacher's surprise that she came to a parent conference. Similar to another participant she used the term breeders, which implies that one is not quite as human:

The stereotypical thinking about black parents and black mothers. You know, we're breeders, like "Oh my goodness, you care?" What? Because you are not supposed to care about their education, so why are you here?

Velma, who is in her late fifties, notes that this stereotype extends into everyday events like shopping at local upscale stores:

You walk in and most time they obviously expect people to look like them. You know how we go shopping. I don't dress up to go shopping. And you know the first thing they say when you come through the door, "the sales rack is in the back." Well, I might've wanted to spend money that day! [Laughs] But that kind of thing where people are assuming...You made the mistake to come in so let me just show you some things over there that we are giving away and you might just be able to afford!

Cinna, a student from another country studying and living in the United States indicates that the negative stereotypes associated with being black exist outside of the United States as well:

In an Indian run government...they don't think they are black, but if they write something they say Indian and black...some of them are very dark, but don't want to think about themselves as black.

From Our Journey There Are Cumulative Effects of Racism on the Psyche

The following exemplars are from unbroken dialogue that took place among
focus group informants as they talked about the physical and mental effects of cumulative racism. The women in the focus group were generally older (late forties to early sixties) than those who participated in the extended interviews. They spoke of internal struggles and stress that result in lack of trust in the white establishment, fear for the future of children, feeling unaccepted, and ambivalence. They felt there is a connection between the psyche and the body:

I think the stress and psychology of how we have come through this journey has really affected our lives totally.

I lived in an area of Virginia where they closed the schools in 1954 because they didn't want to integrate. And I grew up with a lot of questions as to why people don't want to be together, and I saw what happened to a lot of the kids that were older than me, and my parents were really protective of me. We went to a restaurant. There is one restaurant in my hometown that I will never forget. And, of course, it burned down. But I remember that sign that said, "white only" on one door. That really bothered me and my mother really protected me. She didn't tell me the whole story. She just said, honey there are things in this world that just are not right. I think that made me grow up questioning everything, and when it came to my children, I think it was a protective thing. I felt I had one of the best doctors, but there was still just that little bit where I didn't trust him 100 percent.

What resonates with me then is the whole thing of the psyche that comes up, then if people feel unprotected, like what you said about having a wonderful doctor and still not feeling quite like you fully trusted him, suspicious, it's that whole thing about being black and being paranoid and not being crazy because you got reason to be paranoid because of all of the historical kinds of things that have happened because you know you are not the beloved ones in a society.

In terms of black persons, somewhere in the corner there is this eternal need for approval from whites and this translates to me as a sense of self hate...in other words, I am not worth anything unless I am accepted. If I am not worth anything in terms of bringing a child into this world that has to be there depending on where you are, what level, that same kind of psyche, if you are indifferent about your self worth then I would think then that
want would come out as being ambivalence about the worth of this life...ambivalence in terms of I want this child, but what is going to happen.

I truly believe psychology or your psyche has an effect on your whole body. And you talked about this fatalistic attitude...maybe, are you saying that maybe some new mothers who have babies feel that they are not worth having this child or that they may be neglectful because they don’t want their child to go through what they went through?

You hear the saying of that there is no way that I would ever bring a child into this world and I am sure that our mothers think about this before they have a baby because you want to know if this child is going to be protected and you want to know if you are going to be able to love this child and give it what it needs to take care of it until they are old enough to take care of themselves and stuff like that goes back a long way.

What connects all of us as black women? I think it is because we are black, and because of what our ancestors have gone through and what we still battle...it just leaves a little bit of doubt of are we really being treated the way we should?

I grew up in Florida, certainly during segregation and all the civil rights and so forth, and went to DC for school, and then went to Indiana for school, and then ended up in Connecticut. And one of the things that I didn’t realize until later on, no matter where my husband and I went, like hotels and things like that, I was always wondering, would I be allowed to be there? Now I spent 34 years in Connecticut, and I still find myself at times going from anyplace in the country, and wondering if there will be that sign on the door, not allowed or white only, and I thought by now I would think that would be gone. But for how long it’s been in there, those formative years of having these experiences, and its still there!

I think that there is some big psychological stuff going on. I do. I think that as much as some of us have arrived, there is still some of the fatalistic results of having been in a society that we’re not wanted. I think it plays on the emotions even when we don’t know it. Even though we say that we want to be this and that and the other, and we aspire to great heights, there is at the back of our minds that we are not going to get but so far, as long as we’re in a racist environment that...Ultimately, I always use the term "people revert-to-type"...I don’t care how good folks are and how
religious they are, when it comes down to the nitty gritty, when
the choice is us and them, it's going to be them. And I don't
know that this can't play a part in the physiological and
psychological thing. We talk about race consciousness, we talk
about racial...you know going back to our African (roots) and
bringing that back to here, well why not bring up what has
happened to us over the years? I don't know if there is anything to
prove anything like that. When a black parent for example rears
their children, you rear them with more than one thing going on.
You have all kinds of hopes and dreams for them, but you're also
rearing them to protect them from what can happen to them if
they "step out of line." I don't know how to say that...it's
probably very hard to prove.

One woman born outside of the United States expressed during an extended
interview that black women develop a "slave mentality" as a result of historical and
current oppression:

Well within my country black women have a slave
mentality...They get pregnant by people much lower than them,
who abuse them and that puts the children also at risk, even
though they know better. Sometimes they have so many children
that even though they are fully employed, they can't manage
economically so that the kind of care that the children need from
dedicated people is not there. Some study abroad and leave the
children with someone and the child ends up dying, sometimes
they just wander into the streets and choke on food and that kind
of thing. Well, similar to life on a plantation, you have no say on
your own development, your own rights, or your own body, so a
man could always demand of you anything, and you are obliged
to do what he wants and live with him in spite of your
children...and I see the same thing here in America.

Slavery and Tuskegee Are Never Far From Our Minds

Very closely connected to the effects of cumulative racism on the psyche,
participants indicated that given the history of oppression and injustice many black
women are distrustful and question the motives of mainstream society. The words
"generational curses," "historical baggage," "genocide," and "distrust" are used to tell
how the past and the present combine to impact infant mortality. Jade explains:
Well an angry black woman can mean many things in many contexts and in that context I was angry looking at the historical baggage that white people have put on blacks from slavery and how that has transcended into this century...during slavery we had to have the baby working in the fields and then have the baby in the fields and put the baby on your back and keep on working so a lot of times the babies did not survive and if they did they were often malnourished, or the mother wasn't healed emotionally or physically so those things are a part of historical baggage...those things are generational curses, that the white culture has put on us, so it is not uncommon to hear of a black family not having enough to succeed and struggling and then with the drug situation, taking drugs and the effect it could have on a pregnant wife, so I think it ties in well with infant mortality.

Other informants voice distrust that is present because of past injustices:

Well in history because of the injustices that blacks have had across-the-board whether it be in education, job opportunities, medical attention we have always been affected and of course we have made many strides, but have a long way to go even today and when you look at studies that have black women who have babies and their death rates are higher than any other race, as an African American the first question I have is if there is something intentional happening, I know it's bad to say that, but it is the first thing that comes to my mind...is there something being done to actually get rid of African Americans.

When I think of what black women were used for in the past it was childbirth.

One thing that always comes to mind and we know a little about our history and we shouldn't have to feel this way, but one thing that comes to my mind is it genocide? I mean is it something there that is targeting our black babies, one might question is it biological, is it genetic, is there something in the black female race that would indicate that there is something that passes on to the child genetically that causes such problems and I think not because we are humans first.

The genocide. The planned genocide of the people. It's being done in many ways. It is not just infant death, it's finding its voice in many ways that sometimes we are not even aware of or suspicious of. And that's scary to me. The more I read, the more it frightens me.
Well, let's take the issue of affirmative action. If folks will not deal with the fact that the playing field has never been leveled, and it's going to take years and years for it to be leveled, and you have powers that be, both the courts as well as administration, saying they are against, and if they reinterpret this thing saying we have to go back, that's genocide!

*We Have a Constant Source of Stress*

Informants indicated that they were under high levels of stress due to many factors involving race. It is seen as being historical, but manageable if one has a support source. Unlike their foremothers, these participants experience stress as they attempt to work as a minority in professional settings. Stress is one of the overarching themes of the entire study. Hallie sums up what many informants felt:

In life there are the three S's: You are either in a storm, you are coming out of a storm, or you are preparing to go into a storm and as a black woman we are doing those three S's on a constant basis... We are preparing for the next storm in our lives because we are ending a storm as we speak or we are in the midst of one.

Jossie, an informant in her late forties, indicates:

I think black women have a history of having stress in their lives and this stress is measured like on a meter like how you measure an earthquake, you know severe, not as severe and I think the stress is less severe if there is a comfort zone, a comfort zone can be a person...like me when I got pregnant the first time in college, I had no comfort zone and I lost my baby. I felt like I was in a whirlwind...like in a tornado and all kinds of pieces were happening and were introduced into the tornado as I traveled along. Seems like as life went on it was the same tornado and some things flew out and others just flew in and I wonder even now when will the tornado stop and when will things settle down?

Jade, a doctoral student, provides an example of how she experienced stress related to her race in the academic environment:

I think being a black woman has its challenges...I think it takes longer than maybe other groups to get to know yourself...Yeah,
because I am in my thirties and I feel that I am just getting to know myself with a predominately white institution, in a predominately white campus, in predominately white classes, with predominately white teachers and not having any people who look like me is automatic stress in an academic environment. As a graduate student I taught a class that was 98% white and 2% black. I did not want to be there. I always felt like here we go again...going to their rhythm, how they communicate, how they socialize, what they were looking for me to help them with...the class I taught was exciting because it dealt with multicultural issues, but by the time I got to teach it I was tired. I had been there all day and the teacher was white and did not know how to mentor me to teach the course, so it was stressful and a lot of heat and stress came as a result of that. I wanted to be respected as a black woman teaching a class on racism and teaching others how to deal with clients of all different races. I had to confront other's biases and values and because I did not look like them, there was less respect for me and I wanted to be able to challenge that and be critical and be confrontational without being looked at as an angry black woman...and if I was so what, that is what this course was about in this context, LIFE, and I couldn't do that because they were so afraid of my reactions, they did not want to learn to my beat of the drum. They wanted to learn without discomfort and I did not like that; it was one of my worst semesters.

And Our Minds Are Connected to Our Wombs

Informants expressed that the mental state, inner feelings, and stress level influences a woman's body and her ability to have a healthy pregnancy. Several exemplars follow that illustrate this:

Even you are not talking about how physical abuse hurts the body, mental and emotional abuse can affect your physical body and make it not a healthy place to grow a child.

I know what promotes a healthy family and I do think that if the mother is not very stressful during her pregnancy I think she has a chance of helping her baby be healthy. I think that a human being starts before it is born and it takes on emotions inside the mother and that is carried on after they come.

I just don't know how, but I know that the mental state influences pregnancy outcomes. Our physical state and our emotional state
are connected...maybe our stress is weakening the immune system...you know...

I do think an infant can feel and sense that tension and unhappiness in a mother the same way that a child can sense tension in a mother when they are born. If the child gets hurt and you get excited about the little hurt, the child will become upset and cry, but if you just say oh its okay the child is calmer and I think because the fetus is part of you, the fetus feels what you are feeling and if you are not very happy, that is going to hurt the fetus and if you are calm and happy, the fetus will relax and that may have something to do with the longevity.

It has more to do with it than people would ever believe. If the mother is frustrated, angry, restless...the baby is the same...the baby is part of the mother and feels a lot of the emotions that the mother feels. If you are not happy you may not want to survive, if you are unhappy you may not thrive as well.

It is so much sometimes that the woman throws up her hands and says, I can't take it anymore and everything in her body is kinda like the old saying with the dish cloth, everything just chills out and hits the bottom, and that is the way a pregnancy can be. The body is only so strong, it can't take it anymore and it says rather than nurture this pregnancy, we will dissolve it and we will try again later when your body is ready. Sometimes it just happens that way and a lot of women are not ready to believe that stress can interrupt a pregnancy and it can, it can very easily do that. You find that blood pressure builds up and affects pregnancy and it can cause you to lose your baby.

It may be an old wives' tale, but I feel there is some truth to it...when people have pleasant thoughts when they are pregnant they tend to have healthier and happier babies, but when your mind is in turmoil you know it affects your physical body and if you have a baby growing inside of you and your body isn't it's best, then it's going to affect the baby in utero.

Well, the first thing that comes to mind is that many African American mothers whether in a marriage or a relationship and are pregnant for the first time specifically may not know the risk of other African American women and without that knowledge they may unknowingly expose themselves to stress within their marriage, or their jobs or their home and lose the baby through a miscarriage and that is common with the women that I know and I think that that is key...and I have heard that the cervix of
African American women opens up earlier than white women and I'm like why does that happen. I know in marriages that stress from household cause stress on the mother that she may not be aware of. You don't think of it in those terms until asked a question like this.

Our Insides Have Changed

Closely connected to the ability that the mind has to affect the womb environment, informants expressed that genetic changes have occurred to black women as a result of experiencing racism and the social and physical environment that resulted. They spoke of substandard living conditions, the northern migration of rural black women, lack of traditional communal living, and poverty:

Is there anything in the environment, that's against who we are in our native state. Before we got here...sometimes I think our feet were not made for the shoes they make...how we lived traditionally... (Bea, age 60)

What have we done, to our hair, to our complexions, lots of things that were not a part of us way back when, but how much is that way back when is still in us, and that is rebelling against...because I think psychologically we are rebelling. We don't fit in this environment because the African environment is totally different, it's more communal, it is not as, you know the competitiveness. We have had to become some kind of mutant to survive here as much as we can. (Bev, age late 50's)

We all come from the same genetic pool, but we know that genetics can be altered by the impact of the experiences that people have had. We worked and lived in substandard housing...after black women left rural communities and moved to cities to take care of their families and lived in big apartment buildings where all kinds of things happened there. Several things come to mind for me one is the cumulative effects of racism in terms of blacks and who historically lived in substandard housing and what impact that might have had genetically. (Thea, age late 40's)

I have three children, and it is very difficult because there are certain experiences that black women have had traditionally, things that we have kind of inherited, and perhaps there is some factor there that says because of the condition that our great
grandmothers lived in, somehow, someway it translated or transformed us genetically. (Bea, age 60)

We have had to battle so many things like when we first started talking black people have higher incidences of high blood pressure, heart disease, higher incidences of sugar diabetes and these kind of things and I think it is because of what we have had to go through in terms of having equal facilities, having the right kinds of food early on, the stress, the hard work, just all those kinds of things combined affected us maybe genetically. Of course I couldn't prove that but it has all played a part. (Lu, age mid 60's)

*We All Have Burdens, but Our Burdens Are Not Recognized*

The number of white men who came up to me yesterday after my speech to identify with the fact that I grew up on a farm, poor. I am going, [laughter] you don't begin to...! I mean, came over there ... I'm like, we have a connection now huh? Please! (Bev, age late 50's)

Informants felt that black women have unique burdens that have been dictated by historical and current realities. Some burdens deal with historical poverty. Several informants spoke of unbreakable cycles that many black women face as a result of this. Interwoven into the narratives are examples of how these participants avoided being in a cycle of poverty and glimpses of how resilience is developed. The following informant gives a detailed description of the cycle of poverty.

What happens is the women are in poverty and they are uneducated and good-hearted women and they can't seem to get out. They try to work in the textile industries and other industries and jobs, but they can't make the money to get out of the cycle...so they just fall back into the cycle. I worked at the State Health Department and I saw it all the time and you could look at the women and the struggle on their face when they come in and they are trying to get immunizations for their children and they are trying to get money for their kids or a week's vouchers and it is a struggle for them and they spend a whole day struggling to get something and they only get a little bit and they say how can I get more and when you listen to them talk these women are very smart women. They know how to make ends meet but they just
can't seem to get out of the cycle of having babies and teaching their children that it is okay to have a baby whether or not you are married... just have that baby and get that check and that's going to take you through another month and you will have shelter and food for a month even though you have this baby. Some girls break the cycle and decide that they don't want to be like their mother or grandmother, when you look back and your baby's grandmother is thirty years old and the great grandmother is not much older, those young girls break the cycle and they get out by going away to college on a scholarship through a church or something... but some girls do break the cycle.

She continues and gives a glimpse into her world. While doing this she provides information on how her world is constructed:

It is kind of like a puzzle, you have to be around the women who are going through this... women who don't have. When I come home, I come home to my children, my husband, and my house and in there is a safe haven for me and anything else is on the outside. It is safe haven and I don't have to worry about anything in my home... I don't worry about violence, or guns and I don't worry about drugs and I don't worry about people constantly coming through my house and when you put yourself in the place of some women they are coming into a three room place that is subsidized place with a front door and a back door that you see when you walk in, and a bedroom, bathroom and kitchen and it is throughway from the front door to the back door and when you talk to these women you see that their life is so stressful because you don't know who is coming through the front door this time and you don't know if your child is okay and these women just get tired of fighting the system and they give up and they give their children up to the system too because they are tired of fighting it... I am tired of living in this house, I am tired of not having money to get to the end of the month, I tired of not having food, and when I worked with the health department, I saw it. If you are sitting there and all of a sudden there is a bug crawling on you, you can't sleep or function and that is what some of these women do so any way that they can get out of the system they try to, but they wind back up in the same place and the children that they are having it comes back to the same place and they are seeing it. It is all that they see, they don't know anything different, they don't know it is a different lifestyle because they don't go any where, they don't know that there is such a thing as a functional family. I had one of my children one time to ask me, Mom is it something wrong with that family, because everyone
thinks it is ridiculous that we have a mom and a dad and is that wrong? He was really young and did not understand. I told him that it was okay to have a mom and a dad and to have a home, it's okay to have a family and that is what I want for you. I want you to be educated and to have these things for yourself. But in order to do that things will be put up in front of you and you will have to learn how to go around it, I said you can't just stand there at that wall and beat that wall until that wall beats you down, you have to learn to go around it.

Some burdens deal with being both female and black. The participants expressed that black and white women may both have issues surrounding gender, but that the black woman has to contend with race as well. Participants express that they have a "double whammy" because they are members of two marginalized groups in society. This is apparent in employment and often times housing:

I think with a white woman instead of having a wall up there like a black woman, has a door and all she has to do is open it and walk through...she has a choice about whether she is going to stay where she is or change herself or make herself look different.

One of the things that makes me most angry is first when they try to justify and make you feel like you are some kind of nut, and the other one is, that you have been in my place. I have never ever had a conversation with someone who is of different ethnicity--white, Protestant, Jews, Irish Catholics--where their situation compares to mine. It does not compare to mine...I even have feminist issues. Talk about in comparison to mine! [laughter] We have a double whammy! We're black and we're female. You only have one part of it. A lot of times people cannot tell anything just by looking at you, and can tell us by looking at us. So the high visibility is a thing...and you can see that played out in real estate and stuff. In Connecticut in the sixties when we tried to buy a house they wouldn't show us a house!

Well it is difficult in this area, it is tough. A white woman will tell me, I have been there or I can do this and I say to her, what is offered to you is not offered to me. I say it is done at a different level, but it is not offered to me and I tell her, you can't see that. But I tell her walk a mile in my shoes, you know that simple phrase, and you see things differently.
I put myself as being white on a job application because I heard that this institution would hire you if you were white, but at the same time that I did this I also submitted an application with the same information, same data except that I put myself as a black woman. The white woman, the white me got the interview...and when I went to the interview I explained to them why I did this and they said it must have been an oversight, but at that point they had no other choice but to offer me the job because they knew it would be ramifications if they did not, but this particular job I turned down...I told them that I was not pleased that they would hire me because of being white and not hire based on my education. Then I applied for and got the job that I have now and everything on the application was true to fact. I got an interview right away and I have only had one or two people that have given me grief over the job and I chalk it up to their ignorance and one of the people is a housekeeper and I am not putting that job down, but he is a devout racist.

I have good education and all, but you are either under or over qualified for positions and white society is always beating you down...it is hard to find the right employment...this is my experience...it is hard to find the right job. It is hard to fit into what you desire to do. When I obtained this job...my resume was used and I changed the way I spoke to fool them over the phone...when I walked in the door it was too late to not give me the job. I think black males have it difficult because they are not wanted to be the boss over others and it is taboo that this will happen. If it does happen they will have to convert to be part of the good old boy system, or take on their own identity and struggle with it and say this is my identity and I am not going to give it up.

Once I wasn't hired because of my race. But I love to tell this story...One of my students was looking for a job and brought in a paper because she wasn't qualified, but felt that I was. It looked great, but my husband and I decided not to pursue it and I threw the paper in the trash. It was in academic affairs. I did change my mind and decided to apply. The next morning I was sent in for an interview and when I walked in they were shocked...my being possibly black just never came up because they did not think a black person would have the experiences that I had. We had only been in the area for six months and we were not known in the community yet. So they were like we don't know her and we know all the sharp black people. I did get the job and it produced many promotions. People admitted to me later that they were shocked when I was black.
One informant, who is married to a white male, expresses that as a couple they do
not have the same burdens and barriers in employment or housing that most black
couples have, but she still has the burden that comes with being a black woman:

I hate to say it this way, but because he is white, I feel a certain amount of privilege and I know that because of him there are certain things I am going to have...and I really did not think about this until he got this last job. We are looking at us having this $200,000+ home and I am driving a nice car and I have three healthy perfect kids and I don't have to work, he told me I did not have to work. I can't say it is like night and day, but I don't feel I have to work as hard as a black couple would have to work because he automatically has certain doors open to him and a black man is still struggling just to get that door open. Now for me and we have argued about this often...I am a woman number one and I am a black woman two...so the glass ceiling is still there in a number of ways, but because of my experience and being in the military; I know how to knock that door open, get through that door. I will challenge anyone who says differently. We got into this discussion that if it were between a white woman and me I still feel that the white woman would get the job. He feels that I would because of double minority experience. He did not understand it and I told him from my experiences, which he will never understand, I know for a fact that that white woman would get it with the exact same qualifications. We have to go that extra step to prove ourselves, but thankfully because of my background in the military I know how to work around race.

*Our Pain Is Often Swept Under the Rug*

Some participants expressed that black women have poor relationships with men, sometimes abusive in nature and for various reasons often kept secret. Living in hidden abusive situations and the stress resulting stress is seen as negatively impacting infant mortality:

It's that "don't tell your business" kind of thing that is happening too and with infant mortality if abuse is an issue and there is something serious going on and there is a baby as well, maybe she can't help that child and when the baby needs her maybe she can't get to it. And I have seen this.
I have a friend who is a professor and she has been abused all her life, they (men) have lived in her house for free and abused her and her children, you know...she was always well educated and in the end she put him out and now is pretending to be sad. I chose not to take that risk...I have learned from others. You have to have some self worth, you know...it's not about marrying an intellectual, but he cares about you, should not abuse you and curse you and call you names...beating you up and coming to places and embarrassing you...I had a friend who was married to a man that would not give her any money to see about her daughter. The one or two times he gave her money he kicked her. This man had 11 children outside and I am just NOT going through that. I am just not.

Well I don't think most black women have good relationships with men and I don't know if it is because of the way we were socialized or raised? I think it's a cycle women who have not had or observed good relationships with men, including family, don't know what one looks like and they have lower expectations and are more tolerant of behavior that other women wouldn't put up with. Now granted my father was abusive, my grandfather was abusive, my brothers were abusive of their girlfriends and my only sister was always in an abusive relationship...and I promise you that it was not until I got to college that I found out that men actually loved women. I promise you I did not know that. I never thought I would get married because everything I saw was not a good relationship. When people found out I was married they were shocked...I never dated at home because everything I saw was not good. I liked myself too much to be in those types of relationships and I thought all relationships were like those...so I don't think most black women have good relationships because they haven't observed them and are more likely to tolerate abuse and their daughters observe it.

This was still my husband and I was supposed to do certain things and he was doing all these horrible things to me and it took control over my mind and my whole body shut down. It was a good two weeks before I realized something was wrong. Somebody saw me and told me I needed to go to the doctor, she told me that I needed to make a choice, couldn't continue to live this way...basically the whole town knew what was happening and this woman was trying to help me. I was alone...the only friend that I had there was being abused by her husband physically far worse than I was being abused and she was raised on the reservation so for her she thought this was the way it was.
supposed to be and I told her no man should be hitting you and mine only hit me one time and that was all that I needed and that is when I got papers to make him stay away.

_With Our Education We Can Knock Down Walls_

Informants were all well educated women and saw it as one of the ways that black women have been able to survive in spite of racism and oppression. Most indicated that getting an education was stressed from early childhood and they felt it was their only choice out of oppressive situations.

She (the educated black woman) can make it happen for her, she can manipulate the situation and she can make herself more attractive and put herself up there on the totem pole. She can put herself in high places. I have seen her (a well educated friend) in several different roles...how she talks to people on the phone and how she uses her education to obtain what she wants...she focuses of what she wants and obtains it...she introduced me to this world...how she uses her position to get what she wants and how she makes her life better and at the same time does not forget that person down there.

The fact that I have gone to college helped me prepare myself mentally and physically to have a child, so I think the education piece is important. I know racism comes into play, but because I am assertive and educated and speak my mind, it does not overtly affect me.

I think the more educated a black woman is it gives her more leeway if she is smart, not flaunting it, but uses the education to manipulate her way through society...that is control it, but I think the less education you have or if you don't have the wisdom to use it to your advantage then you are that poor person that works at McDonald's or Burger King or cleaning someone's floor.

We have racism and it hasn't affected me because I have an attitude and I took advantage of getting an education and paying for it myself.

_Our Blackness Is Always With Us_

Similar to stress, race was seen as a constant factor in the lives of black
women. A woman is seen as black regardless of her socioeconomic class or pregnancy status. While these women saw their education and good marriages as buffers, they still spoke of numerous subtle incidents that they have encountered, or do encounter on a daily basis as a result of their race:

When we first moved to N.C. and he (white husband) got an interview for a job, the first thing my grandmother said to me was to tell him not to tell them that your wife is black. I told him. He had a California mentality, like we would fit in, but my grandmother told him not to tell...But then after my husband's first two days of work he said they were saying nigger this and nigger that...joking and all jokes were saying something derogatory about black people. My husband came home and asked me if there weren't laws in place or something that could be done and I called a couple of attorneys and they said there was nothing that could be done and I couldn't believe this was still happening in 1999...this is why my dad joined the military to get us out of this kind of situation here (in North Carolina) and he asked me why we were moving back this way.

I was at Civil Rights Lawyers committee conference a week ago and they were talking about judicial races. They were talking about state and local judgeships and the elections and they were saying that you could be a black judge and be very conservative and all your opponent has to do is to show your face and to show a picture of a criminal right beside that person and regardless of your record as a judge people will assume that because you are black you are soft on crime and those individuals lose elections, and it is difficult to elect black judges...it doesn't matter if you are liberal or conservative, what matters is your face and skin color...So now what I have done since undergraduate life is I am really, really comfortable with racial identity and talking about issues of race, cause it is there. I don't let it be an invisible elephant in the room that no one talks about anymore. That's what they always say, there's another irate black woman at the desk. She's not irate, she is just tired, she is fed up, she has enough of the bureaucracy, she is just there to get one thing done and nobody wants to do it. They send her to five different offices to do what the first office could have done for her whereas if the white woman comes in they tell her we can handle it right here for you and she is out the door, the other woman is still standing there...I saw that a lot and I would say why did you send her over there when you could have done it, so I found myself standing up
and saying we are going to do it this way whether you like it or not, you can't fire me, what can you do other than do it the right way, if you do it for this one, then do it for all, either do it equally or don't do it at all. And so now they find out if I am around, they are going to do it for all.

...But there again you have to be very careful in the environment and just see how things are done, like people will say, I have a black student that is giving me grief, they never say I have a white student that is giving me grief and not only are they racist towards the African American students, but they are also racist towards the Asians, call them slant eyes and stuff. It does exist. I talk to my co-workers a lot and I watch them and it makes them really nervous and when you talk to them in detail and you are on a-one-to-one basis with them they are really fragile...

At the scientific society, I looked around and there was no one else there, no other black. I sat alone and I knew I was black.

One day I had a coworker say, trouble follows me like the black plague, AND I WAS WALKING BEHIND HER...and I said why does the plague have to be black? And she said because it is dirty. I did not have to follow her up, she showed herself up so much that she lost her job and I didn't have to do it because revenge is not mine and I just pray and I know that God will work out things in his own time so I don't worry about things like that.

One informant gives a detailed example of a recent incident in her life that illustrates the subtle daily insults that accumulate over a lifetime:

Let me kind of shift here and give you some of the subtle kinds of things that I have experienced and these experiences may not just happen to black women but we see and feel it in different ways and experience it in different ways, but just the subtle daily insults. A couple of weeks ago I went into a bank. I am sensitive about going into places and being ignored whether it is a bank or_______ Hall. If I walk in, I am tall you got to see me you can't miss me, but it's like I am invisible or something and sometimes I will just stand there and just wait just to see if they are going to see me. So I go into the bank, usually I don't go into banks I just use my ATM card, but this day I couldn't find it so I went in and there are these two white women and this one Asian American guy and the white women were working on something and talking back and forth, but they were open because they usually
have something that says window closed...They were open. Did they acknowledge me? Of course not! The Asian American guy finally asked me what I needed and I said I had this whole stack of savings bonds and I said, Oh God, you were the one that was nice enough to acknowledge me and you have to do all of this work and I said it like that and I stood there and just observed to see what they do and how they responded to others... but that kind of experience in terms of always not knowing, just not being sure if you are being treated the same way that other people are being treated that maybe they have responded to you in a way that is different just because they have seen your skin color.

A mother tells of an incident involving her child's schooling that she feels was race related:

Well one year, my child was supposed to have gotten the gold, the highest award, because of her grade point average and because of certain tests that they take, and that was part of the criteria, and so when the award was made, my husband and I were looking at each other because we knew she should have gotten the other one, so of course I went to the guidance counselor, and I said I think maybe there was some kind of an error, but I would like to know what the criteria was and how did she miss it, because I think she should have gotten so and so. And she looked and she said, Well she really should have gotten the gold, but you know the silver is good! Yes she did! So even though my child earned the gold, she got the silver, and I should be happy with that because that's a good award.

Another informant speaks to an issue that illustrates the double messages black women are often sent:

I am not sure...you know all blacks are interrelated. You know...they kind of tell you to stay away from white men that kind of thing...In my country it is more prevalent, but they are still not that happy for black women and white men to be together...black men can come back with a Ph.D. and a white woman you know, they marry who they think will put milk in the coffee, but it is an offense if you marry an Indian or a white man, it seems to be the same here in America.

As black women experience racism, they must decide how to negotiate:

We have two different attacks in terms of dealing with your black
experience. See I won't allow them to not speak to me. I am just right bold with it [loudly] Oh good morning, how y'all this morning. See me? That's a difference in personality, I dare you not to speak to me. I have kind of come that way too because you know I work in an environment where there are mostly men, Anglo-Saxon Americans. I can walk into a room, there's a meeting, and I can say good morning, and it's like she didn't say anything. And so I have gotten to the point now where I say well I guess no one really heard me and then someone will turn around. But you know that kind of stuff really aggravates you. You know.

Sometime I want to observe, because I want to make sure what I am seeing. And sometimes I go in, it just depends on what state of my mind I am in, whether I am going to go in as the observer, like is this stuff real, or are these people just rude to everybody? Or is this something I need to confront?

*Racism Does Exist in the Medical System*

The majority of women in this study were able to afford the best medical care during pregnancy and had good relationships with their providers. In spite of this, they felt that both overt and covert racism existed in the medical system. One participant born outside of the United States indicates that racism does exist in her country and she suspects the same is true in the United States because all black issues are somewhat interrelated:

The past five years or so we have seen an increase in doctors in my country but the Africans get less care than the Indians and there has been an increase in infant mortality in hospitals where the Indian mothers get more care than the African mothers and some have written in columns that they just want to eliminate the race.

Another participant indicates how important good medical care was to her daughter who recently had a baby:

I have read that doctors do not give black mothers or black people period the same care that they do people of other races and when my daughter was pregnant she had a very, very good doctor and to me that was one of the things that saved our baby
because she had medical problems to begin with and the baby had stopped growing and if it had not been for the doctor telling her we must get this baby out here and now, to save her, we probably wouldn't have the beautiful little girl that we have now, but as I said, she had many problems to begin with but he kept a close watch on her and he was very good to her.

One participant indicated that perceptions of black women held by providers' impacts care and lead to a two-tiered system of medical care:

Well it could apply to prenatal care we get...maybe our medical providers have different expectations, so maybe we are not given the full benefit of certain treatments and information. I know for many black people treatments are imposed on them without knowing what questions to ask... treatments and withholding treatments. Maybe the differential expectations impact the kind of care that they give to us.

This participant feels doctors can select what they choose to treat and while that very selection could be grounded in racist beliefs, it is very hard to define:

It's hard to define racism because you can go to a doctor and he can find a problem and choose to treat what he wants to treat and can say I did not know that problem existed, when he did know that it existed. But he is the doctor, he is doing your internal exam, he can see it, but you can't see it so you very well don't know it and he can say I did not treat it because I did not think it was necessary and so we as a black race can find a black doctor that is available and willing to take care of us and you see more and more black women going into fields like obstetrics and gynecology and when you go in to talk with these women they understand what you are going through. They understand your struggles, they understand PMS, they understand post-partum blues, they understand because they are women and if they have had children they understand even more, but a white male doesn't understand a bit of it...he tries to, some do, some don't. But racism to me works in that whole general way...well I work in the medical field and I see it and I see how doctors talk about their patients after they leave and how they decide, well I am not going to listen to what she says cause she always says the same thing, but sometimes women will keep saying the same things because there is an underlying problem and they do not know any other way to explain it to a doctor. And the doctor doesn't want to listen to how they are explaining it because he feels like he is
being harassed by the woman, but she doesn't know how to explain it any other way because a lot of the women are often not very well educated, and often those who are educated end up in the same place.

*When Pregnant We Need Strong Support Systems*

The majority of the informants were in happy marriages during pregnancy. Additionally, they had other support networks, including extended families. One informant describes her pregnancy:

Well, all of my pregnancies were good ones, except the miscarriage. They were all planned and after being married for two or three years we knew we wanted to start a family and I stopped taking the birth control pills and we got pregnant right away. I was happy and took aerobics and my husband sang to my baby in utero. My labor was unbelievable and the pains were 5 min apart and it just didn't hurt enough to me, but my husband said it was time to go so we checked in. Well...it was just peaceful. We both had jobs and could pay the bills...we were not rich or anything...we may not have even had savings, but we were healthy, had planned the pregnancy and we had and still have a good marriage. The baby was going to be the first grandchild on my husband's side of the family and I am the youngest in my family and so it was a big deal that we were getting ready to have a baby and there was so much excitement about that.

Other informants echoed this need for support both during and after pregnancy. Additionally, they indicated that taking care of an infant is learned and most women need to be taught or have someone model this behavior. One informant indicates that she was not close to her own mother and learned how to be a mother from other women, those she babysat for and from the mothers of her friends. She had this to say about the need for support:

I think a lot of it has to do with your support. To be alone in that situation itself is very hard, depression comes from it, when you are in that situation and there is no one else to turn to and they think they are supposed to know everything and are afraid to ask,
pride gets in the way. There is no manual for having children, but
there are those who have experienced it…I asked for help and
received it, especially with a new baby. Support. It also depends
on their situation, where are they financially and your
demographic location, are there resources nearby like
transportation. Today, in my home town the women in my age
group that I would go play with as a child have no jobs, education
or automobiles and a lot of them I know one just lost her third
child and she has had several miscarriages on top of that…and I
am thinking what is going on…

Another informant echoes this need for support and education after the birth of a
child:

With me I never thought about the infant mortality piece. It was
more from…well before I had my daughter, I had never even
changed a diaper…so experience and qualifications for this
job…none. What were my experiences to be a mother? I did not
have any experiences. I was just there, so when they said here is
your baby, I was like you mean this is it? I need a workbook, or
guide or quiz or something…and then I would worry…Is she still
breathing? The first night she slept the whole night I thought she
was dead and I was like let me go to the crib cause I slept through
the whole thing, you know…

Informants who did not have the support that they needed during pregnancies
attribute negative pregnancy outcomes to lack of support and to stress. This informant
experienced two negative pregnancy outcomes. She describes her first pregnancy as a
very painful time in her life because she was in an unhealthy relationship, received poor
medical advice during pregnancy, and inadequate support after her miscarriage:

I have experienced a miscarriage, actually two. One was in the
fifth month and it was a very traumatic experience and I had
dilated and did not know it and the person that I was involved
with…there was an issue of substance abuse…and I always
wondered if the stress of that had anything to do with it. I did not
know about his substance abuse and finding out about it was
traumatic. At the same time that I found out it seemed to be the
same time that things went downhill with the pregnancy and that
is the thing, a lot of black women don’t talk about these
experiences and it was traumatic and brings up a lot of feelings…but I am glad to do this if it helps your research. I did not find out
about the substance abuse until after I was pregnant and then to have my cervix open up early...and that goes back to what I was saying earlier about not knowing...that black women don't have the knowledge of the risks that we as a group have...here I was having fluttering feelings, but I did not know the danger signs, I thought they were regular feelings. I went to an African American male doctor and he did not examine me, he thought it was a bladder infection and that made it more traumatic and if he had of examined me, he would have known and it went downhill from that point. I started to spot a day or so later. It led into a depression, really severe and the family did not understand why it was so heavy. And not having anyone to understand...I went to a support group, but it was all white and I did not feel like going back.

She continued:

Well, I felt spiritually kind of connected, but I could not relate enough to them culturally and I felt all-alone.

When you say you couldn't relate to them culturally...what was going on?

Well, there was no other black person there, no one else that looked like me, that talked like me and I felt like there is a common understanding of being a black woman going through this substance abuse and losing this child. I think if I had had that I think I would have stayed in the group longer. My family and friends felt like well it's been this amount of time and I should have been further along and it took me a long time to heal, two years, and I did not have any medications so I suffered with depression longer. Somebody would say how are you doing and well you can have another one and I would just start crying and I would look at TV and if I saw a baby I would just start crying and I couldn't stop it and I had to walk around like that praying no one would ask me about it, it was like torture.

What helped you come out?

God and my spirituality and I did see a counselor, but looking back I should have been on medications.

Well the second pregnancy did not even go one month its like my blood count started going down and they said it will be a dissolved pregnancy and I took it as a sign that we just shouldn't even be trying anyway...I felt pressured from him to try again,
which I don't think I wanted to. It was early in the pregnancy and
I don't think God wanted us to have one.

Another informant experienced two negative pregnancy outcomes. While she felt
that police brutality caused her miscarriage, she felt that stress and lack of support were
contributing factors in both miscarriages. A small segment of a very sensitive interview is
presented to protect the identity of the informant. In earlier segments of this interview she
describes having a miscarriage while in college due to family stress and lack of support
from the father of the baby and his family. This participant is educated, but at one point
in her life was unable to find her way in what she terms the straight world. She did not
see a place for herself in the straight world because she was told that she was either
"overqualified" or "underqualified" for jobs. She felt that she had no control in her life
and as a result turned to a life "on the streets." During this time she became involved with
a man who later turned out to be a pimp because of "Wanting to belong to someone and
have someone to love me and care for me." She informed me that while she is not proud
of her street life, she feels that it helped her learn what she needed to do in order to
survive in the straight world...she learned how to have control over her life:

Now I still have control over my life in the straight world because
of the street world...Right now though I feel like I am losing
some control over what is happening. When I found out that I
was pregnant I wanted to leave that life because of my
boyfriend's problems with drugs. I did not want to bring this into
the child's life and he would not leave the drug world alone, but I
still hung in there for awhile. The miscarriage came two weeks
after the jail incident with the police hurting me (she was thrown
on the ground and kicked by a policeman). I did not want to bring
that child into this world and I did not want to bring the child that
I do have in either, I let my mom talk me into it (she has one
child). I did not want to be a parent, I had a lot of things to do,
but I still had my baby. I remember crying one day and I thought
to myself that this baby did not have anything to do with causing
my problems and I apologized to the child that I was sorry that I
hurt you by having you. I did want the baby by my college boyfriend, because I thought that baby had a future, so I cried when I lost it. I was angry when I let my mother talk me into having my only child. We are fine now, but back then I told my mother that I would never have another baby because of the pain and I did not like the way that I felt during labor pains...felt like I had stepped completely out of myself. I had saved money and this is about the time I met my husband and I even asked him to put money away for me. Once someone pulled a gun on me to rape me and I told him if you want some just put on this condom, you can put the gun away and I was in control. Although he had this gun, I was still in control and I was not afraid...

I don't mean to cut you off, but you mentioned control again (She mentioned it many times in the entire interview)...Does this have anything to do with black women?

If you look at the history we were truly in control...take slavery, black women controlled the master and the people around them through intimacy, and they could control whether their males were beaten up or not by giving of their bodies, so I think this is something that still exists today; we control it with our mind or our body and when that control is taken from you...you have nothing and it's just not worth it, but as long as you have control over your situation and you can direct it...and that is true with having a baby.

One of Our Many Roles Is to Help Our Children Learn How to Survive in This World

Informants felt that one of the major challenges facing black women is to pass survival skills on to their young. Being resilient and teaching resiliency is becoming increasingly stressful and these participants feel that as society has changed, children are not learning what they need to become self-sufficient. Teaching children to be self-sufficient has to be demonstrated and lived as one participant outlines:

Yes, but more than teach, you have to show them, you have to live it, breath it, do it on a daily basis. You have to show them that they will fail at certain things, but failure is not always bad. It's kinda like my son tried to get his learner's permit, the first time he was so sure that he would get it, but he failed and I told him, let me tell you something just because you failed does not mean you give up, you get up and dust yourself off and you try

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again and his reply was, well I thought I was supposed to pass
and I said to him sure you are upset that you didn't make it but
you get that book out and study and retake the test. He went back
and did fine. I told him everything is not going to be easy, if it
were we wouldn't be where we are now, I said we could be
making gobs and gobs of money and I told him he had to
understand making money is not always the best, but getting an
education that teaches how to handle the money that you make
will help in the long run and I told him you have to be self-
sufficient and you got to learn how to do simple things like
making your bed, because you don't need a woman to come into
your home to make your bed...know how to do it yourself, know
how to do laundry, know how to cook, know how to buy
groceries to be self-sufficient. Somewhere along the way our
children are not being taught how to be self sufficient and that is
why when they fail at something, they give up, but they have to
learn that just because they fail it is not all bad.

She continues and provides the value base that frames self-sufficiency.

Additionally, she indicates her comfort knowing that other black women are keeping an
eye on her children:

Well to me if there is a black woman that is looking out for my
child's well-being then I am blessed because I know that there is
another set of eyes on my children and I know that if that child is
not in my sight he is in the eyes of another woman that cares
about these children, that she is watching my children and I know
that my child is not going to be exposed to drugs, or my child is
not going to be raped by a friend that is at the house or something
to that effect. Those are the things that worry me in society
because my child will have to learn how to be a child and how to
grow up black at the same time. I have males, no females and I
try to teach them how to be males. You have to teach them how
to respect females, even if a girl decides, I am going to take my
clothes off, the male should say no, don't take your clothes off,
button up your shirt, put your clothes back on, I am not that type
of guy and I don't want you for that reason. Help her understand
that she is a young girl and she should be respected and he should
be the one to give her that respect...not take her clothes off for
her, but giving her the respect and it is a hard thing to teach these
kids when hormones are raging, but they have to learn that they
have to control themselves in life in any situation you are in ... that
control will save your life most of the time, so its temperance
and control in situations and if you can't in that moment you pray
Lord remove me or give me some way to get out of that situation and the Lord will remove you from that situation. He will give you a way out whether it is a phone ringing or a doorbell. So its up to you to take that way out and say, "this is my Mama, let me go."

She informed me that she is from a geographical area where she learned that women took care of all children, not only biological ones:

Coming from the area that I come from I think it is willingly done, it's like getting up in the morning and putting your shoes on, if you see that child, you nurture that child while it is in your sight, you never had to worry about being fed, whoever's home you were at fed you, if you needed a coat, they would give you one. It may not fit you, but you were given a coat. So you weren't hungry or cold. So you were raised so that the neighborhood, or that other woman stepped in to raise you even if it was just for a week or two. You look back and that woman said one or two things that stuck in your head or even one thing and you have to teach these girls as well as the guys that they must respect each other and it's all a learning experience.

She indicates that today it is stressful to carry out traditional ways of caring because society has changed:

It is stressful because you don't always know what the mother will say is okay for her child...the mother might say it's okay for her child to do that...maybe if you could talk to that mother and say why would you think it is okay for your daughter to be out at 12 years old and having sex and sometimes if you get the mother to understand the mother will eventually help the child to understand, but it is a growing process and should be hand in hand and it is hard because you can't save the whole world, but if you save one child it is worth it.

Another informant echoes her concerns:

There is in us a need and a drive to survive but we will be surviving against some terrible odds! And, unfortunately, I see so many of our young people, don't know, because they think that they can get through and make a little bit of money, that they have got it made. And it's not about that because when they leave our nests, if you will, and go into the real world, like one of our Supreme Court justices, we have lost that one. So also along with
this, maybe some education to our young people to be aware. It can't be just us, because we have to pass that information on to them so they can continue the work that we have tried to start.

This informant feels that all black women should think about the role taken with men. Her statement has implications for youth and self-sufficiency:

I don't think we always take the responsible role with our black men, if they just want to have sex and go, and if that is what we want, we need to protect ourselves and not have babies out of wedlock... What I was saying about victims is that a lot of black women don't know themselves and when we get into relationships, we are looking for... I don't know what we are looking for, maybe that is part of the problem and it seems that a lot of times we end up having children out of wedlock and without a commitment from this man and then here goes all the other things that are not good for the relationship after they find out that they are pregnant, so I don't think again that is being responsible. Where is the responsibility? So I don't know if we are just trying to get some love and then by the way I am pregnant, so I don't think the relationships are healthy because the men say, "why get married?" I can have sex and kids without getting married, so all these broken homes and women having the stresses of doing it all alone I think adds to the infant mortality in many areas whether it is... already having kids... medical insurance, working, etc. I am thinking about this for us and bringing in healthy babies. Looking at your research why babies of African American women die more often... I think black women need a national forum on understanding ourselves and what we really want out of life... If you want kids, what is the best way to have them, if you want or don't want marriage... why or why not... what are you looking for in a relationship because sometimes we don't think about these things before we get into a relationship.

We Need the Help of Our Churches, They Have Been the Backbone of Our Community

The following unbroken dialogue is from focus group informants. Informants expressed fear and frustration that churches are not meeting the needs of today's youth or their families. These informants feel that African American children will be lost without the church as an anchor. They feel churches should be at the forefront in providing
information about African American infant mortality and recruiting/engaging participants in studies:

My first thought is the church has always been the center of the community. Historically, it has been a gathering place for their members, and the black church has always been a very strong area where you get information, and it's the responsibility of the church to share this information about infant mortality, it could be the women's group or the church school, but to let people know this is a problem and as Americans we need to be concerned about it. We could start out with what I call "rap sessions" in the churches, but let it be known that it's a concern and then maybe people will come forward who have had experiences with infant death who may want to share what their situation was and then that way, in time, you gather more information directly from the source.

With this church, I know that we have had two infants that died. To me at the time, I know it was sad. And I don't know if everybody was hurting so badly that they didn't want to talk about it. Most black people just want to push things under the rug and go on. This is what happened when these babies died at that time: you had the funeral, people went home, and that was the end of it. Now I can see where there is a need. At that time I was probably feeling the same way that everyone else did.

I also think that churches have been the center for our lives most of the time. The churches must be willing to get their head out the sand and be willing to talk about the real stuff and not what things should be...the fact that certain things happen may not be what should happen, the reality is that it does, and to pretend that it doesn't and people go wanting and ignorant and what not, because we don't want to address that issue. I think churches should provide all avenues for all kinds of people with all kinds of needs. If you can't go to the church, then where can you go? In older days when we were talking about premarital sex and teenage pregnancies, and so forth, they didn't want to know. They wanted to put people out of the church. We can't afford that! We need to address the problems and be there for them. We don't have to condone; we can help direct people toward the right thing or the best thing for them and own up to the fact that these things exist. I think the faster we deal with things like AIDS and all of those things, the better off we will be because it's not going to disappear just cause we want it to. We need to address all issues.
We are losing our young people in the churches. We are not
doing enough to keep the young people in church. They are, the
old generation, they are at the old school and they don't want to
bring anything new so that children can stay in the church. We
grew up in the country, but my parents took us to church. You
can't find parents today who will take their children to church.
We took our children to church and then we would say if they
don't stay there, they know they have been there. Most children if
they have been in the church, they always go back. They have
that spiritual bond that says, from whence I came. And so we
have to raise our children spiritually as well.

Educate them because if they don't have that spiritual thing—that
they know that whatever they are going through, God is there—
then we are going to lose them. We have to do something in the
churches to keep our children and carry your grandchildren.
Please take your children to church because something will be
said there that will help them the rest of their lives. Something
has to change...there are a lot of people who are against dance
ministry, bringing in the drama ministry, and stuff like that, but
you have to look at what attracts the youth.

Yeah. Sure! If you don't have that spiritual background, you're
lost. You don't get it from your education field cause its
dominated by the white man, who has always had, and we are
just coming into this new money thing, and our children grew up
in it and we know we got it, but they don't know how we got it.
We can tell them that by the grace of God we're here, but they
will never know. We are going to lose the children if you don't
take them to church.

Our Issues for a Research Agenda

The majority of informants indicated that a major task is to inform the African
American community of the increased risk for infant mortality. They feel this information
is not shared with the public in a meaningful way. Perhaps this passage sums up the
thoughts of many:

I don't think we can push things like this (infant mortality) under
the rug. There are still many black Americans who really don't
want to face the problems that we really have, and if we as a
people don't take ownership and let people know that we care and
get up to that political level, then the concern will not be there for
others to solve the problem. Infant death is a huge problem. And we are becoming the smallest minority in the United States. Something has to be done and we have to take ownership.

Additionally informants had these thoughts and ideas:

You know what I think...it's going to be hard to tease this out but I wonder what are the impacts of home remedies and infant care and if that has an impact on infant mortality. Two things we don't have true data on is the extent to which people are using home remedies, folklore, generational knowledge and advice and secondly I think a lot of the data from pediatricians is not the truth because the women don't see it in their best interest to tell the truth because the medical community is not responsive to it...so that might be two other things that could be an issue. And who knows, if we weren't using some of these home remedies maybe the infant mortality rate would be worse. I don't know. I am not necessarily saying it is a bad thing, I am saying we do not know the impact. Maybe there are geographical variations as well, but that is one thing that comes to mind because I did it. You got grandma telling you to just throw the book away and listen to her and give that baby some food and do this and do that...I did what she said.

I think we need to talk more to black women and then gather information about their generational histories and lifestyles... Healthy lifestyles both mentally and physically. We need to find out what we have been taught and what we can do to be healthier. We learned a lot from our parents and we did not read to obtain the knowledge. So looking at generational knowledge that has been passed on.

I think most people can go back to their ancestors...because I know my ancestors were on slave plantations in South Carolina. They may not be able to say which plantation, but some of that could be traced from names. We know that our names are connected to those white folks who owned our ancestors. Some of it can be traced to some extent, if not to the exact plantation, then the state or region. And I would want to know if they came as slaves, what plantations they came from, because there may be some things that would help in terms of isolating some factors there. It would be interesting to find that people living on plantations...were the ones that the descendants of those folks entirely...there is something going on...Slavery...In terms of, to see the point of entry for black women. Some comparative data looking at their ancestors. Did they come in as slaves, and if they
did, where did they live. Something that would isolate that information. Something would look at the regional differences, or state differences. Are there some things there? And look at all of the different levels, in terms of neonatal to death. As far as where they should target the study, I don’t know, but I certainly know, and I mentioned this early on, a lot of times to get answers it involves politics, because you have to have money to do research, and your voice has to be heard. I think politically, we, as black women need to let America know that we are concerned.

I know one organization, the NAACP, is working on the infant death syndrome, and we’re trying to make that more known to America. I think we have to target infant mortality in general, because if you don’t know there is a problem, how can you solve it? This has been very informative for me. Another area would be to do this same kind of focus group with women who are in the highest risk category, with women who have had infant mortality versus those who have not, in terms of what can we learn from them.

I think we have to go back to the way that black women think about family, relationships and marriage and that kind of thing….Like give some structure to the situation.

These informants have given us a glimpse into their lives. Their narratives have been combined to weave a complex story of the black woman’s plight in America. These experiences start in childhood with a layering process that includes stress and racism. Black women grow up learning to carry these layers of burden. As will be discussed in the next section, learning to carry these loads has dire health consequences for black women.
CHAPTER 5: DISCUSSION

The Load Looks Light Because It Is Carried So Well: The Irony of Race and Health

I had a dream once that seemed just like a vision...I was going up the staircase and I started running into barriers and I had to sit down and try to figure out how to go around the barrier, or deal with it, or how to stop this block. So being black and female it doesn't matter how low on the totem pole you start out with, but where you end up and yeah you are going to run into a wall, but the wall is not iron, steel, or permanent, you can tear it down. (Jossie, age 49)

This informant expresses what is seen as a way of life for many black women...constantly tearing down barriers. Tearing down these barriers and walls may look easy, or even go unnoticed by an observer. Outwardly, it is often done with such ease, but internally the cumulative effects of tearing down walls of racism, sexism and oppression appear to have negative results in terms of the black woman's physical and mental health. Always expecting the worse and being prepared to fight and tear or kick something down creates a certain type of strength, but the process of creating this strength compromises well-being. Amidst this ongoing battle, the reproductive system cannot be somehow snatched away from an overwhelmed mind and body during a nine-month pregnancy, given vitamins and ultrasounds, and then be gently infused back in place once the baby is born. The womb is not a free agent. The load of current and historical pain only become heavier while a woman is pregnant; it does not go away. While many black women in America have healthy pregnancy outcomes, their risk for infant mortality is twice that of white women. The informants in this study have shared some of the everyday experiences that they feel contribute to the infant mortality gap between white and black mothers. They accomplished this by sharing past and present everyday life experiences.
What do these informants tell us about infant mortality? First and foremost, they have verified that there is a constant interplay between race and stress that has historical roots and is firmly planted in the current lives of African American women. Black women experience a constant source of stress as they cope with pervasive racism in their places of employment, as they pursue educational opportunities, in their marriages, in all aspects of motherhood, and in their communities. A key finding of this study is the participants' belief that mental state, inner feelings, and levels of stress influence a woman's body and her ability to maintain a healthy pregnancy. While this finding in itself is important, these participants have provided much more...they have identified some of the mechanisms through which race and racism can be deconstructed as a source of stress that negatively impacts pregnancy.

I began this study with the following questions:

- What do African American women believe are the factors/circumstances most responsible for higher rates of infant mortality among African American mothers?
- What types of programs, services and resources do African American women believe would help reduce African American infant mortality?
- What role should African American churches and communities play in reducing African American infant mortality?
- What thoughts do African American women have about a research agenda on African American infant mortality?

Using the information provided by the informants and my life experiences, I will share my understandings of the findings to address these questions. Additionally, I will use both classic and contemporary African American female writings along with results
from recent studies to strengthen and support the findings. As one informant expressed, putting this together is like fitting together the pieces of a puzzle.

Informants indicated that the factors responsible for the increased risk of infant mortality emerge initially in childhood as black girls' experience stress related to negative experiences involving race. Depending on one's age and geographic location, these experiences tend to range from overt forms of racism that involve physical or verbal abuse to subtle messages of white privilege and lowered academic expectations. These early experiences can later negatively affect the psyche. Added to this are the additional stresses of gender that black girls experience due to racist and sexist views on beauty... Caucasian features are considered the standard or norm for beauty in American society. While these norms are difficult for some white women...it is almost impossible to attempt to look white when one is black. African American women have many painful, complex experiences beginning in childhood that revolve around their attempts to attain this dictated standard of beauty. Like many black women I remember as a child sitting to have my hair pressed with a hot comb and being told that if I moved I would be burnt. It was impossible not to move or jump with heat so close to one's head. I received my share of burns. The least amount of moisture would cause my hair to revert to its natural state. Rain was an ever-present threat and I was lucky if my hair would remain straight for church attendance on Sunday. Then it was back to school on Monday to experience a racist environment at school while worrying if my hair would stay straight for Tuesday.

These issues and experiences are deeply embedded within the African American community (Golden, 2004). While a full discussion is beyond the scope of this study, events associated with norms of beauty are mentioned because they have implications in
the area of maternal and child health. African American women often experience physical changes while pregnant that make attaining this standard of beauty even more difficult and this elicits stress. Hormonal changes often cause hair to grow longer, coarser, and more difficult to straighten. Due to the hormonal changes, black women who have their hair chemically straightened (permed) must have this process performed more frequently during pregnancy. The effect of these widely used 'perms' on the health of black women and the developing fetus during pregnancy has not been studied. The hyperpigmentation that all pregnant women experience tends to be more exaggerated in black women. While pregnant my entire neck, abdomen, and upper thighs were several shades darker than other parts of my body. My nose became wider and other facial changes occurred. I noticed these types of changes on the faces of other pregnant black women. I did not feel beautiful and did not feel comfortable addressing these changes with my white male physicians.

Even more troubling is the stress that many black mothers experience regarding the skin color and hair texture of the expected child. Once the black mother counts the fingers and toes of the infant, her concern is the infant's skin color and hair texture. Generally at birth, African American infants are very light; they gradually darken in pigmentation as they age. The genetic makeup of most African Americans dictates that skin color can range from ivory to ebony. Cuticles and ear lobes are inspected for clues about the future color of the infant's skin. Mothers want their children to have the best advantages at birth...for many having the lighter skin and straighter hair that are so prized in this society is seen as such an advantage. This additional source of stress is often unrecognized in mainstream society and is one of many that African American
pregnant women juggle and battle. Events that occur during the formative years begin what is for many a lifetime of oppression and self-hatred. According to the informants when a woman questions her self-worth, on some level she questions the worth of her expected infant. The early emotional and physical health status of black girls has implications for their future reproductive abilities (Lu & Halfon, 2003).

It is conceivable that these types of unacknowledged burdens combine with historical messages and overtones to provide additional sources of stress for pregnant black women. The informants in this study expressed that thoughts of slavery and other painful past events are always present. There is a constancy of history and the effects of slavery and racism on the sexuality and reproductive aspects of black womanhood. A recent reminder is the revelation that Senator Strom Thurmond (now deceased) fathered a black daughter (Staples, 2003). Senator Thurmond was at one period of his very long career one of America's most prominent segregationists. I grew up in South Carolina and heard the hateful messages that Senator Thurmond delivered, and I also was aware of the rumors that like many white men, he had black children. Many in the majority culture were amazed by the revelation of Senator Thurmond's daughter and wondered how someone who voiced such racial hatred could at the same time father a child by a black teenager. This teenager was working in his parent's home as a servant.

It is disturbing that many in the majority culture are unaware of the negative and stressful events that commonly affect the African American community and other minority groups. Often white society is protected from ugly secrets since generally their lives are restricted to the white community. African Americans are not protected; the things that amaze the majority culture tend not to amaze the black community. Did not
the slaveholder father children with black women and many times make these children slaves?

This is an example of the kinds of negative and stressful experiences that some black women have had. Dee (peer debriefer) provided another more recent example. Dee told me my study touched on themes in a narrative that she read in the July/August 2004 issue of *AARP, The Magazine* (Williams, 2004). In this narrative, Dr. Ida Mae Holland (now 53) tells a painful story of early experiences of poverty and racism:

> The obstacles and bitterness began early. On my 11th birthday, I was invited to the home of Mr. and Mrs. Lawrence, a white family. Mama did washing and ironing for. I thought I was there to play with their granddaughter. But soon Mrs. Lawrence said that her husband wanted to see me upstairs to give me a birthday present. There I found Mr. Lawrence naked in bed. I can still feel the arms of Mrs. Lawrence lifting me off my feet and into the arms of her husband...In the South I was often told, no white man wanted to die without having sex with a black woman (p. 66).

Dee further comments that "most black women have not escaped the problems of race because we are not shielded completely from the forces in the wider community...so in the above example being told to 'keep one's dress tail down' by a mother would have done nothing to protect this young girl."

As a result, many black women and youth do not feel that they have sufficient means to protect themselves from the oppression of white males. Black women historically have been unprotected from the sexual advances of white males. Black women in this study recalled this history. They spoke of women who gave birth to children while in the fields and who did not receive adequate medical care during pregnancy or childbirth. They are aware of the wet nurse who had to breastfeed both the mistresses' infant and her own infant...often these infants shared the same father.
becomes difficult to forget or reconcile the past in light of current insufficiencies. It is equally frustrating for black women to be told that these insufficiencies do not exist and have one's mental status challenged when one has lived a life iced with oppression. Pregnancies can be negatively impacted when women lack available avenues to share painful events involving struggles revolving around sexuality and race. Many of these struggles are intergenerational—grandmothers and mothers passing painful memories to their daughters and granddaughters.

The informants mentioned the multiple roles that they perform. Black women have historically performed multiple roles in society—many linked to the survival and socialization of black children (biological and non-biological) in a racist environment. Jackson and colleagues (2001) see this function as a burden of gendered racism and as a major source of stress for black women. It is becoming increasingly difficult and stressful for black women to maintain these multiple roles in a society whose values are shifting to a less communal way of life (hence, the importance of the church where a communal approach is still valued and promoted). While performing multiple roles, she is constantly navigating between the black and white communities. The participants expressed that black women experience considerable stress as they move back and forth between the white and black communities, learning and following different rules for each community. They indicated having negative experiences while shopping, banking, schooling children, attending professional conferences, working and receiving medical care. Several times a day they must decide how they are going to negotiate race and gender. There is both the physical movement and the mental processing that operates simultaneously—in many
regards the black woman is never still. What it takes to be strong can be harmful to health and well-being.

Mullings and Wali (2000) coined the term the Sojourner Syndrome (after the life of Sojourner Truth) to conceptualize the multiplicative effects of race, gender, and class on health. One dimension of this syndrome speaks to the unusual individual and collective roles that black women have performed historically to ensure the reproduction and survival of the black community. These roles included mothering in a system where slave families were not recognized as legal, addressing community needs with scarce resources, and work...constant work outside of the home when discrimination against blacks did not allow a family wage. The investigators conclude that as a survival strategy this syndrome has negative consequences—one of them being the poor health of black women. Lin (peer debriefer) makes the following connection between the historical roles that black women performed and implications for health. Her doctor advised her not to work while she was pregnant because there were indications that she was at risk of preterm labor. She discontinued her full-time job, but began to work part-time against doctor's orders because she was afraid not to work. Her mother had taught her that black women always had to work to make sure they would be okay. All that she could think of was making sure everything would be taken care of. She asked the following questions: "Will I ever get to a point where I can not worry about everything being taken care of?" "I look at my mother's life and all the stress she endured while she was alive and I ask myself...Is this how it all ends? "Will it ever end?" "When will the stress of having to do it all go away?"
Maternal stress is emerging as a variable explored in infant mortality studies and investigators are exploring racial discrimination as a stressor. These investigators conclude that the experience of racism negatively impacts overall health for African American women (Kwate, Valimarsdottir, Guevarra, & Bovbjerg, 2003; Pavalko, Mossakowshi, & Hamilton, 2003; Schulz et al., 2000; Williams, 1999) and negatively impacts pregnancy (Fiscella, 2004; Stancil et al., 2000) often increasing the risk of preterm birth (Dole et al., 2003; Rosenberg et al., 2002). These conclusions are given added strength when linked to studies that show how a pregnant woman's body responds to stress. Culhane and colleagues (2002) measured stress at the individual and community levels. Black pregnant women experienced almost twice the level of stress when compared to pregnant white women on both levels. These types of stressful exposures were positively associated with bacterial vaginosis. Bacterial vaginosis is associated with poor pregnancy outcomes.

Hobel and colleagues (1999) explored the relationship between maternal stress, maternal levels of corticotropin releasing hormone (CRH), and preterm birth. CRH is produced in the brain and the placenta and causes the body to release chemicals that trigger uterine contractions. Pregnant women were followed and evaluated for CRH level changes at three gestational ages (18-20 weeks, 28-30 weeks, and 35-36 weeks). Increased levels of corticotropin-releasing hormone in early gestation were strongly associated with levels of maternal stress. Levels of corticotropin-releasing hormone were increased in women who delivered preterm (regardless of gestational age). Wadhwa and colleagues (2001) found similar results. A major implication is that women who experience stress early in their pregnancies may be at increased risk for preterm labor and
birth. These findings have dire implications when viewed in conjunction with this study and other studies that have found a connection between race, stress, and the well-being of black women.

Black women experience both racism and sexism due to their double minority status. Jones and Shorter-Gooden (2003) completed the African American Women's Voices Project, a study designed to explore the effects of racism and sexism on black women. This is the largest and most comprehensive study of its kind to date and the results are shared in their book *Shifting: The double lives of black women in America*. A total of 441 women ranging in ages from 18-88, representing 24 states and diverse backgrounds, completed a combination of surveys and in-depth interviews. The study examines the concept of shifting and the many ways that black women have shifted historically and currently in order to survive racial and gender bias in America. Shifting can be many things including, speech modification, denial of sadness or loneliness, or altering outer appearances. According to the investigators, black women "shift inward, internalizing the searing pain of going out into the world day after day and hitting one wall after the next, solely because they are black and female." (p. 61). They conclude that while shifting seems easy to do, it has devastating mental and physical health consequences for black women.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing telephone and mail survey that obtains information from mothers shortly after they deliver. Mothers are routinely sampled; low birthweight infants are over-sampled to find out more about high-risk mothers. Several states participate in this system and publish reports based on the data (Williams et al., 2003). South Carolina PRAMS used 1996 data
to examine levels of stress and social support. Results showed that a greater proportion of pregnant black women than white women experienced almost every stressful life event covered by the survey and also received less social support. Other studies have similarly found increased levels of stress experienced by black pregnant women (Culhane et al., 2002; Mullings & Wali, 2001).

The harmful effects of stress are also addressed in feminist literature. This body of literature addresses many of the "double whammy" effects of gender and race that my informants spoke of. In *Sisters of the Yam: Black women and self-recovery*, Bell Hooks (1993) states that "life-threatening stress has become the normal psychological state for many black women (and men)" (p. 54). She makes two points that have particular implications for this study: (1) Stress-related illness cuts across socioeconomic class and (2) Black women are so socialized to push beyond healthy limits that they are unable to set protective boundaries that would actually eliminate certain kinds of stress. This clearly was identified and experienced by informants in this study.

Informants indicated that society continues to maintain historical stereotypes of black women that often negatively impact health care access and quality of health services. These stereotypes also wound black women emotionally (internalization of racism) and often limit how they see themselves, leaving them feeling invisible. According to Lynn, (peer debriefer), "we kind of just fade out." Taylor (1999) identifies five colonizing images that influence how black women are treated within the health care system. These images are the mammy, the matriarch, the welfare mother, the Jezebel and the black lady overachiever. Black women are treated based on the way they are perceived by the health care professional. The mammy is not expected to ask questions or
need to have procedures explained fully; a matriarch is the strong black woman not needing any support because she can take care of her own. Similarly, Lin, (peer debriefer) often sees differences in care based on race in her nursing practice in a woman's health care center. She explains that various reproductive options are not offered to infertile black women, especially poor black women and she considers this "as racism in the first degree--no loss when there is a loss of a black life." As a result, an additional source of stress arises for her...taking care of black women who are less educated and vulnerable, ensuring that as much as possible the care is the same as it is for white women. For many middle class black women, stress levels are compounded due to her race and gender--the poor black woman's worries become hers as well.

Closely connected to stereotypes, black women also have perceptions about physicians and the medical system that impact care. Informants expressed that racism does exist in the medical system with black women receiving inadequate/unethical care. Dee (peer debriefer) indicates "In my small town where several black women were childless, scenarios indicate that women who were hospitalized for ailments such as appendicitis were subject to the removal of reproductive organs...they took everything out...I never wanted to have appendicitis and I spent many years trying to figure out the connection between appendicitis and not having children."

It became evident that informants generally lacked trust in the medical system when they asked if something deliberately was being done to get rid of black babies. It should be noted that many black women have not had a significant relationship with white males other than through the medical encounter. These women are being asked to trust someone whom she has not had the opportunity to see as trustworthy. The historical
past can send mixed messages to her. She must once again navigate between the two worlds of folk wisdom and conventional medical advice. Does she listen to grandma or the doctor? Who does she see as caring about her the most? Bogart (2001) found that African American women who perceived their physicians as warm and competent utilized health care services more often. It is important for health care professionals to establish a trusting relationship with black women in an effort to improve health care utilization. Mullings and Wali (2000) found similar results from a three-year qualitative study in Central Harlem. They concluded that the negative perceptions about poor black women held by medical providers influenced patient care. Equally important, they indicate that when women perceive these negative attitudes they restrict compliance, attendance, and communication, thus further compromising health outcomes.

Informants felt that physical abuse and poor relationships with men are two areas that negatively impact infant mortality. Equally important, informants felt that many black women maintain secrecy and silence around these events and the pain becomes submerged. Informants offer several explanations for this situation. They suggest that as a result of coping in a racist society, black women actually feel they should be strong enough to bear the physical pain, or they have learned to hold pain in. A history of oppression sets a high bar upon which to measure pain. Another explanation is that this is something that is to be kept quiet. Perhaps this is a cultural coping pattern developed in response to racist stereotypes of the black family, or one that developed as a means to continue the historical role of protecting black males from the penal system in which they remain overrepresented. Additionally, physical abuse was seen as an intergenerational cycle that continued in some families because women do not know anything else actually
exists. According to Lin (peer debriefer) this is "a psychological prison that is seen as normal."

Recent studies confirm the extent to which black women experience physical abuse. PRAMS data from 1997-2000 for the state of North Carolina indicates that black women experienced physical abuse at rates more than twice that of white women before or during conception (Avery, 2003). PRAMS data from 1996-1997 representing fourteen states also indicated that abuse was reported at higher rates among black women. The results from this report link higher rates of abuse with unintended pregnancies. Black women were also found to have higher rates of unplanned pregnancies (Gazmararian et al., 2000). Black women need culturally appropriate avenues to share hidden pain stemming from physical abuse. These findings have implications that were addressed by informants.

Informants indicated the resources and services that they felt would improve pregnancy outcomes for black women. Prenatal care is seen as important; however, Corine (peer debriefer) indicates that "It is not that we neglect prenatal care. Prenatal care does not change patterns of doing and ways of being. We still have the same things to juggle while pregnant. For most women it cannot change during pregnancy!" "We still have to focus on so much that we cannot focus on health." A major need identified was social support. The majority of women in this study planned their pregnancies, but felt that they had lives that were not typical of most African American women. Informants in this study were highly educated and the majority were married to men equally well educated. Their marriages were strong and their finances were secure. For these women their strong marriages, education, and income were seen as buffers to some of the
negative effects of being black and female in America. They had husbands who held
them while pregnant and sang to the infant in utero. They had supportive extended
families and strong friendship circles. This type of social support was seen as having a
positive impact on their pregnancies. The informants who lacked this type of support felt
that their pregnancies were negatively impacted.

Informants felt black women needed support groups that were culturally sensitive
and had black women as members and facilitators. These support groups could address a
host of issues faced by black women, including the pain of fetal/infant loss. One
informant remained severely depressed for two years following a miscarriage because the
support group, while "nice," was entirely white and was not culturally sensitive. This
represents a dual challenge because what informants indicated is that they need both a
culturally sensitive group facilitator and the comfort of group representation. Similarly,
Mullings and Wali's (2000) participants indicated that they did not attend childbirth
classes because of racial and cultural insensitivity.

Informants suggested that black women need national forums to address the
unique burdens of black women that are unacknowledged. They suggest that African
American women need to acknowledge unique burdens, stop and reflect upon their lives,
find out where they are going, and what they want. There is a need to address certain
issues that include motherhood, unplanned pregnancies, male-female relationships, abuse,
internalization of racism, and higher education.

Informants felt African American churches must be involved in infant mortality
research. There was a sense of urgency and frustration because some informants
expressed that many churches are not fulfilling the mission set forth historically to
provide services to assist African American families. Informants expressed that nothing was as important to African American survival as strong values and morals based on spiritual principles. They further expressed disappointment that after all the work that black women have done to ensure survival, young black men now disrespect black women through negative words in rap music. Additionally, they fear that many young African Americans are incorporating negative values from the dominant culture, especially those focusing on obtaining wealth at any cost. They voiced concern that a generation could be lost if churches are not involved..."We have worked too hard and just can't afford to lose our children."

Informants felt that churches needed to address infant mortality in the following ways: (1) Begin to provide information to the African American community about infant mortality. The church should be a significant source of education. They expressed that similar to them, many African American women are not aware that they are at greater risk, (2) Be directly involved in the data collection process by gathering information from women who have either been pregnant, or incurred an infant loss, (3) Provide services when appropriate and connect women to resources and services, and (4) Be a source of social support for all women. Most importantly, it was felt that churches should return to the historical role of teaching and addressing issues important to the well-being of the African American family. These issues include male-female relationships, guidance for youth, pregnancy, racism, and health-related issues.

My understanding of what informants shared with me is expressed in the title of this discussion. So what is the load that has been carried so well by the black woman? The load represents layers and layers of intergenerational pain and oppression. Bartky
(1990) provides the following definition of psychological oppression that speaks to the experiences of my informants: "To be psychologically oppressed is to be weighed down in your mind; it is to have a harsh dominion exercised over your self-esteem. The psychologically oppressed become their own oppressors; they come to exercise harsh dominion over their own self-esteem" (p. 22). These informants while not suffering some of the economic oppression experienced by many black women have not escaped many of the unique burdens that black women share. These burdens include years and years of stress—years and years of coping with stress in unhealthy ways and passing the burden along to daughters. Not feeling loved, wanted or protected. Not feeling control over most everyday situations, feeling silenced, and invisible...less than. More importantly, either being blamed for the problems resulting from this very oppression, or blaming each other. Being called dysfunctional or resilient depending on the perceived reaction to racism. Negative stereotypes both whispered and shouted aloud, and written into medical records and studies. A group of women who are descendants from a group of people captured, enslaved, raped, bred to be physically strong, who lived through slavery, Jim Crow, and the pretense of desegregation and actually survived the physical and mental pain of this oppression, by resisting screaming when she was hurting...hurting while being raped, hurting while looking down at all the hair she lost from perms... that is piled up to her knees, hurting while cleaning public bathrooms, hurting while being turned away from white hospitals when sick, hurting while knowing that she was not considered to be beautiful or desirable...when men said her hair was too nappy and her skin too black and ashy; hurting when she lost a child she was unsure how to protect...from hurting.
The pain became internalized, submerged, hidden, buried, and put on a shelf. She forgot her story. The tears fell on pillows in the middle of the night and she told herself, "I can take this...I am a strong black woman, so tears you just dry up." It does not create a healthy internal environment to learn how to squeeze the process of being oppressed into the very blood that flows through the chambers of one's heart—to have to act like it only takes up a small part of one chamber, when indeed it is a major part of all four. It is not healthy to hide how much this tainted blood hurts and destroys as it is pumped throughout all parts of the body, including the womb. A healthy environment is not created when black girls are taught from infancy that life will never be easy and walls will always be there to be knocked down, that mainstream society will not appreciate their beauty, especially the natural tightly curled state of their hair. A healthy environment is not created when black women are told that they must go above and beyond the task, doing much more than required if they want to even be in the running for the prize. A healthy environment is not created when black women are taught that they must always be strong, not even strong for themselves, but strong for everyone else. A healthy environment is not created when black women allow themselves to be praised and called strong, in some cases called resilient, for learning how to politely die on the inside. Unfortunately, many black women have learned to live in unhealthy environments and how to politely die as a result. These polite deaths are reflected in the health profiles and health statistics of black women, including the infant mortality rate. What is the irony of race and health? It's been said that only the strong survive...African American women have been strong and have survived for centuries, but at what price? For black women, being so strong and surviving is silently killing them and their babies.
Old problems become new problems, and these problems combine to form contemporary issues that relate to infant mortality. Becoming very well educated is seen as the major weapon against racism for black women as we move into a new century. But as is the case for African American women, everything has a second lens through which it must be viewed. While young African American women are increasing opportunities to experience a life unknown to their predecessors, a new source of stress arises: as they become highly educated, options for relationships with black males decrease. This combined with obtaining advanced degrees, often demands that childbirth is delayed into middle age. Studies indicate the health status of African American women begins to decline by the age thirty. My daughter was a Princeton University student when I began this study. She, along with a small group of her very accomplished black female peers, started a club. It was called the Lonely Umbrella Club. Why the name? It rains a lot in New Jersey and unlike their white peers, they were always alone under their umbrellas. They were also alone when it was not raining. They felt alone in classes and at social functions. Excluded. As she and one of her friends wrote at the end of a poem (one of several that they have written together) "Lights, camera, action...Is anyone watching? This is not funny anymore." Not only is it not funny, it is not a healthy environment for young black women. New generations of African American women, unlike their middle-aged mothers have never walked through a door that said "colored," but they continue to face barriers and stressors unique to African American women. How much of the African American female experience is truly understood or appreciated by the majority culture, particularly as it relates to health? It is my hope that findings in this study add to the limited amount of knowledge in this area. Equally important, it is my hope that those in
helping professions reading this dissertation will realize the need to dialogue with black women around issues pertaining to their well-being. Issues relating to well being impact infant mortality. To tell a woman with a ton of bricks on her back that if she works just as hard as someone does with only a few bricks the end result will be the same is almost inhumane. These bricks must be removed and as helping professionals we can develop creative mechanisms to reach out to African American women, address issues of structural oppression, and work towards decreasing its negative effects on her health, including infant mortality.

Limitations of the Study

This is an exploratory study using qualitative methods and as such there are inherent limitations. The sample size, socioeconomic status of participants, and location of the study should be considered.

As is the case in qualitative studies of this scope, these findings cannot be generalized to all African American women. The small sample size was appropriate for purposes of this study, but a larger sample size may have produced different findings. The informants in this study were well-educated, middle class, and for the most part, in stable marriages. Findings may have been different with increased diversity. It should be noted that findings from this study are consistent with those from two recent longitudinal studies that have received national recognition. Both were based on a very large and diverse sample of African American women and were supported by a multidisciplinary research team. Findings from these studies, The African American Women's Voice Project and The Harlem Birth Right Project, were documented in the discussion.
Location is also a consideration. The informants resided in a picturesque rural college community located in the Blue Ridge Mountains. If the study had been conducted in an urban environment, the findings may have been different. My experience has been that African American women in urban environments experience greater levels of stress without the social support that is sometimes available to them in close-knit communities.

This study was based on the lived experiences of the informants. The findings are based on the interpretation of an investigator of the same race, gender and worldview as the informants. While every attempt was made to identify and account for my personal views as I went through the analysis, there is the possibility that an investigator of a different gender and race may have interpreted the lives of these African American women in a different manner.

**Recommendations**

*Social Work Research*

The following recommendations stem from needs and concerns identified by the informants and insight gained as a result of this study. Often what is seen with the eye alone is poorly understood, or misinterpreted. One sense alone does not provide adequate information upon which to begin to understand, or see a phenomenon. My mother once told me a story about a white woman who observed a black woman crying. This woman saw the tears, but her curiosity made her do more than look and observe. She wiped the tears from the face of the woman and tasted them. Her remark was "Your tears are salty, they taste just like mine...When you people cry, you are really crying tears." Yes, African American women do cry and have cried unacknowledged tears for centuries. It will take culturally sensitive investigators using creative research methods to begin to
understand the depth of their pain and the consequences of their oppression. The health status of African American women and their families is a crucial area.

I began this study with the premise that African American women needed to have significant roles as partners in infant mortality research. Additionally, I felt that the quantitatively soaked knowledge base in infant mortality needed the increased understandings that qualitative approaches can provide. Fortunately, a growing number of qualitative studies are beginning to be used in infant mortality studies. The findings from these qualitative studies are beginning to add depth and dimension to existing quantitative studies. As a result of this study I make two observations regarding research in the area of black infant mortality. First, research strategies similar to interpretive phenomenology should be used. Phenomenological research is classified as both a naturalistic (ways data are collected) and a qualitative method. It tends to expand beyond the restrictions present in some qualitative methodologies and allows for multiple ways of understanding how people make sense of their experiences (Cohen, Kahn, & Steeves, 2000). It provided the underpinnings I needed to explore the connection between race and health with black women. Second, after conducting this study, I have come to understand diversity and oppression are two important and separate issues for African American women and must be carefully delineated in studies. From my understanding, diversity addresses who the African American woman is (cultural differences), while oppression speaks to the forces that contributed to shaping how she became (cultural knowledge). Often when issues of diversity and oppression are merged in qualitative studies they become diffused and neither can be fully understood. Worse yet, these well-meaning qualitative studies reinforce the negative stereotypes of black women held by many. I argue that studies
framed in the context of historical oppression explain more fully the connection between race and health versus those that focus on cultural difference and allude to oppression.

The African American church is a cornerstone of the black community (Taylor et al., 2000). During the course of the study I was made aware that issues relating to health are paramount to pastors and their congregations. Coupled with this, there is a national agenda that encourages faith communities to be involved in providing helping services (Farris, 2002). Additionally, African American women want the church to address the needs of the family. One way to address these needs would be to have social workers assist African American churches in developing research agendas and conducting research in the area of infant mortality. As seen in this study, most variables that impact black families and health also impact infant mortality. Investigators must address infant mortality from a broad perspective and examine not only infant death, but also what services and supports women need before, during, and after pregnancy. Examples include: 1) recruitment and retention in support groups/peer mentoring, 2) breastfeeding, 3) childcare, and 4) body image. Infant mortality reflects the well-being of a group and must be understood holistically. Forming partnerships with African American churches will help provide culturally appropriate medical care and support groups based on knowledge and experience versus stereotypes and supposed-to-be truths.

The National Institute of Health (2001) has provided an excellent summary of the progress and future strategies for health research. Based on my review of the literature and understanding of knowledge gaps, these efforts should have a positive impact on national efforts to address infant mortality and are consistent with those identified in the
Aim of the Study. Informants gave several ideas for future research. Keeping these ideas at the forefront, I formulated the following future research topics:

- Conduct case studies with black women who are from families that have experienced multiple and/or intergenerational infant loss.

- Conduct ethnographic studies with black women during the course of their pregnancies. Have both rural and urban black pregnant women involved as research partners.

- Use a combination of qualitative and quantitative studies to examine stereotypes and perceptions of black women held by physicians in the prenatal encounter.

- Use qualitative methods to explore the content of prenatal care for black women.

- Explore the pregnancy planning process for black women.

- Explore folk wisdom surrounding health, wellness and pregnancy with black women who are elders.

- Explore male-female relationships with black women and black men.

- Use qualitative methods to explore contemporary issues impacting the reproductive health of young black women.

Social Work Education

Delivering social work services to oppressed populations is one of the basic tenets framing the profession, (NASW, 1996) yet from my review of several texts; concrete information on health disparities is not included in core courses like Human Behavior and the Social Environment. Furthermore, even courses that focus on diversity do not fully help students grasp the deadly effects of oppression and health. Given the findings of this study, social work students must fully understand this connection. Racism and oppression
are not forces that simply inconvenience people; they kill the body in very specific manners. I read through recent copies of Human Behavior texts. In one text, the three-page discussion on low birth weight and preterm infants did not mention infant mortality and African American risk. Interestingly, the text mentioned that social workers should be brokers for pregnant women who needed increased resources. Many dots were left for students to connect. When the dots are connected, it is doubtful students will have a complete picture (there will be nothing to color in) that will allow them to practice effectively with women of color. They cannot be expected to advocate for women they have no knowledge of. Unless the health consequences of oppression are included in core social work courses, students will not gain a full understanding of race and health—therefore they will not understand how to connect the dots and see a picture that explains oppression.

Before I began this study, I was convinced that multidisciplinary teams should be used to conduct social science research. The issues and concerns that we face as a nation will take this kind of effort and worldview. Fortunately there is a small, but growing trend to have multidisciplinary teams address social issues holistically. A natural place for the type of preparation is a graduate level qualitative methods class composed of anthropology, nursing, social work, and medical students taught by representatives from each discipline. Students would have the opportunity to learn how different disciplines think about and conduct research. Research centers could be formed in universities based on these efforts and it would be a natural avenue to have universities support and nurture the communities in which they reside. Multidisciplinary efforts to devise and teach
graduate level research courses should lead to the development of new methods to address complex issues of the new century, like infant mortality.

Social Work Practice

Social workers must advocate for comprehensive care for women regardless of pregnancy status. This is particularly important in medical and school settings. The focus on facilitating care during the prenatal period and for a short time in the postpartum period is insufficient for improving pregnancy outcomes and infant health, as well as women's long term health (McCloskey, Bigby, & Brand, 1997). Current policies isolate the reproductive capacity of women from the more basic comprehensive health care of women. This results in intermittent access to clinical and supportive services, and concentrates interventions on complex medical and social problems during a limited period of time (Chomitz et al., 1995). To date, no care coordination programs or enhanced services have focused on high-risk women before they become pregnant (McCloskey et al., 1997). Behaviors and social stressors that may contribute to a black woman's risk of preterm delivery are there before, during, and after the pregnancy. Given the findings from this study, preventive strategies should address racism across many systems including the primary health care of black women and girls. Such interventions promise to be more successful than the current intermittent strategies based on a woman's pregnancy status.

It is important to develop strong interpersonal relationships with the African American women served. According to informants, there is a strong distrust of the medical system. It is important that women who are culturally, racially, and/or ethnically distinct from the mainstream health care system have at least one person on the team with
whom they can build a strong relationship. Older African American women could serve as "medical mentors" for young women entering the medical system. Strong interpersonal relationships form the basis of access to care (McCloskey et al., 1997). Given social work's mission, medical providers could be assisted with knowledge and skill development that would enhance the relationships with the African American women they provide services. Social workers should incorporate principles from the Afrocentric perspective (previously mentioned) into their practice knowledge base (Schiele, 1996). One way that this could be accomplished would be to consider the art, history, folkways and fiction of African Americans as legitimate ways of increasing cultural knowledge. Increasing cultural knowledge is an important step in becoming culturally competent (Fong, 2001).

Outreach must be extended to all African American women of childbearing ages. Informants indicated that they needed support and education on childcare, issues dealing with abuse, grief and loss, and stress management, regardless of class. It has been verified that African American women seek support in different ways depending on social class (Mullings & Wali, 2000). The traditional model of home visitation is not appropriate for or desired by all women, nor do these methods tend to reach African American women who are considered to be middle or upper middle class. Social workers should use natural settings to network with African American women (self-help organizations, sororities and fraternal organizations) in an effort to ensure that a broader base of African Americans become educated and mobilized around issues regarding their health and the health of their infants.
It is crucial that social workers participate in health disparity research. They must ensure that fetal infant mortality review boards (FIMR) are inclusive of black social work professionals, including those from colleges and universities. I participated in the final phases (data analysis and writing the final report) of the most recent FIMR study (1999) sponsored by the Marion County Public Health Department in Indianapolis, Indiana. Social workers were underrepresented in this study.

It is paramount that as social workers our research efforts and practice reflect our attempts to effectively meet the challenges present in the lives of those we have a mission to serve. Our research efforts, as well as our practice and social work curriculums must indicate that we are attempting to understand the complexities of race, and the health effects of racism. Unhealthy people cannot reach their full potential and in the instance of infant mortality, some members of our society are not given a chance to live. It must be understood that even those black infants who survive the first year face a very uncertain future in America. Chima (2001) indicates that social workers must take social change initiatives from an ideological level to a programmatic one. Social action strategies must demand that government contribute to a better quality of life for African Americans that provides equality of opportunity and social justice through public policies and services to enhance their well-being. Specific policies include those that address the structural barriers in the area of employment, housing, education and health that will reduce family stress (Chima, 2001).

This study is unique among infant mortality studies because it uses the life experiences of middle to upper class African American women to increase knowledge in the area of infant mortality. This study provides the insider's perspective...African
American women have suggested some of the factors they feel are related to the increased risk of infant death based on lived experiences. This study did not limit or ask information that focused on any one area, for example prenatal care. In this manner, women were given the opportunity to recall experiences without predetermined parameters. It allowed them to determine what was important to explore. The findings suggest that such policies as outlined by Chima (2001) would begin to address and relieve some of the historical burdens of black womanhood. Such efforts would in turn, improve pregnancy outcomes and as a society we could begin to ensure that babies born to black mothers have the same chances of survival as babies born to white mothers. It is the year 2005 and infants whose mothers are black continue to die at rates twice those of infants whose mothers are white. Social workers and other helping professionals must challenge this unfair, yet pervasive trend in America. We must move beyond the point where one's race serves as the litmus test for good health or poor health--life or death, especially for the most vulnerable members of our society...our babies.
IUPUI AND CLARIAN INFORMED CONSENT STATEMENT

Understanding the Social and Cultural Factors Related to African American Infant Mortality:
A Phenomenological Approach

STUDY PURPOSE:

Why do babies born to African American mothers die more often before their first birthday (infant mortality) than other babies do? As part of my doctoral study I am trying to find answers to this problem. In order to do so, I need your help. I feel that the life experiences, thoughts and knowledge that African American women have are important in understanding infant death. I want to know what you think, feel and know about infant death. It would be a wonderful privilege to have your participation in this study.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of 20 women who will be participating in this research locally. Ten women will be members of a focus group held at Asbury United Methodist Church and 10 women will have an individual interview with me.

PROCEDURE FOR THE STUDY:

If you agree to be in the study, you can participate by either being a member of a focus group or having an individual interview with me. The focus group will meet for no longer than two hours and will be held at Asbury United Methodist Church in Christiansburg, Va. You will be responsible for your transportation to Asbury United Methodist Church. I will chose a convenient time based on the availability of most participants. Approximately 10 women will meet and the group session will be audiotaped to accurately gather the information that is shared. You will not be personally identified in any of the reports of this study. If you choose to have a personal interview with me, you may select the location and time for the interview. You will receive copies of the information gathered in the study and will have an opportunity to review what I have written. It should be very informative and stimulating to sit around the table and hear and reflect on what African American women think and feel about infant mortality. I will make every effort to make this a pleasant and rewarding experience for you. Light snacks will be served.

RISKS OF TAKING PART IN THE STUDY:

While I will make every effort to maintain your confidentiality, there is a chance that there could be a loss of confidentiality. You may refuse to answer any question that you do not wish to. I will use my expertise in interviewing and group process to ensure that each participant feels comfortable and valued. If at any time you feel uncomfortable during either the group session or the personal interviews, you may discontinue participation in the study.

BENEFITS OF TAKING PART IN THE STUDY:

The majority of studies on African American infant mortality do not seek the worldview of African American women. You will be among a handful of African American women
who have had the opportunity to make a contribution to a growing body of research in the area of infant mortality.

CONFIDENTIALITY:

This study will be published as a doctoral dissertation and some sections of it will be published in both professional journals and magazines of interest to the general public. The IUPUI Institutional Review Board (IRB) or its designees may review study records. Any information obtained in connection with this study that can be identified with you will remain confidential. Participant’s actual names will not be used during the group sessions or individual interviews or in any subsequent publications or presentations about the study.

CONTACTS FOR QUESTIONS OR PROBLEMS:

For questions about the study please contact me at 540-961-4731 or by email at glennabarnes@psknet.com. In addition you may contact the chair of my doctoral committee, (Dr. Margaret Adamek) at (317-274-6730), or use her email address madamek@iupui.edu. For questions about your rights as a research participant, contact a subject representative who is not involved with the study in Research Compliance Administration at 317-274-8289.

VOLUNTARY NATURE OF STUDY:

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. There will be no consequence to you for leaving the study.

PARTICIPANT’S CONSENT:

In consideration of all of the above, I give my consent to participate in this research study.

I acknowledge receipt of a copy of this informed consent statement.

PARTICIPANT’S SIGNATURE: ___________________________________________________________________________ Date: ____________________________

(must be dated by the participant)

WITNESS: ____________________________________________________________________________________________

Date ____________________________________________________________________________________________
Figure I
Infant Mortality Rates by Race of Mother from 1950-1990
National Vital Statistics System NCHS 1998
Figure II
Infant Mortality Rates by Race of Mother for the Years 1990, 1995 and 1998
NCHS January 2002
Figure III
Educational Attainment of Mother by Race and Infant Mortality Status
NCHS January 2002

[Bar chart showing educational attainment by race and infant mortality status]
Figure IV
Infant Mortality Rates by Race and Gender
NCHS January 2002
Figure V
Marital Status of Mother by Race and Infant Mortality Rates
NCHS January 2002
Figure VI
Maternal Smoking During Pregnancy by Race and Infant Mortality Rates
NCHS January 2002
Figure VII
Age of Mother by Race and Infant Mortality rates
NCHS January 2002
Figure VIII
Trimester of Prenatal Care by Race and Infant Mortality Rates
NCHS January 2002
REFERENCES


Office of Behavioral and Social Sciences Research, National Institutes of Health (2001). Toward higher levels of analysis: Progress and promise in research on social and cultural dimensions of health (NIH Publication N. 01-5020). Bethesda, MD: NIH.


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