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Cruel and Unusual Punishment:

Reproductive Inequity among Incarcerated Black Women

Danielle Quick Holmes

May 2021

Vassar College

Poughkeepsie, NY

Advised by Elizabeth Bradley and Jose Perillán



A Senior Thesis Submitted to the Faculty of Vassar College in Partial Fulfillment of the Requirements for the Degree of Bachelor of the Arts in Science, Technology & Society

Trigger Warning

Graphic depiction of violence against Black women and families.

Abstract

In my thesis, I will argue that Black incarcerated women face increased reproductive disparities as a result of their multiple marginalized identities. Even though Black women have the fastest growth rate of incarceration there is minimal evidence on how imprisonment affects their already inadequate reproductive health care. I begin by providing a history of mass incarceration in the United States and explain how it disproportionately affects the Black community. I then document Black women's history of gynecological and reproductive abuse, starting with slavery and closing with present-day inequalities such as forced sterilization and disproportionate rates of infant and maternal mortality. After explaining Black women's reproductive history, I depict stories of the detestable health care afforded to women in prison. Finally, I close with a call to action. I analyze examples of prison reproductive interventions in the hope that the interventions mentioned will be used as a jumping-off point for more large-scale change. It is crucial that the unique reproductive inequity Black incarcerated women face is met with extensive empirical research and documentation in order to effectively bring an end to these injustices.

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This thesis goes to all the strong souls who have fallen victim to America's mass incarceration epidemic and the wonderful people working vehemently to bring an end to it.

Introduction

"There is no such thing as a single-issue struggle because we do not live single-issue lives."

— Audre Lorde (1982)

As a Black woman who has come of age in predominantly white spaces, I have often been forced to reckon with the fact that many of my close friends will never understand the difficulties of moving through life as a woman of color. On March 22nd, 2021, my housemates and I became eligible for the COVID-19 vaccine. After waiting all year, we were thrilled to finally have the opportunity to receive this lifesaving inoculation. Unfortunately, soon after receiving the email, I was forced to grapple with the reality that too often medical advancements are not made with women or people of color in mind. I began researching questions like “Has the COVID-19 vaccine been tested on diverse candidates?” and “What are the effects of the COVID-19 vaccine on Black women?” I was all too aware of the many medical crises that have resulted from doctors and scientists’ lack of consideration for Black patients. Although my anxieties were eventually soothed by my predominantly positive COVID vaccine research, I knew that typically diseases that affect predominantly Black people or people of color often receive less funding than those that affect white people regardless of the disease's impact. For example, my cousin suffers from Sickle Cell Disease (SCD), a condition that affects 1 in 365 Black people in the United States.¹ However, despite the high prevalence of this disease, Cystic Fibrosis (CF) a

¹ MD Faheem Farooq, “Sickle Cell Disease and Cystic Fibrosis Research Funding and Research Productivity,” JAMA Network Open (JAMA Network, March 27, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2763606>.

disease that affects 1 in 2500 white people in the U.S. receives 3.5 times more funding from the National Institutes of Health than SCD.²

This story provides one example of the numerous ways in which my intersectional identity has shaped the way I interact with the medical community and the world. These experiences, however, are not unique to me. Black women often have to question whether their doctors—whom we are supposed to depend on for their expertise—are correct when they dismiss our symptoms as insignificant or whether they are simply falling into a common pattern among physicians of diminishing Black women’s ailments. Life as both a woman and a person of color poses a distinctive set of problems that can be hard to navigate let alone elucidate. My thesis is an attempt to demystify the challenges of living an intersectional life.

Sadly, in the U.S. there are many examples of medical disparities in the Black community. America’s history of slavery and racism has created immense and prevailing anti-Black rhetoric in the medical community. When attempting to narrow my thesis research I wanted to focus on people whose voices continue to go unheard. Like Keeanga-Yamahtta Taylor stated in her collection of essays, *How We Get Free: Black Feminism and the Combahee River Collective*, “always ally yourself with those on the bottom, on the margins, and at the periphery of the centers of power. And in doing so, you will land yourself at the very center of some of the most important struggles of our society and our history.” I accordingly chose to focus on one of the most vulnerable populations in the U.S., incarcerated Black women to ascertain how these combined marginalized identities affect one of the most ill-protected health systems—

² Farooq, “Sickle Cell Disease and Cystic Fibrosis Research Funding and Research Productivity,”

reproductive health. My thesis seeks to explain how the heightened rate of incarceration in Black communities and the inhumane reproductive health care provided for incarcerated women combine to perpetuate high rates of reproductive health inequalities in this marginalized community.

I recognize that while my thesis will be focusing on cis-gender Black women, non-female identifying people also give birth in prisons. Additionally, as a result of their intersectionality as Black, incarcerated, and non-female identifying birthing people, they face added discrimination, health care mistreatment, and violence. It is important to keep all birthing people in the reproductive justice conversation but unfortunately, this was beyond the scope of my thesis.

To elucidate the combined inequity that incarcerated Black women face as a result of their intersectional identities as women, people of color, and women in prison, I will first examine the big picture issues like the effects of mass incarceration on Black communities and the racist history of gynecology. In chapter one, I will explain how Richard Nixon and later Ronald Regan's War on Drugs campaign served as a covert operation to single out low-income Black drug users. The "get tough on drugs" mission disproportionately targeted African Americans thus increasing their—often violent—encounters with the police and drastically increasing their incarceration rates. The chapter will detail the adverse effects mass incarceration has on Black American communities such as heavy financial burdens, family strain, increased health inequalities, and lower life expectancy. Lastly, towards the end of chapter one, I will shift gears and address the significant lack of information on how mass incarceration affects Black women, despite the fact that women of color face the highest growth rate of incarceration.

Chapter two will continue to provide a broader perspective of Black women's reproductive health inequalities by providing a timeline detailing the injustices they have encountered starting with slavery and culminating in the present-day medical inadequacy. First, I will frame these inequities within the context of gynecological history. The gruesome gynecological experiments performed on Black enslaved teenagers by white doctors during the 19th century are not part of some irrelevant past, as their effects continue to inform how doctors see and treat Black women today. The chapter traces these effects through the eugenics movement, forced sterilization programs, and the current high rates of infant and maternal mortality Black mothers face.

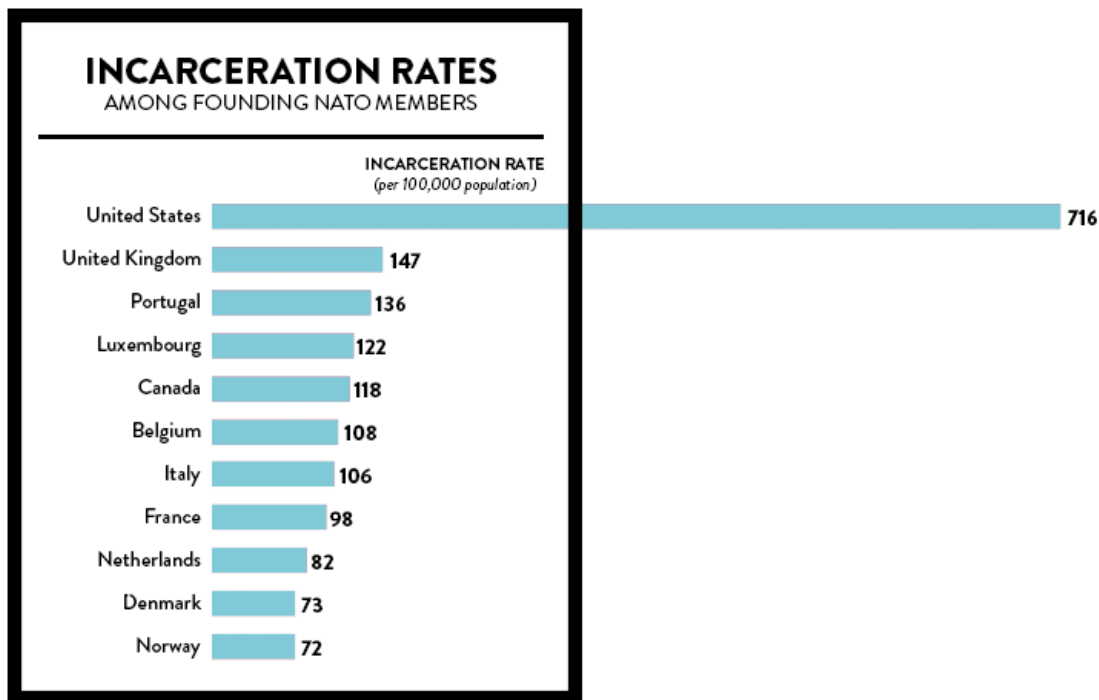
Following chapter two, I begin to draw parallels between the aforementioned historical events and current disparities in the incarcerated Black women's population. I illustrate how our abusive American history led to the dehumanization of Black women and later resulted in the complete neglect of health care for Black incarcerated women. Chapter three takes an explicit look at what life is like for women in prison by recounting interviews and stories from incarcerated women. What emerges is a picture of deplorable health care including a lack of prenatal care, nutritious food, and proper birthing protocol, not to mention the general prevailing neglect, abuse, and trauma of incarceration.

Although nothing short of prison abolition can adequately resolve the damage caused to Black people by the prison system, several smaller-scale reforms can serve to abate the disparities along the way. The final chapter provides an analysis of health care interventions, such as the SisterSong Women of Color Reproductive Justice Collective, a grassroots organization working on prison health care reforms. The final chapter suggests how lessons

learned from reproductive organizations and prison policy interventions can provide hope for the possibility of improved reproductive health care for incarcerated Black women.

Chapter One: Mass Incarceration in the Black Community

The criminal justice system in the United States is born of and continues to perpetuate racial injustice and economic inequity. The U.S. has the highest incarceration rate in the world despite having crime levels comparable to other internally secure and industrialized nations. The U.S. rate of incarceration is more than five times higher than most countries in the world.³ In 2017, approximately 2.27 million people in the U.S. were incarcerated—a figure that amounts to 716 people for every 100,000 residents (*Figure 1-2*).⁴



Source: <http://www.prisonpolicy.org/global/>

Figure 1. U.S. incarceration rate compared to other North Atlantic Treaty Organization (NATO) countries

³ “States of Incarceration: The Global Context,” States of Incarceration: The Global Context | Prison Policy Initiative (Prison Policy Initiative), accessed May 21, 2021, <https://www.prisonpolicy.org/global/>.

⁴ “United States Still Has Highest Incarceration Rate in the World.” Equal Justice Initiative, November 4, 2019. <https://eji.org/news/united-states-still-has-highest-incarceration-rate-world/>.

Source: Prison Policy Initiative, 2021

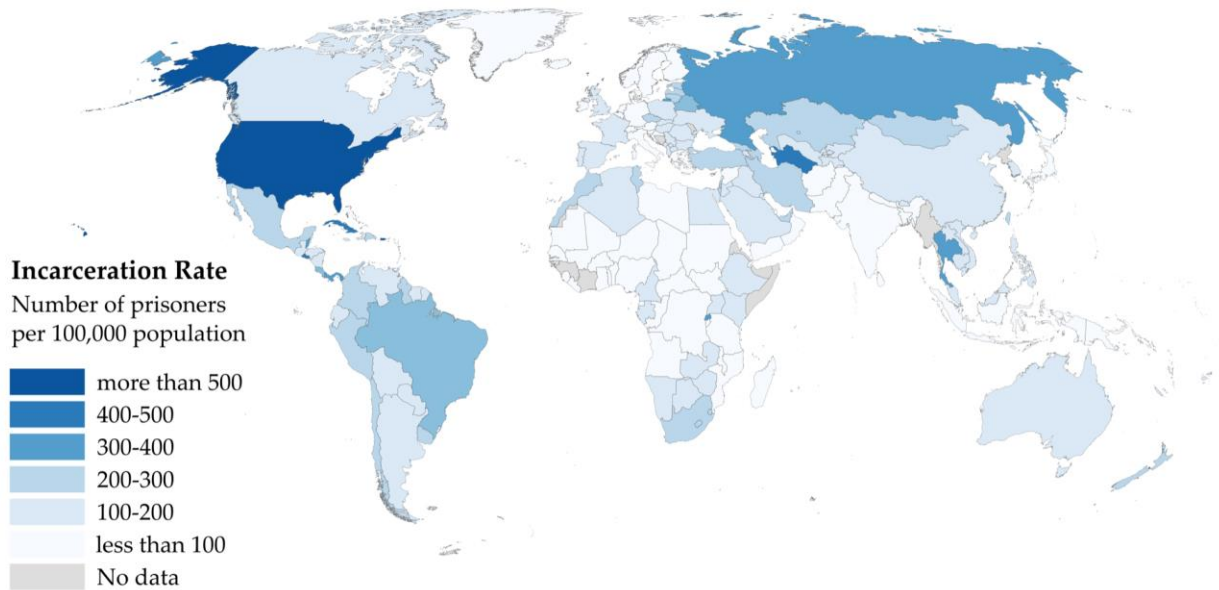


Figure 2. Map of incarceration rates by country

Source: World Prison Brief

Mass incarceration has created challenges within U.S. prisons such as overcrowding, increased health risks, and decreased psychological well-being.⁵ This system unjustly targets the Black community and forces them into submission.⁶ One of the most at-risk and overlooked victims of the mass incarceration epidemic is Black women. The imprisonment rate for Black women was

⁵ "Incarceration Rates By Country 2021," Incarceration Rates By Country 2021, 2020, <https://worldpopulationreview.com/countries/incarceration-rates-by-country/>.

⁶ Susan Shah Genia Wright, Ram Subramanian, and Flozell Daniels, "An Unjust Burden," Vera Institute of Justice (Vera Institute of Justice, February 26, 2018), <https://www.vera.org/publications/for-the-record-unjust-burden>.

1.7 times the rate of imprisonment for white women in 2019.⁷ Black women, and incarcerated women in general, are confronted with inhumane reproductive health care conditions in prisons.

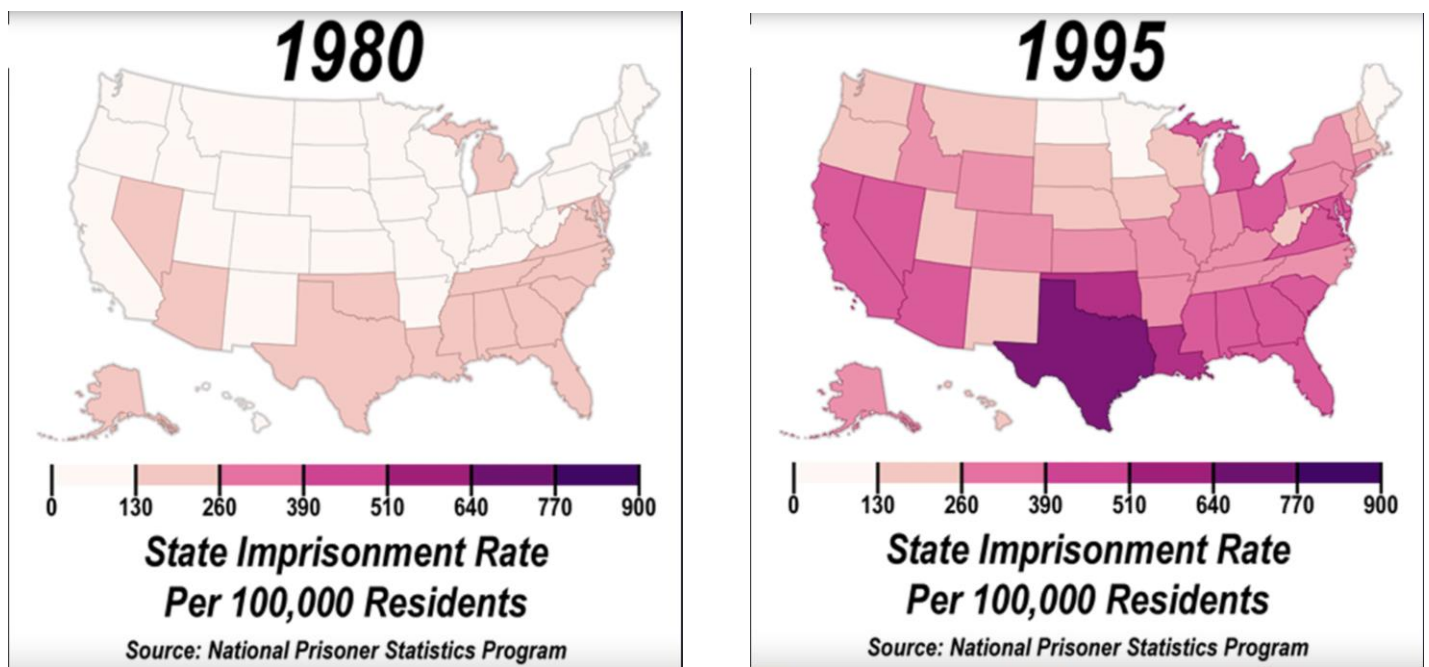


Figure 3. Increase in U.S. Incarceration rate between 1980 and 1995

Source: National Prisoner Statistics Program

The mass incarceration epidemic was fueled by President Richard Nixon’s view that the United States’ drug problem was “public enemy number one” and his declaration of the “War on Drugs.”⁸ Although the War on Drugs was supported by relatively weak federal law-enforcement efforts under Nixon, funding increased following the election of President Ronald Reagan in 1981. The escalation of the War on Drugs in the Reagan, and subsequently Clinton,

⁷ Nazgol Ghandnoosh, “Incarcerated Women and Girls,” The Sentencing Project (The Sentencing Project, November 24, 2020), <https://www.sentencingproject.org/publications/incarcerated-women-and-girls/>.

⁸ Britannica, T. Editors of Encyclopaedia. “War on Drugs.” Encyclopedia Britannica, July 23, 2020. <https://www.britannica.com/topic/war-on-drugs>.

administration created numerous adverse effects that are still being felt in Black communities today. During his presidency, Reagan heavily expanded the reach of Nixon's campaign and focused his efforts on the criminalization of drug use rather than its treatment, which in return led to a massive increase in incarcerations for nonviolent drug offenses. Between 1980 and 1997, the prison population increased from 50,000 to 400,000 (*Figure 3*).⁹

Although the criminal justice system has always struggled with institutionalized racism, the racist undertones of the War against Drugs became more apparent after the 1986 Anti-Drug Abuse Act which placed a mandatory minimum sentence of 5 years on drug offenses.¹⁰ For example, powder cocaine abusers could possess up to *500 grams* before being penalized, whereas crack cocaine abusers were incarcerated when in possession of *5 grams*.¹¹ Aside from how the drug is ingested and how quickly it affects the body, the only notable difference between crack cocaine and powder cocaine is the demographic it attracts. Due to its affordability and high presence in minority neighborhoods, Black Americans are the most likely to be in possession of crack cocaine.¹² Powder cocaine, on the other hand, is more commonly found in middle and high-income white neighborhoods. Despite the difference in pricing, the two substances are largely identical and contain the same active ingredient.¹³ As a result of the higher arrest rates and harsher penalties for crack versus powder cocaine, crack cocaine has developed more of a societal stigma; we are socialized to see those who use it as degenerates, whereas powder

⁹ Britannica, T. Editors of Encyclopaedia. "War on Drugs."

¹⁰ Ibid.

¹¹ Ibid.

¹² Editorial Staff, "Differences Between Crack and Cocaine (& Myths) - Oxford Treatment," Oxford Treatment Center (American Addiction Centers Oxford Treatment Center, August 27, 2019), <https://oxfordtreatment.com/substance-abuse/cocaine/crack-vs-cocaine/>.

¹³ Ibid.

cocaine is heavily associated with wealth, Wall Street, and rich white teenagers. Thus, the War on Drugs created a new form of segregating policies, similar to Jim Crow: laws that wrongfully incarcerated people of color at drastically higher rates than their white counterparts.

Tougher drug policies were endorsed equally across party lines; in 1994, President Bill Clinton passed the Violent Crime Control and Law Enforcement Act, also referred to as the 1994 crime bill, which is now seen as one of the major drivers of mass incarceration.¹⁴ Clinton's crime bill remains the most extensive federal crime legislation ever passed with a total of 365 pages.¹⁵ The crime bill "authorized the death penalty for dozens of existing and new federal crimes, and it mandated life imprisonment for a third violent felony, also known as the 'three strikes and you're out' rules."¹⁶ Additionally, the bill banned 19 types of semiautomatic assault weapons and instituted a Violence Against Women Act (WAWA) designed to protect women who are victims of domestic violence.¹⁷ However, the enduring impact of the legislation is the federal stamp of approval it gave states to pass harsher crime penalties and the grant incentive it gave "to build or expand on Correctional facilities through the Violent Offender Incarceration and Truth-in-Sentencing Incentive Grants Program."¹⁸ The Truth-in-Sentencing Program "provided \$12.5 billion in grants to fund incarceration, with nearly 50 percent earmarked for states that adopted tough 'truth-in-sentencing' laws that scaled back parole."¹⁹ Thus fueling the prison construction

¹⁴ Eisen, Lauren-Brooke. "The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System." Brennan Center for Justice. Brennan Center for Justice at NYU Law, September 9, 2019. <https://www.brennancenter.org/our-work/analysis-opinion/1994-crime-bill-and-beyond-how-federal-funding-shapes-criminal-justice>.

¹⁵ "U.S. Department of Justice Fact Sheet," Violent Crime Control and Law Enforcement Act of 1994. (National Criminal Justice Reference Service, n.d.), <https://www.ncjrs.gov/txtfiles/billfs.txt>.

¹⁶ Eisen, "The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System."

¹⁷ Ibid.

¹⁸ Ibid; Udi Ofer, "How the 1994 Crime Bill Fed the Mass Incarceration Crisis," American Civil Liberties Union (American Civil Liberties Union, June 4, 2019), <https://www.aclu.org/blog/smart-justice/mass-incarceration/how-1994-crime-bill-fed-mass-incarceration-crisis>.

¹⁹ Eisen, "The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System."

boom by allowing states to receive money for expanding their prison capacity.²⁰ Although the crime bill did not initiate mass incarceration in the United States, it created a competition out of increasing tough and ultimately racist crime penalties therefore allowing incarceration rates to continue to climb for 14 more years following the bill enactment.²¹

Over-policing of drug use in Black communities continues today. Black Americans are 3.73 times more likely than white Americans to be charged for marijuana possession despite equal rates of usage.²² Even if a person is not incarcerated for possession of marijuana, the repercussions of being arrested and convicted, which include job loss, ineligibility for public housing, suspended driver's license and restrictions on access to federal student loans can significantly thwart their lives.²³ Similarly, the disproportionate rate of arrest has proven to have long-term effects on minority communities. A study done by the *Sociological Science* journal in 2014 found that young boys whose fathers had been incarcerated were less likely to develop “the behavioral skills needed to succeed in school by the age of 5, starting them on a vicious path known as the school-to-prison pipeline.”²⁴

The United States continues to implement racially discriminatory policing policies; according to the New York Civil Liberties Union, in 2011 at the height of stop-and-frisk—a policy which allowed police officers to randomly stop anyone they deemed suspicious—over

²⁰ Eisen, “The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System.”

²¹ Udi, “How the 1994 Crime Bill Fed the Mass Incarceration Crisis,”

²² Editorial Staff, “Differences Between Crack and Cocaine (& Myths) - Oxford Treatment,” Oxford Treatment Center (American Addiction Centers Oxford Treatment Center, August 27, 2019), <https://oxfordtreatment.com/substance-abuse/cocaine/crack-vs-cocaine/>.

²³ “Drug Law Reform,” American Civil Liberties Union (American Civil Liberties Union, n.d.), <https://www.aclu.org/issues/criminal-law-reform/drug-law-reform>.

²⁴ Lopez, German. “The War on Drugs, Explained.” Vox. Vox Media, May 8, 2016. <https://www.vox.com/2016/5/8/18089368/war-on-drugs-marijuana-cocaine-heroin-meth>.

685,000 people were stopped and 87% of them were Black or Latinx.²⁵ Although the stop-and-frisk policy was eventually banned in 2013 for being both ineffective and racist—9 out of 10 New Yorkers stopped were completely innocent—police officers continue to unfairly target and subsequently imprison people of color.²⁶ Police officers have confessed that federal programs encourage police departments to crack down on drugs in minority communities.²⁷ A retired police officer, Neil Franklin stated that “minority communities are ‘the low-hanging fruit’ for police departments because they tend to sell in open-air markets, such as public street corners, and have less political and financial power than white Americans.”²⁸ Unjust policing tactics like the one Franklin described are part of the reason African Americans make up 33% of the federal and state prison population, despite only comprising 12% of the U.S. population.²⁹ For comparison, adult white Americans comprise 64% of the U.S population but only 30% of the federal and state prison population.³⁰ Even though officers frequently abuse their power, federal grants have increased the militarization of local police departments. Consequently, in addition to being over-policed and over incarcerated, Black Americans are killed by police brutality at disproportionately higher rates than white Americans. Last year, 1,099 people were killed by police brutality, and 24% were African Americans, making them 3 times more likely to be killed by a police officer than white Americans.³¹ Although police brutality and the Black Lives Matter

²⁵ “Stop-and-Frisk Data,” New York Civil Liberties Union (New York Civil Liberties Union, March 11, 2020), <https://www.nyclu.org/en/stop-and-frisk-data>.

²⁶ “Stop-and-Frisk Data,” New York Civil Liberties Union

²⁷ Lopez, “The War on Drugs, Explained.”

²⁸ Ibid.

²⁹ John Gramlich, “The Gap between the Number of Blacks and Whites in Prison Is Shrinking,” Pew Research Center (Pew Research Center, August 27, 2020), <https://www.pewresearch.org/fact-tank/2019/04/30/shrinking-gap-between-number-of-blacks-and-whites-in-prison/>.

³⁰ Ibid.

³¹ Connor Rothschild, “Mapping Police Violence,” Mapping Police Violence, n.d., <https://mappingpoliceviolence.org/>.

movement—a movement founded in 2013 after the acquittal of Travon Martin’s murderer, have been receiving more media attention in the past year as a result of the killing of George Floyd; very little is being done to hold the murderous police officers accountable.³² Furthermore, Black Americans are murdered by police at a higher rate than white Americans despite being 1.3 times *less* likely to be in possession of a firearm.³³ These statistics on police violence and murder are true for both Black men and women. The constant berating of Black people by police officers results from the criminal stereotype that society has cast on them. This stereotype is a byproduct of the many instances of white supremacy in America’s history seeking to control and denigrate the Black population.

French Philosopher, Michel Foucault’s *Discipline and Punish*, seeks to analyze the role of punishment and power in relation to society and the penal system. He explains that the switch from bodily forms of punishment like public execution in the pre-eighteenth century era to the increasingly private prison reforms of the eighteenth century were not a result of concern for prison welfare rather an attempt to make their power and control more effective.³⁴ However, Foucault believed that the shift did result in a more disciplinary form of control.³⁵ His reflection on Bentham’s Panopticon—a circular prison facility where all the incarcerated individuals face one security guard whom they cannot see, is the epitome of his theory on disciplinary power.³⁶ He describes the Panopticon as “an important mechanism, for it automatizes and

³² About,” Black Lives Matter, October 16, 2020, <https://blacklivesmatter.com/about/>

³³ Rothschild, “Mapping Police Violence,”

³⁴ Michel Foucault and Alan Sheridan, *Discipline and Punish: the Birth of the Prison* (London: Penguin Books, 2020).

³⁵ Ibid.,

³⁶ Felluga, Dino. "Modules on Foucault: On Power." *Introductory Guide to Critical Theory*. 2015. Purdue U. 2020 <<http://www.purdue.edu/guidetotheory/newhistoricism/modules/foucaultpower.html>>.

disindividualizes power.”³⁷ He continues by saying, “Power has its principle not so much in a person as in a certain concerted distribution of bodies, surfaces, lights, gazes; in an arrangement whose internal mechanisms produce the relation in which individuals are caught up”³⁸ In the Panopticon penal system, incarcerated individuals start to monitor themselves and therefore internalize discipline because they never know if they are being watched by a guard.³⁹ According to Foucault in a disciplinary society, the shift away from punishing criminals' bodies, like in pre-eighteenth century society, towards disciplining their minds was meant as a form of rehabilitation.⁴⁰ Today, however, Foucault’s interpretation of prisons as disciplinary is out of step with American prisons which have taken a punitive turn away from rehabilitation towards cruel and unusual punishment designed to incapacitate individuals.⁴¹

Although Foucault’s analysis was important to thinking about the institutionalization of power through the prison system, it did not go far enough. An analysis today would require an unpacking of the pervading racial injustices of the prison industrial complex and the inhumane treatment of incarcerated people, specifically Black women. For in contrast to what Foucault believed, the hidden and unofficial practices of the American penal system has allowed brutality and torture to flourish— “away from public scrutiny, it thrives on retribution’s personalized and sadistic logic, all that remains of the criminal justice system’s moral purpose after rehabilitation disappeared.”⁴² In particular, sociologist David Garland states that, "the prison is used today as a

³⁷ Foucault and Sheridan, *Discipline and Punish: The Birth of the Prison*, 202.

³⁸ Ibid, 202.

³⁹ Felluga "Modules on Foucault: On Power."

⁴⁰ Roger Lancaster, “How to End Mass Incarceration,” Jacobin (Jacobin, August 18, 2017), <https://www.jacobinmag.com/2017/08/mass-incarceration-prison-abolition-policing>.

⁴¹ Lancaster, “How to End Mass Incarceration,” Jacobin (Jacobin, August 18, 2017),

⁴² Ibid.

kind of reservation, a quarantine zone in which purportedly dangerous individuals are segregated in the name of public safety."⁴³ Modern prison systems do not seek to better their incarcerated individuals, instead they operate like pressure cookers.

Black women have suffered greater repercussions than both Black men and white women as a result of the increased policing of drug offenses. According to the federal Bureau of Justice Statistics, since 1980 the growth rate of women imprisonment is twice the rate of men.⁴⁴ Additionally, Black women are two times more likely than white women to be arrested and imprisoned; thus, Black women have the fastest growth rate of imprisonment in the United States.⁴⁵

The literature exploring how prison policies affect women, let alone African American women, is limited. Originally, in the early seventies, when the War on Drugs began to increase the incarceration rate, half of the states did not have separate facilities for incarcerated women.⁴⁶ Due to the fact that 97% of prisons in the United States were all-male in the 1970s, the prison system was designed with only men in mind.⁴⁷ However, following the War on Drugs, the number of women imprisoned went from between 5,000 to 12,000 in the 1980s to 90,000 by 1999.⁴⁸ Thus implying that in two decades the number of incarcerated women increased six-fold.⁴⁹ This sudden influx was a result of the changing policies surrounding the arrest and

⁴³ Glenn C. Loury, "The New Untouchables Crime: Punishment and Race in America," United Nations (United Nations, n.d.), <https://www.un.org/en/chronicle/article/new-untouchables-crime-punishment-and-race-america>.

⁴⁴ "Incarceration of Women Is Growing Twice as Fast as That of Men," Equal Justice Initiative (Equal Justice Initiative, October 16, 2019), <https://eji.org/news/female-incarceration-growing-twice-as-fast-as-male-incarceration/>.

⁴⁵ Ibid.

⁴⁶ Marc Mauer and Meda Chesney-Lind, "Imprisoning Women: The Unintended Victims of Mass Imprisonment," in *Invisible Punishment: The Collateral Consequences of Mass Imprisonment* (New York: New Press, 2002), pp. 79-94, 79.

⁴⁷ Ibid,79.

⁴⁸ Ibid, 80.

⁴⁹ Ibid, 80.

incarceration of women. Although in the 1980's, the media suggested that increased incarceration rates resulted from rapidly growing crime rates, data did not support this claim. In terms of the criminal behavior of women, the total number of arrests for women increased by 14.5% between 1990 and 1999 while the number of women in prison increased by 105.8%.⁵⁰ The reason for this drastic increase in the prison population was, however, due to the increased long-term incarceration rates for drug offenses and as a result, women were now receiving long-term sentences for crimes that previously would have allotted them short jail time or probation. New policies increased the sentence for a drug offense from twenty-seven months in July of 1984 to sixty-seven months by June of 1990.⁵¹ Before the implementation of mandatory prison minimums for federal crimes and drug crimes and the implementation of sentencing guidelines—which were ironically created to “reduce race, class and other unwarranted disparities in sentencing males”—nearly two-thirds of women convicted of federal felonies were allowed probation.⁵² However, by the early 1990s, only 28% of women were granted immediate probation. Although women were making up a larger percentage of the prison population their arrests were not for violent crimes (*Figure 4*). The amount of violent female offenders had steadily decreased by the 90s; the percentage of women arrested for violent crimes decreased from 48.9% in 1979 to 28.5% in 1998.⁵³ Even today, women continue to be less likely than men

⁵⁰ Mauer and Chesney-Lind, “Imprisoning Women: The Unintended Victims of Mass Imprisonment,” 87.

⁵¹ *Ibid.*, 89.

⁵² *Ibid.*, 89.

⁵³ *Ibid.*, 89.

to be incarcerated for a violent crime.⁵⁴ Unfortunately, most women were being swept up in the get tough on drugs agenda, thus making the War on Drugs a “war on women.”⁵⁵

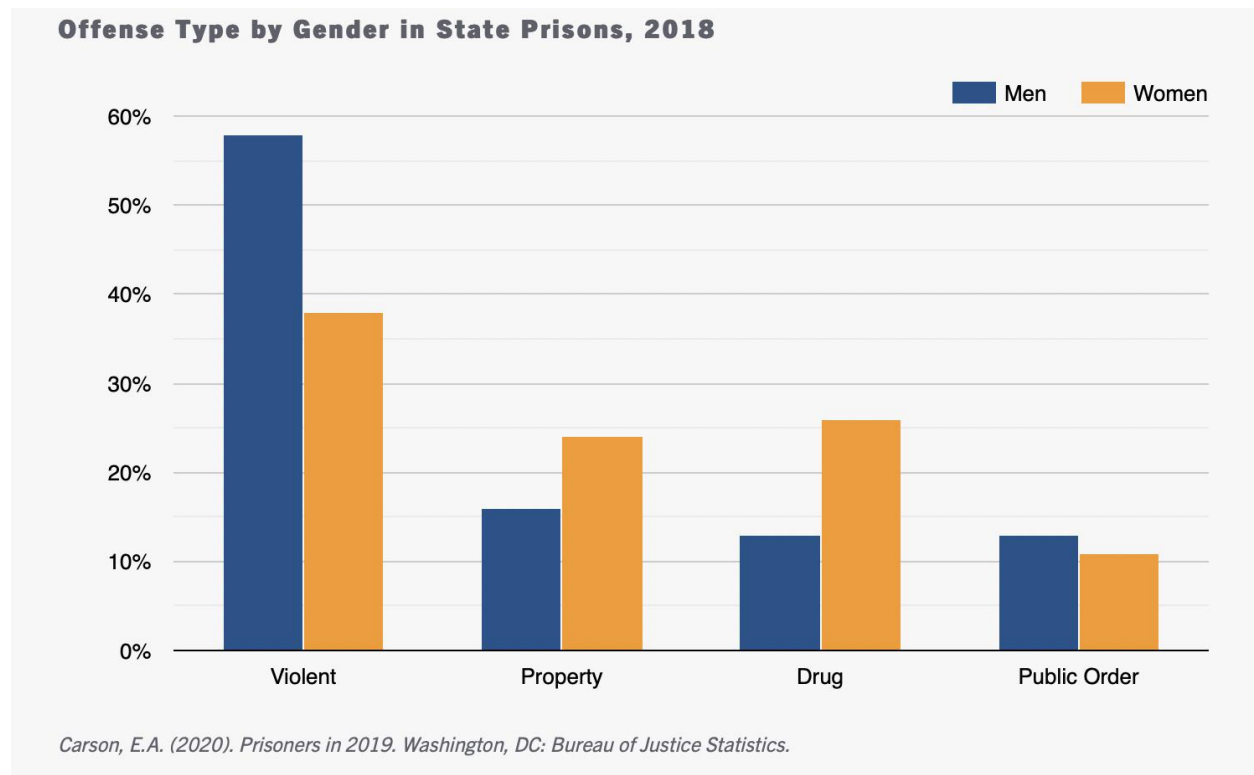


Figure 4. 2018 difference in state prison offense types by gender

Source: *The Sentencing Project, 2020*

As mentioned previously, prisons were designed with men’s needs in mind; therefore, the increase of women in prison created several gendered consequences with the largest repercussions falling on Black women. In a misguided attempt to avoid discrimination when sentencing both men and women, judges were told to avoid considering gendered-based

⁵⁴ Nazgol Ghandnoosh, “Incarcerated Women and Girls,” The Sentencing Project (The Sentencing Project, November 24, 2020), <https://www.sentencingproject.org/publications/incarcerated-women-and-girls/>.

⁵⁵ Mauer and Chesney-Lind, “Imprisoning Women: The Unintended Victims of Mass Imprisonment,” 88.

consequences when sentencing women, however this only further disadvantaged women.⁵⁶ For example, one way mandatory sentencing minimums can be reduced is if the defendant can provide authorities with useful information for prosecuting other drug offenders; however, because women typically work at the lower end of drug hierarchies they are unable to successfully negotiate plea reductions.⁵⁷ Additionally, prisons forcing incarcerated women to engage in strip searches makes them more vulnerable to sexual assault and mistreatment. In 2002, there were as many as 400 cases of sexual misconduct by police officers, however, only 25% of these cases resulted in any sanction for the officers responsible.⁵⁸ Ultimately, while beneficial in theory, a sex-blind approach means that correctional facilities ignore the unique troubles incarcerated women encounter.

Another salient indicator that prisons neglect to properly consider women's needs is the lack of federal policies regarding pregnancies in prison. Therefore, incarcerated women are at the mercy of their individual correctional facilities, which are often privately owned. The American Civil Liberties Union found that although more than half of the states in the U.S. have some sort of pregnancy-specific laws or correctional policies, very few states have policies that meet the standards of the National Commission on Correctional Health Care (NCCHC) or the American Public Health Association (APHA).⁵⁹ Additionally, eight states completely lack policies regarding pregnancy or reproductive health care standards for correctional facilities.⁶⁰ For the

⁵⁶ Mauer and Chesney-Lind, "Imprisoning Women: The Unintended Victims of Mass Imprisonment," 89.

⁵⁷ Mauer and Chesney-Lind, "Imprisoning Women: The Unintended Victims of Mass Imprisonment," 89.

⁵⁸ "Quick Statistics," Survived + Punished (Allied Media Projects, August 6, 2018), <https://survivedandpunished.org/quick-statistics>.

⁵⁹ "State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison," American Civil Liberties Union (American Civil Liberties Union, July 2012), <https://www.aclu.org/state-standards-pregnancy-related-health-care-and-abortion-women-prison-0>.

⁶⁰ Ibid.

forty-two states that do claim to have policies regarding treatment for pregnant incarcerated women, many of them are significantly flawed. For example, only twelve explicitly say that medical examinations are included as a component of prenatal care, six provide HIV testing, seven mention appropriate levels of activity, nineteen include prenatal nutrition counseling—but only ten require actual allocation of appropriate nutrition to pregnant incarcerated women.⁶¹ Furthermore, only eight require an explicit agreement with a community facility for delivery, five require their institution to keep a list of their pregnancies and their outcomes, sixteen provide screening or special treatment for high-risk pregnancies, eleven follow the NCCHC standard which suggests abortion counseling for pregnant women, and only seventeen restrict the use of shackling or restraints on pregnant women during labor and delivery.⁶²

These problems are exacerbated for Black incarcerated women, who face health care inequalities and discrimination and who often mistrust medical professionals. These predispositions serve to disenfranchise Black women before they step foot in an institution that will continue to dehumanize them while stripping them of their rights. Considering that the United States prison system was originally designed to perpetuate the oppression of Black Americans, fully undoing racial injustices may require prison abolition; however, shorter-term reforms are paramount, particularly reform to the reproductive health care system provided for women in prison. In order to understand the inequities that pregnant Black women face in prison, we need to understand the context in which Black women’s reproductive healthcare has evolved in the United States.

⁶¹ “State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison,” American Civil Liberties Union.

⁶² *Ibid.*

Chapter Two: History of Reproduction Health Care for Black Women

“During the first years of my service in Dr. Flint’s family, I was accustomed to share some indulgences with the children of my mistress. Though this seemed to me no more than right, I was grateful for it, and tried to merit the kindness by the faithful discharge of my duties. But I now entered on my fifteenth year—a sad epoch in the life of a slave girl. My master began to whisper foul words in my ear. Young as I was, I could not remain ignorant of their import. I tried to treat them with indifference or contempt. The master’s age, my extreme youth, and the fear that his conduct would be reported to my grandmother, made him bear this treatment for many months. He was a crafty man, and resorted to many means to accomplish his purposes. Sometimes he had stormy, terrific ways, that made his victims tremble; sometimes he assumed a gentleness that he thought must surely subdue. Of the two, I preferred his stormy moods, although they left me trembling. He tried his utmost to corrupt the pure principles my grandmother had instilled. He peopled my young mind with unclean images, such as only a vile monster could think of. I turned from him with disgust and hatred. But he was my master. I was compelled to live under the same roof with him—where I saw a man forty years my senior daily violating the most sacred commandments of nature. He told me I was his property; that I must be subject to his will in all things. My soul revolted against the mean tyranny. But where could I turn for protection? No matter whether the slave girl be as black as ebony or as fair as her mistress. In either case, there is no shadow of law to protect her from insult, from violence, or even from death; all these are inflicted by fiends who bear the shape of men. The mistress, who ought to protect the helpless victim, has no other feelings towards her but those of jealousy and rage. The degradation, the wrongs, the vices, that grow out of slavery, are more than I can describe. They are greater than you would willingly believe.”⁶³ - Jacobs, Harriet, *Incidents in the Life of a Slave Girl*

The advancement of gynecological studies has a direct correlation with the absence of reproductive rights of enslaved Black women. Controlling enslaved women and girls’ reproduction and their sexual agency was commonly utilized as a tool of oppression and power by white men. Doctors that specialized in reproduction during slavery were generally not hired to

⁶³ Jacobs, Harriet. *Incidents in the Life of a Slave Girl*. New York: Open Road Media, 2016, 29.

ensure the safety and care of the Black women: their priority was aiding their employer—white men. The modern-day inequalities in reproductive health care that Black women face are the product of a system that was never intended to benefit them.

Reproduction During Slavery

The pattern of medical and sexual mistreatment of enslaved Black women continues to repeat in reproductive health problems for Black women in the United States today. Beginning with the Middle Passage, white transatlantic slave traders hired surgeons “in hopes of preserving their human ‘cargo’ for maximum profit.”⁶⁴ The commodification of Black bodies continued in the antebellum South when physicians were hired to inspect “the bodies of enslaved men, women, and children before signing certificates of ‘soundness’ for buyers or sellers.”⁶⁵ Moreover, white doctors were hired by insurance companies to examine the physique of enslaved people before the companies distributed life insurance policies to slaveholders trying to assure their financial security.⁶⁶ Even after death, Black people were subject to objectification; enslaved men and women’s bodies were used as teaching “material” in museums and white medical schools.⁶⁷ Early nineteenth-century French historian Georges Cuvier publicly dissected the cadaver of an elderly Black enslaved woman named Saartjie Baartman to determine whether there were biological differences between white and Black people.⁶⁸ Although both men and

⁶⁴ Deirdre Cooper Owens and Sharla M Fett, “Black Maternal and Infant Health: Historical Legacies of Slavery,” *American journal of public health* (American Public Health Association, October 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6727302/>.

⁶⁵ Ibid.

⁶⁶ Cooper Owens and Fett, “Black Maternal and Infant Health: Historical Legacies of Slavery,”

⁶⁷ Ibid.

⁶⁸ *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens*, YouTube (YouTube, 2021), <https://www.youtube.com/watch?v=vUwpZ7mLIVA>.

women in slavery were denied agency over their bodies, enslaved women experienced a unique set of horrors as a result of the legal and medical attention their bodies received.

“When they told me my new-born babe was a girl, my heart was heavier than it had ever been before. Slavery is terrible for men; but it is far more terrible for women. Superadded to the burden common to all, they have wrongs, and sufferings, and mortifications peculiarly their own.”⁶⁹ - Harriet Jacobs, *Incidents in the Life of a Slave Girl*

As the formerly enslaved author Harriet Jacobs stated, slavery was an especially traumatic system for Black women. Their intersectional identity as both laborers and reproducers placed them under constant attack. Procreation, for bonded women, had little to do with personal liberties and everything to do with oppression.⁷⁰ As eloquently explained in Dorothy Roberts’ book, *Killing The Black Body*, “the social order established by powerful white men was founded on two inseparable ingredients: the dehumanization of Africans on the basis of race, and the control of women’s sexuality and reproduction.”⁷¹ White slaveholders used the regulation of Black reproduction to mentally and physically subjugate Black women and consequently Black people.

Beginning in 1662, Black women’s bodies became a key piece in maintaining the system of slavery. When Virginia legislators passed the law known as *partus sequitur ventrem* they declared that the status of a child would follow that of his or her mother. This law thus legalized chattel slavery—the complete ownership of a person—as an “inheritable status applied to

⁶⁹ Jacobs, *Incidents in the Life of a Slave Girl*, 69.

⁷⁰ Dorothy E. Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York, NY: Vintage Books, a division of Penguin Random House LLC, 2017).

⁷¹ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 23.

Africans and their descendants."⁷² After the passing of this law, enslaved Black women's reproduction became a clear means of increasing profit. Black women were now seen as valuable for both their labor and their ability to reproduce more enslaved children. Roberts notes that slaveholders could expect to increase their profits by 5 to 6 percent with natural multiplication thus giving them an incentive to increase the fertility of enslaved women.⁷³ Consequently, bonded women were quickly reduced to the status of "breeder." One slaveholder stated that "[a] breeding woman is worth from one-sixth to one-fourth more than one that does not breed."⁷⁴ Thus, childbearing became an increasingly important economic activity—the birth and death of enslaved people were recorded in slaveholder's business ledgers rather than their family Bibles, further exhibiting the constant commodification of Black people (*Figure 5*).⁷⁵

⁷² Cooper Owens and Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery,"

⁷³ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 24.

⁷⁴ *Ibid*, 24.

⁷⁵ *Ibid*, 24.

Figure 5. Photo of slave owner Henry L. Leverich's account statements with names of enslaved workers and their earrings.

Source: Joseph R. Rzek, 1985

EXHIBIT 1
STATEMENT OF ACCOUNT WITH HENRY L. LEVERICH & CO.

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The Accounting Historians Journal, Spring, 1985
EXHIBIT 1
STATEMENT OF ACCOUNT WITH HENRY L. LEVERICH & CO.

Wm. S. Memor. Est. in 4 cols. Feb. 9, 1839 with Henry L. Leverich.

Date	Description	1838	1839	1839	1839
Jan 19	J. Lambert & Thompson Off. a/c to yr	3,800			
Apr 16	of Off. for d. D. Mason Esq.	15 hms	5,500		
4	Carb. fr. Mr. Jackson fr of yr	4 apr	170		
May 11	"	18 May	70		
Aug 22	Carb. fr. Mr. Jackson fr of yr	4 5 apr	50		
Sep 4	"	18 Sep	50		
15	"	18 Sep	50		
7	Mr. Military article	17 h	1669	81	
15	Services, Mrs. Spence, Susanna	18 Sep	131	83	
18	Carb. fr. Mr. Jackson	18 Sep	50		
Oct 2	"		50		
"	Mrs. M. Adams chd.		70		
"	Box Street fr. Susanna	18 Oct	6 55		
20	Mr. Jackson		20		
20	Mrs. A. S. Bond W.		17		
Dec 10	of Off. a/c for Mr. Howard & Co	19 Dec	4000		
"	of Mr. Howard, Cap. V.C.		5 83		
Jan 25	Balance of Substant		143 87		
1839			\$ 17,858 85		
Jan 25	To Balance fr. Jan 9, Feb 7, 1839			2920 20	
<i>Wm. S. Memor. Est. 25. Jan 1839</i> <i>Henry L. Leverich</i>					
Dec 20	By Balance of yr			14 95	
Feb 10	Sal. 99 Mr. S. S. S. S. S.			6667 91	
Aug 8	"			7255 76	
Jan 25	of Mr. Jackson Total 42 10 fr			1,000	
	Balance to yr. (Jan 9 Feb. 1839)			2920 20	
				\$ 17,858 85	

Statement of Substant a/c to yr

Date	Description	1839	1839	1839	1839
Jan 25	OC	14 95			
Feb 10	OC	6667 91			
Aug 8	OC	7255 76			
Jan 25	OC	1,000			
Jan 25	OC	2920 20			
Dec 10	OC	4000			
Feb 10	OC	6667 91			
Aug 8	OC	7255 76			
Jan 25	OC	1,000			
Jan 25	OC	2920 20			
Dec 10	OC	4000			
Feb 10	OC	6667 91			
Aug 8	OC	7255 76			
Jan 25	OC	1,000			
Jan 25	OC	2920 20			

The exploitation of Black female fertility was worsened by the 1808 ban on the transatlantic slave trade and the steady price inflation of enslaved people.⁷⁶ After the ban, slaveholders no longer had access to African captives and thus the reproductive abilities of

⁷⁶ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 24.; Cooper Owens and Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery,"

enslaved women became their sole means of obtaining more enslaved people. As a result, women in bondage were unable to choose who they engaged with sexually and were often sexually abused.⁷⁷ If an enslaved woman was considered “strong” she would be even more likely to be routinely sexually assaulted in order to conceive more children into slavery.⁷⁸

Although the rape of bonded women at the hands of white slaveholders sometimes resulted in procreation and commercial profit, rape was not only seen as a means for economic gain. Rape was mainly a “weapon of terror that reinforced whites’ domination over their human property.”⁷⁹ The threat of rape was a common act of violence used by white men to “stifle Black women’s will to resist and to remind them of their servile status.”⁸⁰ Law during slavery blatantly promoted the sexual abuse of Black women by allowing white men to assault bonded women and children without consequence.⁸¹ Public acceptance of the sexual mistreatment of Black women was founded on “the prevailing belief among whites that Black women could not be raped because they were naturally lascivious.”⁸² Research indicates that 58% of enslaved women between the ages of 15 to 30 years old were sexually assaulted by slaveholders or other white men.⁸³ In 1860, this roughly amounted to 10% of the enslaved population being biracial.⁸⁴ While

⁷⁷ Cynthia Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,” *Health equity* (Mary Ann Liebert, Inc., publishers, September 24, 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6167003/>.

⁷⁸ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*,

⁷⁹ *Ibid*, 29.

⁸⁰ *Ibid*, 30.

⁸¹ *Ibid*, 30.

⁸² Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 31.

⁸³ Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

⁸⁴ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 29.

this culture and these abusive practices may seem far away in the popular imagination, they laid the foundation for the dehumanization and medical mistreatment of Black women today.

Slaveholders' dominance over Black women extended far past the act of reproducing; they also had authority over enslaved women's children. Legally, as a result of the 1662 law, bonded women had no claim over their children; the slaveholders' ownership over their children "was automatic and immediate."⁸⁵ Therefore, they could enforce their "values upon the enslaved and assume the power to own and to socialize slave children."⁸⁶ Enslaved people were stripped of all parental responsibilities such as instilling values, culture, and heritage to their children.⁸⁷ A similar removal of parental power happens today: Black women are disproportionately arrested and incarcerated and thus unable to raise their children.

Slaveholders also used enslaved children as a way to keep mothers from running away—"owners could threaten unruly slave women with the sale of their children to make them more submissive."⁸⁸ This resulted in fewer bonded women running away from their plantations; in North Carolina between 1850 and 1860, only 19% of runaway enslaved people were women compared to the total 49.8% of enslaved women in the South.⁸⁹

In addition to being deprived of the right to socialize their children, enslaved women were also unable to nurture them as infants. Quickly after giving birth, enslaved women were forced back into the field. Consequently, they had to leave their babies with other enslaved women who had been appointed the role of caretaker. These women were sometimes told to

⁸⁵ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 31.

⁸⁶ *Ibid.* 31.

⁸⁷ *Ibid.* 39.

⁸⁸ *Ibid.* 43.

⁸⁹ *Ibid.*, 43; Aaron O'Neill, "United States: Black and Slave Population 1820-1880," Statista, September 1, 1975, <https://www.statista.com/statistics/1010277/black-and-slave-population-us-by-gender/>.

watch as many as 40 babies at once and were often too inexperienced or overwhelmed to give them adequate attention.⁹⁰ Infant mortality rates for Black babies in 1850 were “twice that of whites, with fewer than two out of three Black children surviving to age ten.”⁹¹ As later described in chapter three, this drastic disparity in infant mortality rates among whites and Blacks in the United States persists today. Along with having higher infant mortality rates, enslaved Black American babies were more likely to have lower birth weights than white babies.⁹²

Although Black enslaved women were reduced to the status of cattle, they were not completely helpless. Many Black women refused to let slaveholders compromise their principles and worked hard to secretly instill the same values in their children. A formerly enslaved woman named Minnie Folkes recalled, in a 1937 interview with Susie Byrd, her mother’s teachings: “Don’t let nobody bother yo principle; ‘cause dat wuz all yo’ had.”⁹³ Minnie explained how her mother was beaten after refusing to engage sexually with her slaveholder. Enslaved women were commonly punished for refusing white men’s sexual advances. One Black woman named Sukie Abbott burned her overseer with a pot of boiling lye for trying to rape her. Although she was later sold, Sukie Abbott reported that the overseer “never did bother slave gals no mo.”⁹⁴ Black women also rebelled against their role as producers by refusing to bear children by abstaining from sex or using contraceptives or abortions.⁹⁵ In extreme cases, “some enslaved women killed

⁹⁰ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 36.

⁹¹ *Ibid.*, 36.

⁹² *Ibid.*, 48.

⁹³ Author: Minnie Fulkes, “Interview of Mrs. Minnie Fulkes’ (1937),” Encyclopedia Virginia, March 5, 1937, <https://encyclopediavirginia.org/entries/interview-of-mrs-minnie-fulkes-1937/>.

⁹⁴ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 45.

⁹⁵ *Ibid.*, 46.

their newborns to keep them from living as chattel,” but research suggests that infanticide was uncommon.⁹⁶ The suicide rate among enslaved people was one-third that of whites which “suggests that they did not commonly view death as a good way to escape from slavery’s horrors.”⁹⁷ Far more often, enslaved women saw the survival of their children as a means to resist slavery.⁹⁸ For enslaved mothers the growth of their population and the wellbeing of their children was a victory over the numerous crimes against them.⁹⁹

The Birth of Gynecology

The system of slavery not only produced generational trauma that continues to affect the Black community as well as Black women’s reproductive health, but it also deeply influenced gynecology studies. Although enslaved women have been the subject of science pilot experiments since the beginning of slavery. During the early nineteenth century, several white physicians received global recognition for their experimental surgeries on enslaved women. Slave-owning, Virginia-born physician, Ephraim McDowell, obtained the title “Father of Ovariectomy” after performing the world’s first successful abdominal surgery.¹⁰⁰ He then went on to conduct several experimental surgeries on enslaved women in the state of Kentucky. Similarly, French surgeon François Marie Prevost became famous for his invention of the Cesarean Section (C-section), in the nineteenth century his experimentation on enslaved women in Haiti and then Louisiana granted him global recognition.¹⁰¹ As a result of Prevost’s legacy,

⁹⁶ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 48.

⁹⁷ Ibid, 49.

⁹⁸ Ibid, 50.

⁹⁹ Ibid, 50.

¹⁰⁰ *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens, YouTube*

¹⁰¹ Ibid.

Louisiana continues to perform more C-sections—an invasive operation with several negative short and long-term effects on Black mothers and infants—on Black women than any other state.¹⁰²

In the 1830s, American surgeon John Peter Mettauer pioneered the treatment for vesicovaginal fistula (now known as an obstetric fistula).¹⁰³ A vesicovaginal fistula is an opening that forms between the vagina, bladder, and sometimes anus wall during childbirth. The formation of these fistulas, or holes, result in incontinence, otherwise known as urine leaking from the vagina.¹⁰⁴ Mettauer performed experimental surgeries on both white and Black enslaved women with fistulas but was unable to perfect his procedure and thus lost several enslaved patients.¹⁰⁵ Mettauer's experimental work heavily influenced the practice of Dr. James Marion Sims, a notorious antebellum gynecologist born in South Carolina in 1813. Sims has commonly been referred to by physicians and historians as the "Father of Gynecology"—despite his unethical experiments on Black women and his crimes against humanity.¹⁰⁶ To better understand Black women's complex relationship with the U.S. medical system specifically in the realm of gynecology, it is crucial to recognize the role that slavery, and racist physicians like Sims, played in the foundational history of the field. Additionally, because there is no recognition by the scientific community of these historical roots in experimentation on enslaved women, their traumas not only persist but cannot be healed.

¹⁰² Ibid.; Sandall J;Tribe RM;Avery L;Mola G;Visser GH;Homer CS;Gibbons D;Kelly NM;Kennedy HP;Kidanto H;Taylor P;Temmerman M; "Short-Term and Long-Term Effects of Caesarean Section on the Health of Women and Children," *Lancet* (London, England) (U.S. National Library of Medicine, October 13, 2018), <https://pubmed.ncbi.nlm.nih.gov/30322585/>.

¹⁰³ *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens, YouTube*

¹⁰⁴ Michael Stamatakos et al., "Vesicovaginal Fistula: Diagnosis and Management," *The Indian journal of surgery* (Springer India, April 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4039689/>.

¹⁰⁵ *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens, YouTube*

¹⁰⁶ Holland, "The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women,"

Sims was often hired by rich slaveholders to perform gynecological operations on their enslaved women. Although most procedures took place on the plantation, Sims built a small hospital in Montgomery to operate on his patients.¹⁰⁷ The goal of his hospital was to ensure that enslaved women were capable of producing and reproducing for their slaveholders (*Figure 6*).

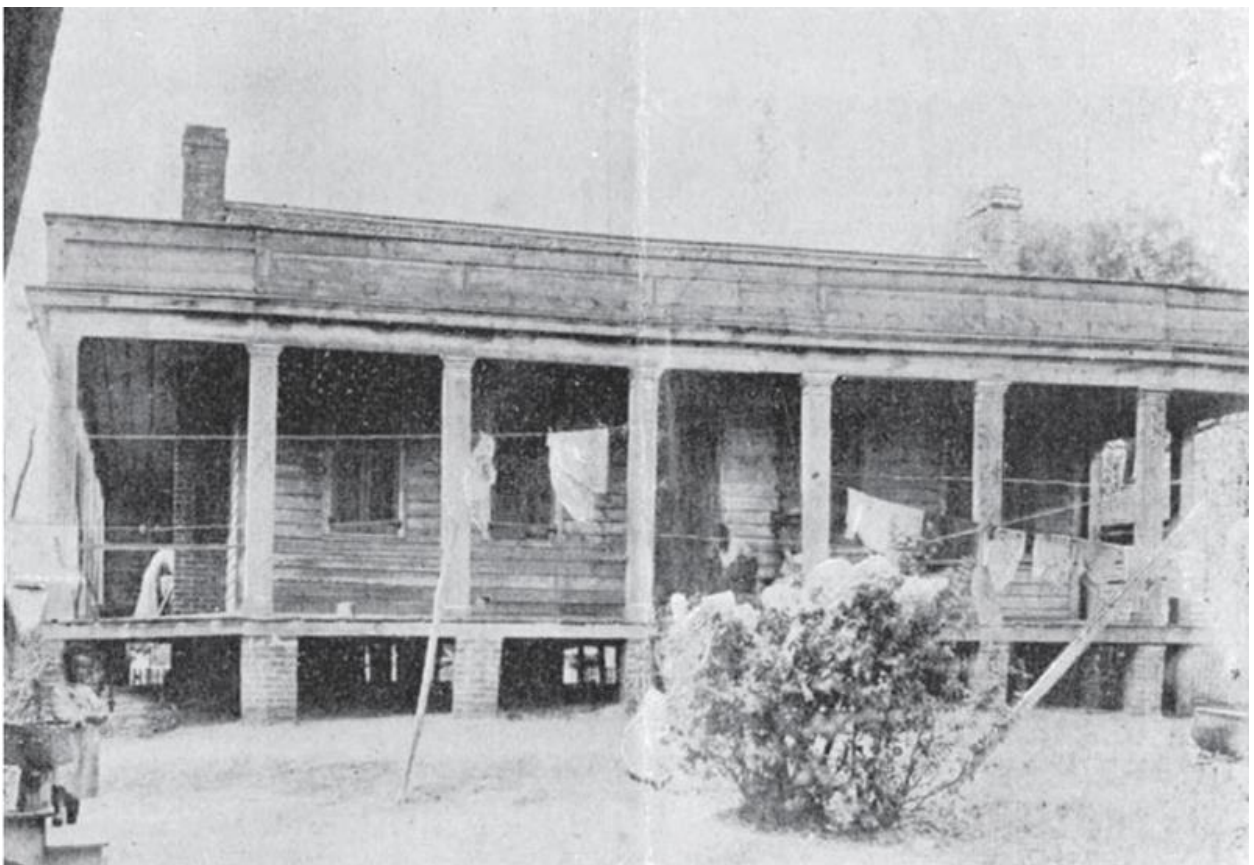


Figure 6. J. Marion Sims Montgomery hospital for enslaved women

Source: Rich Kelly, 2019

¹⁰⁷ Holland, "The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women,"

Originally, Sims had little interest in treating women and no experience in gynecology.¹⁰⁸ During the early nineteenth century, it was considered distasteful for doctors to treat women's ailments and was only done by a select few physicians like the ones mentioned above.¹⁰⁹ However, Sim's interest in women's organs changed when he encountered a white woman who suffered from pelvic and back problems as a result of falling off a horse.¹¹⁰ To treat her condition, he looked inside of her vagina and noticed that she was suffering from a vesicovaginal fistula.¹¹¹ In 1845, Sims began experimenting with techniques to treat vesicovaginal fistula on enslaved women. Fistulas typically resulted from friction caused by a delivery that had been prolonged for days and since enslaved women regularly received abusive medical care they were more likely to be afflicted.¹¹² Sims' patients were often brought to him by their slaveholders—"if the patients' owners provided clothing and paid taxes, Sims effectively took temporary ownership of the women until their treatment was completed."¹¹³ He later stated in his autobiography; "there was never a time that I could not, at any day, have had a subject for operation," thus demonstrating his complete control over his Black patients.¹¹⁴

Sims routinely operated on three young Black women named Lucy, Anarcha, and Betsy. All of the operations he performed on these women were done without consent and without anesthesia or pain medication.¹¹⁵ His first patient, eighteen-year-old Lucy, was brought to him

¹⁰⁸ Holland, "The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women,"

¹⁰⁹ Ibid.

¹¹⁰ Ibid.

¹¹¹ Ibid.

¹¹² *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens, YouTube*

¹¹³ Holland, "The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women,"

¹¹⁴ Ibid.

¹¹⁵ Ibid.

because she was unable to control her bladder a few months after giving birth.¹¹⁶ Lucy was forced to endure agonizing hour-long operations fully naked and perched on her knees and elbows so her head sat in her hands, during which an audience of a dozen white doctors watched as she screamed.¹¹⁷ Sims wrote in his autobiography that “ ‘Lucy’s agony was extreme... I thought she was going to die... It took Lucy two or three months to recover entirely from the effects of the operation.’ ”¹¹⁸ Lucy’s illness was made drastically worse by Sims’ laboratory use of sponges to soak up her urine—this controversial practice led to blood poisoning.¹¹⁹ Sims finally “perfected” the fistula procedure after four years of experimenting on enslaved women.¹²⁰ He concluded that silver sutures, rather than Mettauer’s silk sutures, were the best method for adequately stitching up fistulas.¹²¹ Anarcha, a seventeen-year-old enslaved teenager, endured thirty anesthesia-free operations at the hands of Sims before he felt confident enough to move on to treating white women—this time with the use of anesthesia.¹²²

Although some doctors in the nineteenth century did not trust the use of numbing agents due to its novelty, Sim’s refusal to use anesthesia on his Black female patients was largely because he falsely believed that African Americans did not experience pain—despite his clear depiction of enslaved women’s agony during surgery in his autobiography. His refusal to provide his Black patients with pain relief, although not uncommon, caused untold suffering and placed his medical experiments among the long list of ethical atrocities committed by white American

¹¹⁶ Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

¹¹⁷ Ibid.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

¹²¹ *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens, YouTube*

¹²² Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

medical professionals on Black patients.¹²³ Other prominent examples include the Tuskegee syphilis experiment, Henrietta Lacks, and the testing of mustard gas and other toxic chemicals on Black soldiers during World War II.¹²⁴

The racist notion that Black and white people have fundamentally different biological compositions has been a belief present among physicians, slaveholders, and scientists for centuries. During slavery, physicians sought to find medical anomalies about African Americans in order to “distinguish him from the white man” and justify their monstrous treatment.¹²⁵ Some of the common beliefs among white physicians and scientists were that Black people had “thicker skulls, less sensitive nervous systems, and diseases inherent in dark skin.”¹²⁶ Dr. Samuel Cartwright, an antebellum physician, believed that African Americans had a disease that made them “insensitive to pain when subjected to punishment.”¹²⁷ The assumption that Black people, particularly Black women, experience less pain than their white counterparts continues to be observed in modern medicine. A 2016 study, performed by Dr. Kelly M. Hoffman and other University of Virginia psychologists and Family Medicine professors stated that, “beliefs about biological differences between [B]lacks and whites—beliefs dating back to slavery—are associated with the perception that [B]lack people feel less pain than do white people and with inadequate treatment recommendations for [B]lack patients’ pain.”¹²⁸ According to this study,

¹²³ Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

¹²⁴ Ibid; Kelly M. Hoffman et al., “Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites,” PNAS (National Academy of Sciences, April 19, 2016), <https://www.pnas.org/content/113/16/4296.full>.

¹²⁵ Hoffman et al., “Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites,”

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ Ibid.

50% of medical residents and students surveyed “reported that at least one of the false belief items [presented to them] was possibly, probably, or definitely true.”¹²⁹ This indicates that a significant portion of medical professionals in the United States today continue to hold false beliefs about Black bodies that could affect the treatment of Black patients, and may begin to explain the large disparity in reproductive health for Black and white women.

Many modern scholars have criticized Sims for performing experimental surgeries on enslaved women without their permission and without pain relief; however, some scholars believe Sims is falsely chastised. In 2005, academic Wall LL claimed that the medical ethics “charges that have been made against Sims are largely without merit” because they overlook the pain women with fistulas were experiencing without surgery.¹³⁰ Furthermore, Wall LL suggests that historical documents have noted enslaved women’s consent to these procedures.¹³¹ While it is true that Sims claimed that women “clamored” for operations to alleviate their pain, unbiased historical documents have yet to capture their written consent.¹³² Additionally, although vesicovaginal fistulas are a painful condition, when considering the number of excruciating operations enslaved women suffered without medication it is unlikely that these women would have repeatedly consented to surgery—let alone clamored for it. Furthermore, given that Dr. Sims assumed temporary ownership over these young women when experimenting on them, they presumably could not refuse his surgeries. As stated by Bettina Judd, author, and professor of

¹²⁹ Hoffman et al., “Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites,”

¹³⁰ L L Wall, “The Medical Ethics of Dr J Marion Sims: a Fresh Look at the Historical Record,” *Journal of medical ethics (BMJ Group, June 2006)*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563360/>.

¹³¹ Ibid.

¹³² Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

gender, women, and sexuality studies at the University of Washington, consent is not simply “whether you can say yes; it’s also whether you can say no.”¹³³

Between Sims’ operations on enslaved women he tested, largely unsuccessful, medical techniques on enslaved Black children with neonatal tetanus—a life-threatening disease often caused by unclean delivery and umbilical cord cutting practices.¹³⁴ In addition to believing that Black Americans do not feel pain, Sims, along with most antebellum physicians, believed that Black people were less intelligent than whites “because their skulls grew too quickly around their brains.”¹³⁵ To remedy this false assumption, Sims used a shoemakers’ tool to force Black children’s bones apart and “loosen their skulls.”¹³⁶

Although Sims committed numerous crimes against humanity, his racist ideologies about biological differences between Black and white people did not originate nor end with him; they developed largely in the eighteenth century and have subsequently been passed down as a cultural practice to rising generations.¹³⁷ As a science and Technology academic, Sheila Jasanoff’s co-production idiom provides an interpretive framework for analyzing how and why we continue to see the legacy of these incorrect biological ideologies in the outcomes of modern-day health statistics for Black women. In her book, *States of Knowledge: The Co-Production of Science and the Social Order*, Jasanoff states that “science and technology permeate the culture and politics of modernity.”¹³⁸ She explains that science, technology, and society exist in a

¹³³ Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

¹³⁴ Ibid; “Maternal and Neonatal Tetanus Elimination (MNTE),” World Health Organization (World Health Organization, July 16, 2020), https://www.who.int/immunization/diseases/MNTE_initiative/en/.

¹³⁵ Holland, “The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women,”

¹³⁶ Ibid.

¹³⁷ *The Long Arm of Slavery in the Development of American Gynecology - Dr. Deirdre Cooper Owens, YouTube*

¹³⁸ Sheila Jasanoff, “The Idiom of Co-Production,” in *States of Knowledge: the Co-Production of Science and the Social Order* (London: Routledge, 2004), pp. 1-12, 1.

feedback loop that is constantly molding one another.¹³⁹ Co-production, she states, “is shorthand for the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it. Knowledge and its material embodiments are at once products of social work and constitutive of forms of social life; society cannot function without knowledge any more than knowledge can exist without appropriate social supports.”¹⁴⁰ Co-production provides a framework to effectively interpret the ways in which the social and the natural shape each other, therefore, allowing us to better understand the covert racism present in modern medical institutions. When applied to the issue of discriminatory practices in present-day gynecology, the co-production framework explains that these past racist beliefs become deeply embedded in technology thus shaping modern medicine. Therefore, even though most modern doctors are not overtly racist they can still practice anti-Black medicine because prejudiced social norms are embedded in the technology they practice. Keeping Jasanoff’s co-production foundation in mind, we move to the twentieth-century eugenics movement and forced sterilizations.

Life After Slavery

Although the Emancipation Proclamation in 1863 provided freedom from formal enslavement, it afforded few civil liberties for Black women. Black women were freed from forced reproduction at the hands of their slaveholders, however they were now systematically denied rights along with health care through new legislation. In particular, Black Codes

¹³⁹ Jasanoff, “The Idiom of Co-Production,” 2.

¹⁴⁰ Ibid, 2-3.

“restricted African Americans' labor advancement and migration,” while Jim Crow laws refused overall civil rights to Black Americans.¹⁴¹ Since Black women received no protection under the law, they continued to endure frequent rapes which compromised their self-esteem and trust in the government. Additionally, public lynching became a common punishment for Black men and women who were deemed rebellious by white citizens. Black women also endured public gang rapes and genitalia mutilation.¹⁴²

During the nineteenth century, eugenics—a term coined by Francis Galton which advocated for a system that would allow “ ‘the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable’ ” turned to forced sterilization as a means of population control in the Black community.¹⁴³ The eugenics program operated on the belief that to forestall the degradation of society, those who were socially inadequate must be prevented from reproducing. Since Black Americans were commonly seen “as less than” by their white counterparts—another inherited belief from slavery times—the movement disproportionately targeted the Black community. Government-sponsored eugenics programs, which began in the late 1880s and continued into the 1970s, coerced Black women to undergo sterilization surgeries without fully informing them that the operation was irreversible.¹⁴⁴ Ideas around forced sterilization originated as a punishment for Black convicts. In 1899, Dr. Harry C. Sharp, a physician from Indiana State Reformatory, “ ‘pioneered a plan to remedy race degeneration by

¹⁴¹ Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

¹⁴² Ibid.

¹⁴³ Wilson, P. K.. "Eugenics." *Encyclopedia Britannica*, February 19, 2019. <https://www.britannica.com/science/eugenics-genetics>.

¹⁴⁴ Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

sterilizing criminals.'"¹⁴⁵ Sharp's plan ignited a campaign among physicians across the country to mass castrate men deemed degenerative.¹⁴⁶ In 1907, Sharp's movement proved successful when the state of Indiana passed an involuntary sterilization law for criminals and "imbeciles."¹⁴⁷ Presently, we continue to see the mass sterilizations of imprisoned people, predominantly people of color. For example, in 2020, a whistleblower divulged news about coerced sterilizations of immigrant women in Immigration and Customs Enforcement (ICE) detention centers.¹⁴⁸

Although eugenics was regarded as pseudoscience by the 1940s, thirty states continued to support "formal eugenic programs that enforced compulsory sterilization from the early 1900s to the 1970s."¹⁴⁹ The eugenics movement was responsible for over 70,000 sterilizations.¹⁵⁰ Considering that sterilization, for decades, was the only form of birth control publicly funded, it is unsurprising that Black women were 14% more likely than white women to be sterilized between 1982 and 1990.¹⁵¹ Moreover, the racial disparity of sterilization transversed economic lines. In 1990, 9.7% of college-educated Black women had been sterilized, compared to 5.6% of college-educated white women.¹⁵² The likelihood of a woman being sterilized increased with a decrease in education levels; "among women without a high school diploma, 31.6 percent of Black women and 14.5 percent of white women had been sterilized."¹⁵³

¹⁴⁵ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 66.

¹⁴⁶ Ibid, 66.

¹⁴⁷ Ibid, 67.

¹⁴⁸ "ACLU News & Commentary," American Civil Liberties Union, n.d., <https://www.aclu.org/news/immigrants-rights/immigration-detention-and-coerced-sterilization-history-tragically-repeats-itself/>.

¹⁴⁹ Prather et al., "Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity," ; Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 89.

¹⁵⁰ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 87.

¹⁵¹ Ibid,97.

¹⁵² Ibid, 97.

¹⁵³ Ibid, 97.

In addition to devaluing Black reproduction, the eugenics movement further strained the Black community's trust in public health. Many Black women and families were hesitant to utilize reproductive clinics as they believed such clinics perpetuated their race genocide.¹⁵⁴ The Black community has been regularly used as guinea pigs for experiments or given inadequate treatment, thus forcing Black women to be vigilant about their health care.

Modern Medical Racism

Black female reproduction has suffered at the hands of the American government and white physicians since the founding of this nation. As aforementioned, during slavery African American reproduction was utilized to control women and keep them in a perpetual state of submission. After emancipation, the control of Black female bodies continued but this time by forcefully removing their ability to reproduce with sterilization programs. Today, Black women continue to encounter systemic racism through racially biased healthcare providers, unequal medical treatment, and mass incarceration. Their history of abuse and racial oppression has made Black women more susceptible to reproductive problems, including pregnancy-related hypertension and chronic hypertension.¹⁵⁵ A 2018 study done by seven Centers for Disease Control and Prevention (CDC) scientists specializing in Reproductive Health, HIV/AIDS prevention, Violence Prevention, and Global HIV Prevention, suggests that “the origins of adult health begin with intrauterine and early postnatal experiences or as a result of “weathering,” through which repeated experiences with discrimination result in physical health deterioration in

¹⁵⁴ Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 97.

¹⁵⁵ Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

early adulthood.”¹⁵⁶ A 2014 study performed by Department of Epidemiology Professor, Tené T. Lewis and a team of researchers found evidence suggesting that African American people who report experiencing discrimination have an increased risk of cardiovascular disease.¹⁵⁷ They also confirmed that women with high exposure to lifetime discrimination were more likely to have hypertension than women with low exposure.¹⁵⁸ Accordingly, Black women’s history of trauma and racism has resulted in physical and mental repercussions on their health that has been passed down generationally. It is thought that the experience of living in America as a Black woman induces toxic stress that affects their reproductive health which in turn produces low birth rate babies and causes maternal and infant mortality.¹⁵⁹ The adverse reproductive conditions that were present in the African American community since slavery continue to affect the reproductive outcomes of modern-day Black women. According to a 2018 study on racism and reproductive health, “low birth weight among contemporary African Americans has been proposed to be a result of differences in current exposures to social and environmental factors that affect fetal development” as well as a lasting effect from adverse conditions experienced during slavery.¹⁶⁰ This highlights the concept of “fetal programming” which explains that “the physiological development of the fetus can be affected by environmental events, which may endure into adulthood, thereby affecting future generations.”¹⁶¹ This helps to explain the notion

¹⁵⁶ Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

¹⁵⁷ Tené T Lewis et al., “Self-Reported Experiences of Discrimination and Cardiovascular Disease,” Current cardiovascular risk reports (U.S. National Library of Medicine, January 1, 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3980947/>.

¹⁵⁸ Ibid.

¹⁵⁹ *Why Are Black Mothers and Infants Far More Likely to Die in U.S. from Pregnancy-Related Causes?*, YouTube (YouTube, 2018), <https://www.youtube.com/watch?v=AODAk-accVc>.

¹⁶⁰ Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

¹⁶¹ Ibid.

that although slavery was abolished in 1865, “there has not been enough time to eliminate the physical effects of slavery; this, in turn, contributes to the disproportionately high levels of low birth weight in African American infants born in the 21st century.”¹⁶²

The 400 years of slavery, oppression, and discrimination Black women have suffered in America has created a generational trauma that both physically affects Black women’s reproductive health and produced an inherited distrust of health care institutions that continues to be felt by contemporary Black communities. The development of gynecology during the peak of racist ideology instilled deeply rooted institutionalized racism in not only gynecological practices but in medicine itself. This demonstrates that Black women are predisposed to medical mistreatment well before they enter the prison system. They are therefore coming into a system of mass injustice with a history of inadequate health care. Black women have already been historically dehumanized before being forced into a structure that operates under the guise that the people within it deserve less respect.

¹⁶² Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,”

Chapter Three: Reproductive Care for Incarcerated Black Women

In America’s patriarchal and racist society, Black women live at an unfortunate intersection of discrimination—being both gender and racial minorities frequently puts them in positions of increased vulnerability and neglect. Unfortunately, the increased discrimination that Black women face is either overshadowed, downplayed or ignored due to the competing injustices and social movements. The issue of mass incarceration signifies the extent to which Black women have been overlooked in modern society. Despite the fact that Black women in America have the highest growth rate of imprisonment, there remains minimal research on how mass incarceration affects their wellbeing and mental and reproductive health. The majority of research surrounding the adverse effects of mass incarceration either focuses primarily on incarcerated Black men or female incarceration as a whole. Although both groups constitute at-risk populations, the effects of mass incarceration on Black women are distinct due to their double discrimination and history of reproductive abuse.

Black Women and Delivery Complication

According to a 2019 study done by the Center for Disease Control and Prevention, there is evidence that the physical effects of Black womanhood in America, such as stress caused by racial prejudice, create disparities in pregnancy-related illnesses.¹⁶³ The study found that Black women are three times more likely than white women to die from pregnancy-related causes or

¹⁶³ “Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths,” Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, September 6, 2019), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>.

delivery complications.¹⁶⁴ Although the amount of pregnancy-related complications Black women face increases with age, it does not substantially decrease with higher income and education levels.¹⁶⁵ Black mothers with doctorates are still more than twice as likely to lose their babies than white women with high school educations; suggesting that there is something inherent in being a Black woman in America that creates higher birthing complications.¹⁶⁶ Poverty and poor education are not the only cause of high infant and maternal mortality among Black women.

In 2007, neonatology doctors, Richard David, and James Collins sought to understand why Black women have higher pregnancy-related complications and whether these racial disparities were related to geography or genetics. To create a proper evaluation, the researchers compared the birth weight of babies from the U.S-born white and Black women with that of African-born women.¹⁶⁷ The results of this study were extremely compelling. Their data found that “the overall birth-weight distributions for infants of US-born white women and African-born women were almost identical.”¹⁶⁸ Contrastingly, “US-born Black women’s infants comprise a distinctly different population, weighing hundreds of grams less. Black women born in the United States also experienced higher rates of very low birthweight than either the white or African-born women.”¹⁶⁹ Thus, the low birth rate of African American babies and high rates of infant mortality were not unique to the African race but instead revealed something about their

¹⁶⁴ “Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths,” Centers for Disease Control and Prevention

¹⁶⁵ Ibid.

¹⁶⁶ *Infant Mortality Rate Higher for Black Mothers than Any Other Race, YouTube* (YouTube, 2018), https://www.youtube.com/watch?v=EsFgHO7_zeg.

¹⁶⁷ David R; Collins J; “Disparities in Infant Mortality: What’s Genetics Got to Do with It?,” *American journal of public health* (U.S. National Library of Medicine, July 2007), <https://pubmed.ncbi.nlm.nih.gov/17538073/>.

¹⁶⁸ Ibid, 1193.

¹⁶⁹ Collins J; “Disparities in Infant Mortality: What’s Genetics Got to Do with It?,” 1193.

geographic location. Moreover, the study reflected that Black and Caribbean immigrants “gave birth to girls who were heavier than the girls born into established Black American families. Most striking, the first-generation Black girls grew up in the United States and went on to have daughters whose birth weights were lower on average than their own weights had been at birth. This generational trend is opposite to that seen in the nonimmigrant population and opposite the trend in European immigrant families.”¹⁷⁰ Not only does this research show that African-born women have higher birth weight rates than U.S-born Black women, but once the first-generation African and Caribbean girls grow up and have children of their own, their birth rates decline and become more comparative to Black women who have lived in the U.S for generations. Thus demonstrating the physical repercussions of executing an American medical practice that is embedded with racist ideology. As Jasanoff states “we gain an explanatory power by thinking of nature and social orders as being produced together.”¹⁷¹ The history of sexual and reproductive abuse pre and post-slavery, which contributed to the amalgamation of America’s racist health care system and the race-related stressors Black women endure, perpetuates reproductive inequalities in Black reproductive health.

Women’s Health “Care” in Prison

Reproductive health care for Black women is further impaired by their high rates of imprisonment. Not only are Black incarcerated women already disadvantaged as a result of their status in America, but when incarcerated they are legally stripped of their agency and offered

¹⁷⁰ Collins J; “Disparities in Infant Mortality: What's Genetics Got to Do with It?,” 1194.

¹⁷¹ Jasanoff, “The Idiom of Co-Production,” in *States of Knowledge: the Co-Production of Science and the Social Order*, 2.

egregious medical care. To better grasp the type of medicine practiced in prison, this section presents personal narratives from incarcerated women that were written by Silja J.A. Talvi in her book *Women Behind Bars: The Crisis of Women in the U.S. Prison System*. The stories depicted in this book showcase numerous instances of medical neglect, refusal to disclose medical information, a complete denial of care, dehumanization of incarcerated women, botched or experimental surgeries, ineffective prevention of the spread of disease, inadequate or lack of cleaning materials, and physical or sexual abuse by medical staff.¹⁷² In prison, even the most basic amenities required for living, like clean water, nutritious food, and proper shelter, are nearly impossible to acquire. As a result of the constant dehumanization of incarcerated women, many Americans believe that women in prison are undeserving of basic human rights.

During an interview with an incarcerated woman, Talvi was informed that the imprisoned woman slept in a small, unheated room, which was designed for a maximum of two women but was packed with eight.¹⁷³ The woman described the room as crawling with “roaches, spiders, and vermin.”¹⁷⁴ Another woman named Debi Campbell wrote to Talvi from the Federal Correctional Institution in Victorville, California explaining that the lights in her small “human warehouse” were never turned off thus making it impossible to fall asleep.¹⁷⁵ The living conditions in these jails are cruel and unusual. In addition to the appalling living environment, incarcerated women are provided with some of the worst food and water in the country. While visiting a prison in Washington state, Talvi was told that since fruits and vegetables were so rare, one slice of a

¹⁷² Silja J.A. Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System* (Seal Press, 2007), 90.

¹⁷³ Ibid, 107.

¹⁷⁴ Ibid, 107.

¹⁷⁵ Ibid, 107.

discolored tomato is a “cause for celebration,” even if it later gave the women diarrhea.¹⁷⁶ When asked if the kitchen staff was provided with fresh fruits and vegetables to cook with, a correctional officer at the Valley State Prison for Women stated that they were not because “there are no ‘special’ diets at VSPW.”¹⁷⁷ As for healthy drinking water, in 2003, women in a Texas prison were told to drink “no more than three six-ounce cups of water” a day due to the high level of water contamination. Additionally, in 2001, women at William P. Hobby Unit women’s prison in Texas were told they were being provided with a meat substitute called “Vita-Pro,” however when the kitchen crew attempted to cook the mystery meat “the whole prison stank like a wet dead dog being burned with napalm.”¹⁷⁸ One of the imprisoned women on kitchen duty kept a copy of the foreign label and asked a friend to translate it. The friend later confirmed that “Vita-Pro” was not meant for human consumption but was in fact meat for canines.¹⁷⁹ Despite the absurdity, the exploitation of these women goes far beyond food and water disparities.

For incarcerated women, access to medical care is extremely difficult to come by, even in dire situations. According to a health care study done at the California Institute for Women, most women in prison have never had a Pap smear—a standard, annual cervical exam done to detect and prevent cancer and other gynecological complications—because the \$5 copay is too steep a price when you are making twenty-eight to thirty cents an hour.¹⁸⁰ Moreover, many imprisoned women are only provided with 6 tampons a month and one roll of toilet paper a week.¹⁸¹ For

¹⁷⁶ Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System*, 108.

¹⁷⁷ *Ibid.*, 109.

¹⁷⁸ *Ibid.*, 111.

¹⁷⁹ *Ibid.*, 111.

¹⁸⁰ *Ibid.*, 88.

¹⁸¹ *Ibid.*, 109.

reference, tampons are only supposed to be inserted for a maximum of 8 hours. Since there are 24 hours in a day, this equates to at least 3 tampons per day.¹⁸² A period typically lasts anywhere from 3 to 7 days therefore necessitating at the very least 9 tampons a month but usually closer to 15 or 21.¹⁸³ Depending on how much a woman bleeds and how long her period lasts she could need to change her tampon more frequently. If incarcerated women run out of either tampons or toilet paper before they can receive more they are forced to use rags as a replacement, which is unsanitary and likely to cause infection and disease.¹⁸⁴ Incarcerated women in need are often refused care and instead “regarded as complainers, maligners, or drug seekers who have more psychosomatic than actual illnesses.”¹⁸⁵ These women are seen as having fewer “real” medical complaints than males, likely because of the internalized misogyny present among correctional officers.¹⁸⁶ However, according to Dr. Sylvia I. Mignon, an Associate Professor and Director of Master of Science in Human Services Program at University of Massachusetts, 67% of women in jails and 63% of women in prison report having chronic health conditions.¹⁸⁷ Additionally, 25% of women in prison and 20% of women in jail have had infectious diseases.¹⁸⁸ Therefore, there is a clear need for medical support in women’s prisons, and yet a high level of neglect remains.

¹⁸² Office of the Commissioner, “The Facts on Tampons-and How to Use Them Safely,” U.S. Food and Drug Administration (FDA, September 30, 2020), <https://www.fda.gov/consumers/consumer-updates/facts-tampons-and-how-use-them-safely>.

¹⁸³ Planned Parenthood, “How Long Should the Average Period Last?,” Planned Parenthood (Planned Parenthood Federation of America Inc., October 14, 2010), <https://www.plannedparenthood.org/learn/teens/ask-experts/i-just-got-my-period-and-i-have-been-having-it-for-six-days-now-and-i-am-getting-scared-is-that-to-long-to-be-having-you-period>.

¹⁸⁴ Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System*, 109.

¹⁸⁵ *Ibid.*, 91.

¹⁸⁶ *Ibid.*, 91.

¹⁸⁷ Sylvia Mignon, “Health Issues of Incarcerated Women in the United States,” *Ciência & Saúde Coletiva* (ABRASCO - Associação Brasileira de Saúde Coletiva, July 2016), http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232016000702051#:~:text=The%20most%20recent%20data%20show,report%20chronic%20health%20conditions15.

¹⁸⁸ *Ibid.*

Stories like that of Shirley Southerland and Sherrie Chapman illustrate some of the traumatic prison medical experiences. Although these injustices can be difficult to read, it is important to hear the testimonies of those who have been victimized by the prison system. In the 1990s, a woman named Shirley Southerland was dubiously arrested for the murder of a woman whom she barely knew. Even though the court had no physical evidence to justify Southerland's arrest, she was convicted because a drug dealer and jailhouse informant claimed she was guilty.¹⁸⁹ Southerland was sentenced to life in prison at Mountain View Unite, one of the three women's units in the Texas Department of Criminal Justice.¹⁹⁰ In addition to being stripped of her agency, she spent the rest of her life suffering from "relentless physical pain" as a result of the prison's medical neglect and officers' cruelty.¹⁹¹

One year into her imprisonment, Southerland began to experience severe pain on the lower left side of her body. As per state and federal prison protocol, Southerland filled out the paperwork needed for a "Sick Call Request" —the only mandated method for incarcerated women to receive medical attention for non-emergency issues—and detailed her escalating pain.¹⁹² Southerland received no response. Consequently, she began sending in forms routinely, and finally, after two months of waiting received a returned copy of her form with a picture of a "crybaby face" drawn on it in Crayola.¹⁹³

Many months later, in July of 1991 Southerland collapsed and was rushed to a nearby hospital.¹⁹⁴ As was evident, she was not exaggerating about her pain—she had a large tumor on

¹⁸⁹ Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System*, 80.

¹⁹⁰ *Ibid.*, 79-80.

¹⁹¹ *Ibid.*, 80.

¹⁹² *Ibid.*, 80.

¹⁹³ *Ibid.*, 80.

¹⁹⁴ *Ibid.*, 80.

her ovary that had to be removed in an emergency surgery.¹⁹⁵ Her doctor informed her that had she not received this surgery, she would have soon died.¹⁹⁶ Despite the clear display of prison medical malpractice, Southerland stated that she was grateful to be alive and living without daily pain.¹⁹⁷ However unfortunate, the abuse did not end there. Four years later, Southerland was moved to the Hobby Unit in Marlin, Texas, where she began a position operating the printing press. On several occasions, Southerland reported that the machine required maintenance but received no response. One day, in an attempt to fix the machine herself she put her hand inside to retrieve the jammed paper but instead “her pinky finger exploded when a chrome cylinder slammed down on her hand.”¹⁹⁸ She was then taken to the hospital where she was forced to wait for four hours. When she was seen, the physician was more concerned with the fact that he could not go home early than her injury.¹⁹⁹ Rather than attempt to save the mangled finger, the doctor amputated above the first joint.²⁰⁰ Since the amputation was performed quickly and haphazardly the bone later popped out through her skin, once again causing excruciating pain.²⁰¹ Southerland was ignored by correction officers and told to “get a bristle hairbrush and brush the bone to toughen it up.”²⁰² Eventually she saw a second doctor who had no choice but to fully amputate her finger down to the knuckle.²⁰³ Southerland’s experience echoes that of thousands of other

¹⁹⁵ Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System*, 80.

¹⁹⁶ *Ibid.*, 80.

¹⁹⁷ *Ibid.*, 80.

¹⁹⁸ *Ibid.*, 81.

¹⁹⁹ *Ibid.*, 81.

²⁰⁰ *Ibid.*, 81.

²⁰¹ *Ibid.*, 81.

²⁰² *Ibid.*, 81.

²⁰³ *Ibid.*, 82.

incarcerated women. Sadly, the sadistic abuse of women in prison by correction officers is far from uncommon.

In 1984, at the California Institution for Women (CIW), a woman named Sherrie Chapman reported to the prison medical staff that she noticed a lump in both her right and left breast. Despite divulging a family history of breast cancer, the medical staff dismissed her condition as fibrocystic breasts—a noncancerous condition where breast tissue appears lumpy—without conducting a proper examination or mammogram.²⁰⁴ With every passing year, the lumps in Chapman’s breast grew, but she was continually refused a mammogram.²⁰⁵ The prison staff labeled her a “drug seeker” thus denying her any medication stronger than a Motrin.²⁰⁶ After a decade of being refused medical service, Chapman was eventually allowed a mammogram, however, by this time the lumps in her breast were visibly protruding from her shirt.²⁰⁷ Eight months later, a biopsy was taken which confirmed what Chapman already knew—she had invasive breast cancer.²⁰⁸ Chapman was quickly taken to the hospital for a mastectomy of her right breast. Following the surgery, she was forced to return to the prison; CIW medical staff refused to let her stay even one night post operation at the hospital.²⁰⁹

Sadly, as the cancer continued to ravish Chapman’s body, the prison continued to deny her care. During 1996, Chapman continued to complain of a lump in her left breast. She had also developed vaginal blood clots and uterine pain.²¹⁰ In 1997, surgeons removed her left breast but

²⁰⁴ Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System*, 93.

²⁰⁵ *Ibid.*, 93.

²⁰⁶ *Ibid.*, 93.

²⁰⁷ *Ibid.*, 93.

²⁰⁸ *Ibid.*, 93.

²⁰⁹ *Ibid.*, 93.

²¹⁰ *Ibid.*, 93.

refused to examine her uterine pain until later that year. By the time they examined her again, Chapman had developed uterine cancer which required an immediate hysterectomy.²¹¹ Within a few years, Chapman's body was irreparably disfigured as a result of CIW's abuse.

Although both Southerland and Chapman's filed lawsuits against their respective correctional facilities, they could not undo the severe physical and mental damage these prisons had caused. In Chapman's case her cancer had progressed far beyond recovery. In June 2002, the Legal Services for Prisoners with Children (LSPC) fought to get Chapman parole, but she was once again denied care.²¹² Even in her final days, correction officers withheld her breast cancer treatment prescription for Tamoxifen. Sherrie Chapman passed away in prison later that year on December 12, 2002. In both scenarios, these women were not only met with doubt when they complained of pain, but they were denied treatment even when doctors confirmed their sicknesses. For these women, as well as many more like them, the prison's neglect resulted in worsened conditions and necessitated aggressive and invasive surgeries.

Prison Births

Similarly, even though “roughly 4 percent of women in jail and 4 and 3 percent of women in state and federal prisons, respectively, are pregnant on intake”—more than 12,000 women a year—the federal government has never created a national standard for reproductive care or health care in general for women in prisons and jails.²¹³ Since the guidelines around

²¹¹ Talvi, *Women Behind Bars: The Crisis of Women in the U.S. Prison System*, 93.

²¹² *Ibid.*, 95.

²¹³ Dana M. Britton, Shannon K. Jacobsen, and Grace Howard, *The Gender of Crime* (Lanham, MD: Rowman & Littlefield, 2018), 75; Alysia Santo, “For Most Women Who Give Birth in Prison, 'The Separation' Soon Follows,” PBS (Public Broadcasting Service, May 6, 2020), <http://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/>.

prenatal care for incarcerated women are unregulated, pregnant incarcerated women seldom receive proper medical attention and are often forced to give birth alone in their cell.²¹⁴ This lack of government supervision means that pregnant incarcerated women are at the mercy of their officers during one of the most vulnerable times of their lives. Although 94% of pregnant incarcerated women in prisons and 48% of pregnant women in jails reported receiving at least one obstetric exam, requirements for child care, exercise, diet, medication, and special testing for pregnant incarcerated women is rare, “with only 54 percent of women in state prisons reporting these kinds of pregnancy-related care.”²¹⁵ It is important to note that even for the women who reported receiving some semblance of reproductive care in prison, the treatment they are receiving is abysmal. Additionally, due to the large information gap regarding the experience of pregnant incarcerated women there are not many statistics on the results of prison pregnancies. Recently, however, researchers from Johns Hopkins Medicine conducted a study on a sample of prisons in the United States which house 57% of the incarcerated women’s population. Their study found that between 2016-2017, 1396 women in these prisons were pregnant on intake. Out of those 1396 women, 753 had live births, 46 had miscarriages, 11 had abortions, 4 were stillborn, 3 had newborn deaths, and 2 had ectopic pregnancies.²¹⁶ Furthermore, 6% of the live births were premature and 30% were Cesarean deliveries (*Figure 7*).²¹⁷ These statistics suggest a high prevalence of pregnancy complications in prison, most of which go uninvestigated.

²¹⁴ Britton, et al. *The Gender of Crime*, 75.

²¹⁵ Ibid, 75.

²¹⁶ “First of Its Kind Statistics on Pregnant Women in U.S. Prisons,” Johns Hopkins Medicine Newsroom (The Johns Hopkins University, The Johns Hopkins Hospital, and The Johns Hopkins Health System Corporation, March 21, 2019), <https://www.hopkinsmedicine.org/news/newsroom/news-releases/first-of-its-kind-statistics-on-pregnant-women-in-us-prisons>.

²¹⁷ Ibid.

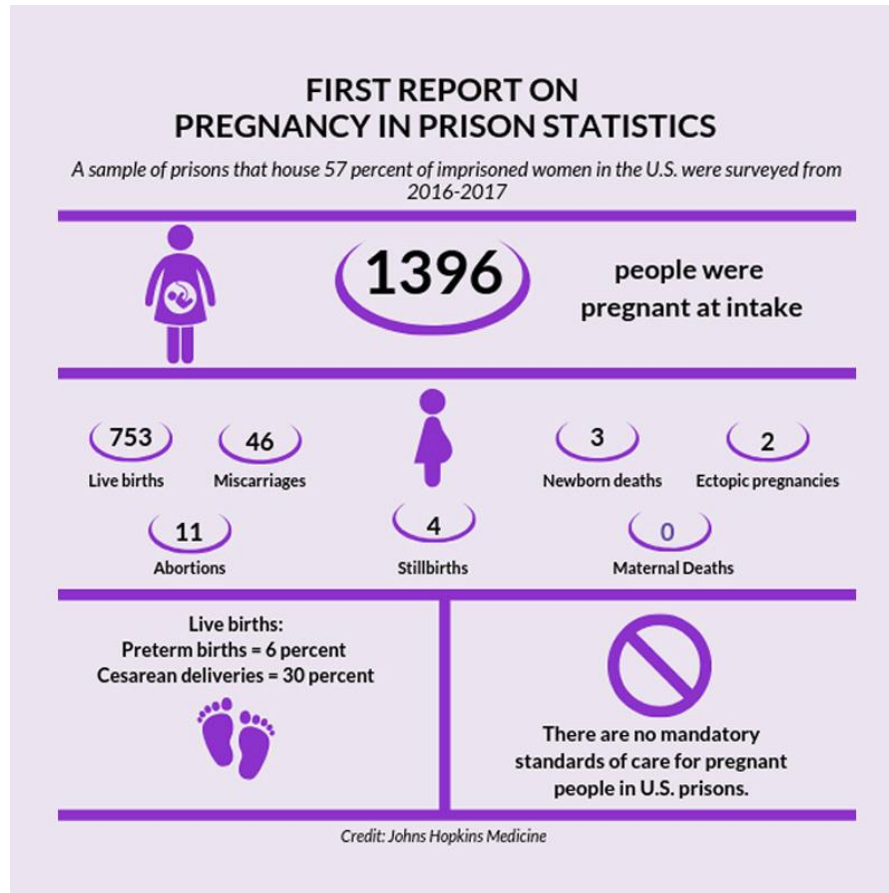


Figure 7. Prison Pregnancy Statistics from 2016-2017

Source: Johns Hopkins Medicine, 2019

Although there is a lack of widespread empirical research on the reproductive injustices incarcerated women experience, there are countless stories of pregnant incarcerated women giving birth in highly unfavorable circumstances. Author of *The Gender of Crime*, Dana Britton provides two extreme examples of women in prison being denied proper access to medical care when going into labor. First, she tells the story of a woman named Tawni Kosnosky who filed a lawsuit against Snohomish County in 2015 after being forced to give birth alone in her jail cell

three years prior. Kosnosky's water broke two days after being booked at the Snohomish County jail while she was seven months pregnant. She called for medical help because she was bleeding and was in extreme pain but "she was told to use a sanitary pad and lie down."²¹⁸ She would later give birth "alone, sitting on the toilet in her jail cell, to a baby that was eight weeks premature."²¹⁹ Nicole Guerrero was yet another woman forced to give birth alone in prison. According to Britton, Guerrero was imprisoned on a drug offense while thirty-two weeks pregnant. While in prison, Guerrero began feeling contractions and used her cell's emergency button to call for help. Guerrero's calls were ignored, and she was placed in solitary confinement for "abusing the emergency button."²²⁰ While in confinement, Guerrero gave birth prematurely and her child came out with the umbilical cord wrapped around its neck.²²¹ The baby was later pronounced dead at the hospital.²²² The lack of federal health care policies in jails and state and federal prison permits officers to abuse their power. Once in prison, women with reproductive or health care problems are essentially left to die.

Despite the prevailing and abundant reproductive inadequacies, there are many organizations fighting for the rights of incarcerated women. Additionally, several prisons have begun taking the necessary steps to improve the lives of their incarcerated women. Again, there remains a need for comprehensive research on these issues, however, small-scale interventions are necessary.

²¹⁸ Britton, et al. *The Gender of Crime*, 75.

²¹⁹ Ibid, 75.

²²⁰ Ibid, 75.

²²¹ Ibid, 75.

²²² Ibid, 75.

Chapter Four: The Effects of Prison Reproductive Health Interventions

Reproductive program inadequacies in prison include an absence of special prenatal diets, lighter work assignments, and resources for deliveries, labor complications, premature births, and miscarriages.²²³ Although the issues incarcerated mothers face cannot be fully eliminated through policy, apart from decarceration, organizations like the American Correctional Association, the American Medical Association, and the American Public Health Association have devised policy proposals to help combat their physical and psychological problems.²²⁴ These recommendations include infirmaries with overnight care, greater access to pain medicine, “prenatal care in prison, full-time nurses or midwives for pregnant [women], allowing nursing infants to remain with their mothers during incarceration, extended visiting programs for mothers and their children, and special counseling problems.”²²⁵ Volunteer organizations like Project REACH, developed by James Gaudin, work to provide centers where incarcerated mothers can spend one Saturday a month with their children.²²⁶ Additionally, Project AIM, developed by Sandra Barnhill and Paula Dressel, helps provide children with incarcerated mothers with free transportation to visit them.²²⁷ The goal of these organizations is to help circumvent some of the long-term problems faced by children who are unable to see their mothers while also reducing some of the mothers’ separation anxiety.²²⁸

²²³ Wooldredge and Masters, “Confronting Problems Faced by Pregnant Inmates in State Prisons,” 195.

²²⁴ Ibid, 197.

²²⁵ Ibid, 196.

²²⁶ Ibid, 197.

²²⁷ Ibid, 197.

²²⁸ Ibid, 197.

The Julia Tutwiler Women's Prison

The Julia Tutwiler Women's Prison in Alabama provides an example of one prisons' attempt at reproductive health care reform. For a long time, Tutwiler was considered one of the worst women's prisons in the United States, however they have recently been taking steps to reform their reproductive health care.²²⁹ According to the 2019 Marshall Project film, "a 2014 federal investigation found that more than a third of Tutwiler's staff had sex with inmates" resulting in numerous incarcerated women becoming impregnated by their correctional officers.²³⁰ Although it is illegal for officers to have sex with incarcerated women due to the obvious power imbalance, officers are rarely prosecuted for their crimes thus creating a "toxic sexualized environment."²³¹ To bring an end to the sexual abuse of the women at Tutwiler, the prison installed 300 new cameras and hired more female officers. However, one could presume that the increased number of cameras would generate privacy problems and over-policing for the incarcerated women down the line.

²²⁹ *Tutwiler*, PBS (Public Broadcasting Service, 2020), <http://www.pbs.org/wgbh/frontline/film/tutwiler/>.

²³⁰ *Ibid.*

²³¹ Santo, "For Most Women Who Give Birth in Prison, 'The Separation' Soon Follows,"



Figure 8. Outside of Julia Tutwiler Prison

Source: Equal Justice Initiative, 2014

Built in 1942, Tutwiler is Alabama’s oldest prison, and their only maximum-security women’s prison which is home to women on death row (*Figure 8*).²³² Although the prison was designed to house five hundred and fifty people, during the time that the Marshall Project documentary was filmed, there were a total of eight hundred and fifty incarcerated women and ninety officers. As a result of their overpopulation and lack of consideration for gendered ailments, pregnant women were forced to reside in the prisons’ infirmary, likely putting them at increased risk for contracting infections.²³³

²³² Santo, “For Most Women Who Give Birth in Prison, ‘The Separation’ Soon Follows.”

²³³ Ibid.



Figure 9. Participants in the doula program at Tutwiler Prison watching TV

Source: Elaine McMillion Sheldon, 2020

Although the prison has a long way to go before it adequately meets the reproductive and health care needs of the women, the Tutwiler documentary depicts limited improvements made for pregnant incarcerated women (*Figure 9.*). The film begins by showcasing the prison’s new doula program where each woman is assigned a trained companion to meet with and advocate for their reproductive needs. The program is run by the Alabama Prison Birth Project and Tutwiler is the first prison in the state to enact it. In addition to the new doula program, the prison created a lactation room that received statewide praise for having an initiation rate that is higher than that of the local hospital. According to Ashley Lovell, the Director of the Alabama Prison Birth Project, “the hospital breastfeeding initiation rate where these women give birth is about 20%. And since we opened the lactation room in June, we have about a 50% initiation

rate;” initiation rate refers to the time it takes for mothers to start breastfeeding their child.²³⁴ Earlier initiation rate results are ideal because breast milk contains nutrients that infants need to prevent common childhood diseases.²³⁵ Since incarcerated mothers at Tutwiler are only allowed to bond with their child for twenty-four hours after giving birth, they pump breast milk in the lactation room which will eventually be delivered to their babies. Nevertheless, the act of separating a mother and a newborn can cause “severe developmental problems for the infant as well as psychological anguish for the mother.”²³⁶ Infants who are denied a continuous relationship with their mothers during the first two years of their life are more likely to develop traits like: “psychopathology, inability to relate to others, difficulty with intimacy and assertiveness, lack of trust in others, lack of willpower, indecisiveness, fear of abandonment, fear of new experiences, and poor academic performance.”²³⁷ According to Wendy Williams, the Deputy and Commissioner of Women’s Services, Tutwiler is working on providing their women with a space to have their children with them for six months to a year after giving birth, however, the logistical information given was very limited.

In addition to showcasing Tutwiler’s new pregnancy interventions, the film follows the lives of the pregnant incarcerated women using these programs. The documentary shows 36-year-old Misty Cook as she is escorted to an appointment with her doula, Sarah Doyle. During the car ride, Misty and the driver, Sergeant Abbott, engage in a conversation about her expected due day and family. Misty explains that her 10-year-old son is getting in trouble in school and

²³⁴ *Tutwiler*, PBS

²³⁵ “Early Initiation of Breastfeeding to Promote Exclusive Breastfeeding,” World Health Organization (World Health Organization, February 11, 2019), https://www.who.int/elena/titles/early_breastfeeding/en/.

²³⁶ John D. Wooldredge and Kimberly Masters, “Confronting Problems Faced by Pregnant Inmates in State Prisons,” *Crime & Delinquency* 39, no. 2 (1993): pp. 195-203, <https://doi.org/10.1177/0011128793039002005>, 195.

²³⁷ Wooldredge and Masters, “Confronting Problems Faced by Pregnant Inmates in State Prisons,” 196.

Sergeant Abbott warns her not to go easy on him, even though his mother is in prison and his father died four years ago.²³⁸ When Sergeant Abbott asks if her children have ever visited her, Misty states that she “wouldn’t want to put them through that,” referring to the uncomfortable searches.²³⁹ She then reflects on her time spent visiting her father in prison when she was a little girl. Through Misty’s conversation with Sergeant Abbott, the viewers see the devastating realities of many women in prison. Misty, like thousands of other incarcerated women, is a mother who has been a victim of domestic abuse and has family members who are or were in prison. Misty is 9 months pregnant with her third child and is serving a 36-month sentence at a maximum state prison for a low-level drug offense.²⁴⁰ The women in the prison are serving time for offenses ranging from theft to assault, however, most are in for drug-related charges, like Misty, and have a history of abuse. At the time of this film, Misty had only served six out of her thirty-six-month sentence and was expected to be separated from her newborn son for at least thirty months after his birth. Christy, another pregnant incarcerated woman in the film, powerfully reflected:

“a lot of us have been abused our entire lives and we enter into relationships of abuse and then the DHR wants to step in and say we can’t have our children because they’re going to enter into relationships of abuse. Well, help us, you know? Don’t just throw us off in prison or take our children. Actually, help us.”²⁴¹

Christy is addressing the reality that many women in prison have been abused in the past or have a history of drug abuse and are not provided proper resources to recover and become

²³⁸ Tutwiler, PBS

²³⁹ Ibid.

²⁴⁰ Ibid.

²⁴¹ Ibid.

better mothers. According to the U.S. Department of Justice, a third of women in State prison, a sixth in Federal prison, and a quarter in jail have been raped before being imprisoned.²⁴² And another 3% to 6% reported someone attempting to rape them.²⁴³ Rather than provide these women with necessary counselling, they are thrown in jail and provided with subpar health care. When they are finally released, they will likely continue to face the same negative pressures in the outside world.

Despite Tutwiler’s efforts to improve their reproductive health care, the women at the prison continue to face the repercussions of a criminal justice system that was not designed with their needs in mind. The documentary’s film crew explained that a few months prior to filming, they witnessed a woman give birth on a gurney in the prison hallway.²⁴⁴ According to other incarcerated witnesses, “the nurses sent her back to the dorm after she went to the medical unit multiple times to report she was in labor.”²⁴⁵ Once again, indicating the prison’s need for increased reproductive policy change. Additionally, the expecting mothers at the prison are only allowed one ultrasound and visit from a doctor, and according to the film crew, the benches for the infirmary “were packed with women waiting for their turn to speak with medical staff.”²⁴⁶ One of the most heartbreaking aspects of being an incarcerated mother that the film emphasized is their inability to be with their newborns. One woman stated that she constantly wondered how her daughter was doing. “How much did she weigh? What did she like to eat? Is she happy? Is

²⁴² Caroline Wolf Harlow, “Prior Abuse Reported by Inmates and Probationers,” Bureau of Justice Statistics Selected Findings (U.S. Department of Justice Office of Justice Programs, May 13, 1999), <https://www.bjs.gov/content/pub/pdf/parip.pdf>.

²⁴³ Ibid.

²⁴⁴ Santo, “For Most Women Who Give Birth in Prison, 'The Separation' Soon Follows,”

²⁴⁵ Ibid.

²⁴⁶ Ibid.

she calling somebody else mom?”²⁴⁷ Another woman explained that once you give birth you are left feeling empty inside; “it makes the strongest person break.”²⁴⁸

Although Tutwiler claims to be implementing positive reproductive health changes due to the insufficient empirical evidence to accompany these claims it is difficult to determine the effects of these programs on pregnant imprisoned women’s health. Additionally, as a result of the lack of government administration and oversight, organizations that attempt to either collect data on the women’s health care offered in prisons or implement new programs realize that correctional institutions lack proper health care data documentation. As a result, most non-profit organizations have little way of knowing if prisons are implementing their recommendations.²⁴⁹ The paucity of research on the type of programs and medical assistance provided to incarcerated women in general, and especially pregnant incarcerated women, limits the ability to improve the health care of incarcerated women.

Medical Service Documentation Inadequacies in Prisons

To examine the issue of poor data documentation, a 1993 study written by Associate Criminal Justice Professor, John D. Wooldredge and Hillcrest Youth Center Staff Counselor, Kimberly Masters, surveyed correctional officers from U.S. women’s state prisons (N = 100). The survey asked the officers to explain what type of medical services and programs were offered to the incarcerated women, what they believed their psychological and physical needs were, and how they thought the prison could improve on providing them with support and

²⁴⁷ Tutwiler, PBS

²⁴⁸ Ibid.

²⁴⁹ Ibid, 197.

care.²⁵⁰ Out of all the surveys sent out, 61% (n = 61) were completed and returned to the researchers.²⁵¹ The population of women in these prisons represented approximately 76% of all the adult women incarcerated in the United States during August 1, 1991.²⁵² The research report notes that none of the officers from prisons located in New York State completed the survey because during the 1990s the New York Department of Corrections had several lawsuits filed against them by people incarcerated.²⁵³ As a result, N.Y. correctional officers were encouraged not to engage in the study for fear of initiating further litigation.²⁵⁴

Although all the correctional facilities surveyed responded that they had the medical resources and services legally required of them for incarcerated women, only twenty-nine facilities (48%) had policies relating to the care of pregnant women in prison.²⁵⁵ Of those twenty-nine facilities that reported that they had prenatal care for women, only 16% reported providing resources beyond prenatal care.

1. Twenty-three facilities (38%) reported offering “networks with community agencies which provide ‘other’ prenatal care”
2. Ten facilities (16%) reported providing Lamaze classes—classes offered for pregnant participants to teach breathing exercises and relaxation techniques to help them prepare for the pain and discomfort experienced during childbirth.
3. Nine facilities (15%) reported providing special diets and nutritional allowances.
4. Five facilities (9%) reported providing abortion counseling and abortions.

²⁵⁰ Wooldredge and Masters, “Confronting Problems Faced by Pregnant Inmates in State Prisons,” 198.

²⁵¹ Ibid, 198.

²⁵² Ibid, 197-198.

²⁵³ Ibid, 198.

²⁵⁴ Ibid, 198.

²⁵⁵ Ibid, 198.

5. Five facilities (9%) report having full-time nurses or midwives available for pregnant incarcerated women.²⁵⁶

Many of these programs are considered advancements for prison healthcare; however, they are neither far-reaching nor consistent, and the research is very outdated. Numerous prison administrators claim that they are unable to justify providing incarcerated women with women's health resources and prenatal programs because there are not enough women with long sentences.²⁵⁷ Additionally, because these programs are often not state-mandated, there are large variations in the resources and programs provided throughout the country.²⁵⁸ None of the aforementioned programs include programming specifically for the psychological wellbeing of pregnant women in prison. In fact, prison programs for the medical needs of women, in general, are almost as rare as the programs for pregnant imprisoned women. According to the study "incarcerated mothers with children under 18 constitute over 80% of the U.S. female inmate population, but only 18 facilities (30%) offer classes in parenting and only six facilities (10%) offer family counseling. Stress management could be very useful to pregnant inmates, but only 11 facilities (18%) offer such programs."²⁵⁹ Programs that do exist are only mandated for a small minority of the pregnant prison population.²⁶⁰

When asked how they thought their prisons could be improved, the officers surveyed stated that they saw a need for:

1. Adequate services to deal with false labors, premature births, and miscarriages

²⁵⁶ Wooldredge and Masters, "Confronting Problems Faced by Pregnant Inmates in State Prisons," 198.

²⁵⁷ Ibid, 197.

²⁵⁸ Ibid, 197.

²⁵⁹ Ibid, 200.

²⁶⁰ Ibid, 200.

2. Maternity clothes
3. Removal of belly chains when being transported to the hospital
4. Minimum security housing for pregnant women so they are not housed in maximum security facilities
5. Rooms for mothers and their babies to remain together
6. Separate visiting areas for mothers and newborn children
7. Less crowded living conditions

Of all the officers surveyed only eight respondents claimed that there were no problems in their correctional facilities, the rest were conscious of the changes that needed to be made to improve the medical care.²⁶¹ Overall, although these correctional facilities had included a few medical services to alleviate some of the physical and psychological pressure incarcerated pregnant women face, they still have a long way to go before their programs are deemed satisfactory. The few studiable improvements have only occurred in half the states and are only available to a small range of people. Moreover, incarcerated women need more educational opportunities to learn about their options for pregnancy, childbirth, and life after birth for their children.²⁶² It is essential for women who choose to keep their children, and women who already have young children, should have access to classes in parenting skills and child development.²⁶³ This 1993 study exhibits the disparity between what resources prisons claim to offer their prisoners and what they really offer them. Furthermore, seeing as this survey was performed

²⁶¹ Wooldredge and Masters, "Confronting Problems Faced by Pregnant Inmates in State Prisons," 200.

²⁶² Ibid, 201.

²⁶³ Ibid, 201.

almost thirty years ago, there continues to be a need for research on the daily conduct of prison institutions.

The SisterSong Women of Color Reproductive Justice Collective

Working directly with correctional institutions and officers on implementing successful women’s health programming is one way to better the reproductive problem incarcerated women face; however, alone it will not affect change—especially because it is unlikely that the institutions working to disenfranchise Black incarcerated women are likely to liberate them. To create change on a grand scale, the issue of mass incarceration and inadequate health care must be approached from multiple perspectives. The SisterSong Women of Color Reproductive Justice Collective provides an excellent example of a community-based organization working from many angles to reform the reproductive health of underprivileged communities.

SisterSong is the largest national multi-ethnic Reproductive Justice collective in the United States and is based in the South.²⁶⁴ Their mission is to “build an effective network of individuals and organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities.”²⁶⁵ The organization was founded in 1997 by a consortium of women from multiple backgrounds (Native American, African American, Latina, and Asian American) who “recognized that we have the right and responsibility to represent ourselves and our communities, and the equally compelling need to advance the perspectives and needs of women of color.”²⁶⁶ Since its inception, the organization has avidly worked towards

²⁶⁴ “SisterSong,” Sister Song (SisterSong, Inc., n.d.), <https://www.sistersong.net/mission>.

²⁶⁵ Ibid.

²⁶⁶ Ibid.

achieving Reproductive Justice for women of color both in and out of prison. The term Reproductive Justice (RJ) was first coined in Chicago in June of 1994 by a group of Black women who realized that “the women’s rights movement, led by and representing middle class and wealthy white women, could not defend the needs of women of color and other marginalized women and trans people.”²⁶⁷ They, therefore, created their own movement that centered the voices and needs of their people. They named themselves Women of African Descent for Reproductive Justice.²⁶⁸ The structure of RJ is rooted in the human rights framework created by the United Nations and combined with reproductive rights and social justice.²⁶⁹ Three years after the invention of this term and the founding of Women of African Descent for Reproductive Justice, SisterSong created a national membership organization to further support and advocate for RJ.²⁷⁰

SisterSong takes on several roles in the Reproductive Justice Movement. First and foremost, they advertise themselves as ambassadors for the voice of RJ and women of color in the United States. They also publish “the latest in RJ analysis” and uplift lesser known RJ issues by bringing them into the public eye.²⁷¹ Because of their expertise, the organization is often used as a resource by the United Nations, White House, legislators, media, and leaders of large mainstream organizations to represent the RJ perspective and provide accurate details about women’s reproductive needs.²⁷² They frequently train activists on how to incorporate the RJ

²⁶⁷ “Reproductive Justice,” Sister Song (SisterSong, Inc. , n.d.), <https://www.sistersong.net/reproductive-justice>.

²⁶⁸ Ibid.

²⁶⁹ Ibid.

²⁷⁰ Ibid.

²⁷¹ Ibid.

²⁷² Ibid.

framework into their work, and they additionally host one of the largest conferences of women of color working on RJ, and organize movements to raise collective power in moments of need.²⁷³

Moreover, SisterSong has made way for some of the largest reproductive policy changes in America. The organization is currently working with the American College of Obstetricians and Gynecologists and the Council of University Chairs of Obstetrics and Gynecology to file a lawsuit against the Federal Government to prevent them from enforcing in-person requirements on an abortion drug called mifepristone which would make it harder for people to access the treatment during the COVID-19 pandemic.²⁷⁴ SisterSong has played a vital role in the anti-shackling movement for pregnant incarcerated women, a movement which opposed the chaining of pregnant incarcerated women to their hospital beds during labor with handcuffs, leg irons, and or belly chains (*Figure 10-11*).

²⁷³ “Reproductive Justice,” Sister Song (SisterSong, Inc. , n.d.), <https://www.sistersong.net/reproductive-justice>.

²⁷⁴ “FOOD AND DRUG ADMINISTRATION, ET AL. v. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ET AL. ON APPLICATION FOR STAY,” SUPREME COURT OF THE UNITED STATES, January 12, 2021, https://www.supremecourt.gov/opinions/20pdf/20a34_3f14.pdf.



Figure 10. Photograph of a pregnant incarcerated women shackled to her deliver bed during labor

Source: Jane Evelyn Atwood, 1997



Figure 11. Photograph of a pregnant incarcerated women shackled to her deliver bed during labor

Source: Jane Evelyn Atwood, 1997

Although the Federal Bureau of Prisons banned the shackling of pregnant women in federal prisons in 2008, many imprisoned women continue to be inhumanely bound during labor.²⁷⁵ In 2018, SisterSong was contacted by members of a medical health staff that serves Raleigh, Durham, and Chapel Hill; here, SisterSong was notified of two women from the North Carolina Correctional Institution for Women who unlawfully remained shackled during childbirth.²⁷⁶

In both of the cases presented to SisterSong, doctors asked to unbind the women but the correctional officers refused.²⁷⁷ Shackling is an extremely dangerous practice for both the mother and the fetus as it can cause blot clots, serious delays in medical access, and increased risk of falling which can be detrimental to the fetus.²⁷⁸ According to previous state policy, correction officers were required to shackle pregnant women during transportation between prison facilities and local hospitals but were told to unchain them during “active labor.”²⁷⁹ The policy, however, did not define the meaning of “active labor,” therefore giving officers full discretion over when to remove the restraints, even when medical personnel requested otherwise.²⁸⁰

When this story came to SisterSong’s attention in 2018, the organization, along with other groups such as Forward Justice and MomsRising, took immediate action by calling North Carolina lawmakers and Erik Hooks, who served as the secretary of the North Carolina

²⁷⁵ Vania Leveille, “Bureau of Prisons Revises Policy on Shackling of Pregnant Inmates,” American Civil Liberties Union (American Civil Liberties Union, April 20, 2012), <https://www.aclu.org/bureau-prisons-revises-policy-shackling-pregnant-inmates>.

²⁷⁶ Maura Turcotte, Carrie N. Baker, and Reza Khandan, “What’s Next in the Fight for Reproductive Justice for Incarcerated Women,” *Ms. Magazine*, June 26, 2020, <https://msmagazine.com/2018/04/24/the-fight-to-protect-pregnant-women-from-being-shackled-in-north-carolina-prisons-and-across-the-u-s/>.

²⁷⁷ Turcotte, Baker, and Khandan, “What’s Next in the Fight for Reproductive Justice for Incarcerated Women,”

²⁷⁸ *Ibid.*

²⁷⁹ *Ibid.*

²⁸⁰ *Ibid.*

Department of Public Health.²⁸¹ Omisade Burney-Scott, the director of strategic partnerships and advocacy at SisterSong, expressed in an interview with Ms. Magazine that SisterSong wanted to ensure that the department was aware of what was happening. She also explained their desire to ground the prison in the organization's truths:

“One, this is a violation of folks’ human rights, right? Like from a reproductive justice standpoint, this is a complete affront to bodily autonomy and agency. For SisterSong, one of our core values is that a person is able to decide when they are going to have a child and under what conditions they have a child. And so, because someone is incarcerated, [that] does not take away that bodily autonomy or that agency—it just makes it more complex.”²⁸²

SisterSong prioritized educating the prison on their mistakes rather than solely reprimanding them. Additionally, Tina Sherman, a campaign director at MomsRising, explained the importance of raising awareness for this issue—“when the public at large doesn’t even realize that this is going on... it’s a huge barrier to making change.”²⁸³ SisterSong additionally reached out to lawmakers to discuss features of the policy that would work to decrease the rate of maternal mortality rates for Black women. Although Burney-Scott did not believe shackling practices would be immediately resolved, she was hopeful that substantial progress would come soon.²⁸⁴ The organization even offered to assist in drafting the anti-shackling policy reform for the state prisons, however, their help was declined. The department instead contacted the Federal Bureau of Prisons, the National Commission on Correctional Health Care, and the American

²⁸¹ Turcotte, Baker, and Khandan, “What’s Next in the Fight for Reproductive Justice for Incarcerated Women,”

²⁸² Ibid

²⁸³ Ibid.

²⁸⁴ Ibid.

Correctional Association for advice on the policy reform. The department's decision to seek advice from prison-related institutions rather than include the opinion of medical or community-based organizations worried SisterSong.²⁸⁵

The updated policy clarified that wrist restraints must be removed once contractions begin with the caveat “unless there are reasonable grounds to believe the [pregnant, imprisoned woman] presents an immediate, serious threat of hurting herself, staff or others” or if they present “an immediate, credible risk of escape.”²⁸⁶ They also clarified that mothers were not to be restrained during moments of infant bonding (cradling or nursing).²⁸⁷ However, pregnant incarcerated women continue to be required to wear handcuffs during transportation.²⁸⁸

Although the policy reforms provided much-needed clarification, there remain inconsistencies in the approach. For example, under this law, correctional officers continue to have jurisdiction over when to unshackle pregnant women. According to Burney-Scott, the policy change fosters more questions than it answers: How long is the bonding period? Who determines the amount of time? How soon will women be re-shackled? Will they have access to postpartum doctor's appointments? What kind of postpartum care will they receive back at their facilities?²⁸⁹ Furthermore, the new policy neglected to devise a proper procedure for officer oversight. The updated protocol states that officers must notify the Associate Warden of Custody

²⁸⁵ Turcotte, Baker, and Khandan, “What's Next in the Fight for Reproductive Justice for Incarcerated Women,”

²⁸⁶ Ibid.

²⁸⁷ Ibid.

²⁸⁸ Ibid.

²⁸⁹ Ibid.

when restraints are used and complete an incident report explaining why they were used.²⁹⁰ However, the responsibility falls on the officer to hold themselves accountable therefore providing no outside oversight. The North Carolina prison policy states that officers who engage in “unsatisfactory job performance or unacceptable personal conduct” are at risk of facing repercussions ranging from “a written warning, disciplinary, suspension without pay, demotion or dismissal when ‘just causes exist.’ ”²⁹¹ But again, the degree of punishment is at the discretion of the direct supervisor, therefore, making the consequences very subjective.²⁹²

Going forward, Burney-Scott expressed the need for more transparency and accountability in prison policy; “we need to push for stronger laws that also monitor and demand accountability in the practice... allowing a correctional officer with no medical training to override decisions made by a pregnant person’s doctor or midwife, based on their perception of safety or flight risk, is also highly problematic.”²⁹³ She also expressed the importance of knowing what happens in prisons on the ground level, as well as the policy level. Although SisterSong fought hard to reform the shackling policies in North Carolina they are aware that more can and should be done to properly protect incarcerated women’s reproductive rights.

SisterSong Analysis

²⁹⁰ Turcotte, Baker, and Khandan, “What’s Next in the Fight for Reproductive Justice for Incarcerated Women,”

²⁹¹ Ibid.

²⁹² Ibid.

²⁹³ Ibid.

In order to have the most impact, SisterSong took a strategic and intersectional approach to policy reform and institutional change. Their initial strategy to ensure that the department was not only aware of the correctional officer's injustices, but also to delve into why those wrongdoings were unacceptable, granted the institution the opportunity to recognize their mistreatment of the incarcerated women. Moreover, their quest to raise public awareness likely aided them in holding lawmakers accountable as well as provided them with financial support. SisterSong's decision to partner with other organizations like the American Civil Liberties Union (ACLU) bolstered their ability to effect change. In 2019, the ACLU represented SisterSong in their lawsuit challenging Georgia's law banning abortions as early as six weeks into pregnancy. SisterSong argued that the early abortion ban would disproportionately affect people of color, people with financial struggles, and people living in rural areas with the least access to medical care.²⁹⁴ Thankfully, the U.S. District Court in Atlanta stopped the abortion ban which would have been implemented on January 1, 2020.²⁹⁵ Their ability to both organize marches and draft policy reforms demonstrates the organizations' wide array of skills. Lastly, SisterSong's self-awareness allows them to continue to move towards their goal of reproductive justice. Although their fight for anti-shackling policy reform in 2018 proved to be successful, the organization was able to think critically about the new issues that would arise out of the updated policy. Unfortunately, due to the magnitude of maltreatment, sexism, and institutionalized racism

²⁹⁴ 2020 July 13 et al., "SisterSong v. Kemp," American Civil Liberties Union (American Civil Liberties Union, June 28, 2019), <https://www.aclu.org/cases/sistersong-v-kemp>.

²⁹⁵ Ibid.

present in the prison system, grandiose change does not come from individual policy reforms but rather it is born of a monumental paradigm shift.

There are multiple levels in which people, organizations, and governments can effect change. SisterSong demonstrates one route towards reproductive justice and prison reform. The organization utilizes the voices of the affected people to raise awareness for reproductive justice. Their employment of the collective voice creates ripples in the public perspective thus generating reform. However, an issue as big as mass incarceration and Black reproductive disparity require numerous waves of reform. Too often, policymakers, government officials, and advocates employ one solution for a problem rather than utilize multiple ones. Effective movements allow local solutions to be a part of the larger collage of actors that are harmoniously working to solve a problem.

Conclusion

The prison system in the United States is a failing system designed to persecute America's most vulnerable and disenfranchised citizens. Women, particularly Black women, are unfairly targeted and arrested often for non-violent crimes that unnecessarily equate to long prison sentences. Once in prison, these women are neglected, abused, and denied adequate nutrition and health care. The long history of abusive reproductive health care for Black women in America is being compounded by their growing, disproportionate imprisonment rates. As Black women, their multiple marginalized identities combine to create increased vulnerability and their status as "criminals" unfairly denies them the respect and humanity they deserve.

Considering the percentage of women in prison for non-violent crimes, a large-scale decarceration movement would lessen the tragedy that is reproductive health care in prison; 26% of women in prison serve sentences for drug offenses compared to 13% of men. Moreover, 24% of incarcerated women have been convicted of property related crime versus 16% of incarcerated men.²⁹⁶ These women do not jeopardize public safety but are rather in need of counseling, drug treatment, and parenting programs. Additionally, the money saved from large-scale decarceration could be reinvested in these programs that would not only enrich the lives of these women but also work to prevent any future women from falling victim to America's prison system.²⁹⁷

²⁹⁶ Nazgol Ghandnoosh, "Incarcerated Women and Girls," The Sentencing Project (The Sentencing Project, December 9, 2020), <https://www.sentencingproject.org/publications/incarcerated-women-and-girls/>.

²⁹⁷ Mauer and Chesney-Lind, "Imprisoning Women: The Unintended Victims of Mass Incarceration,"

Author, scholar, and Black reproductive advocate, Dorothy Roberts, explains that America's call for liberty is not enough to protect those who have been systematically disenfranchised by the government; "liberty protects all citizens' choices from the most direct and egregious abuses of government power, but it does nothing to dismantle social arrangements that make it impossible for some people to make in the first place. Liberty guards against government intrusion; it does not guarantee social justice."²⁹⁸ Liberty and government neutrality, she states, "conceals the racist origins of social practices that do not overtly discriminate on the basis of race."²⁹⁹ As we have learned by drawing connections between the origins of gynecology and the current disparities in Black reproduction, its racist origins continue to be perpetuated through medical training. And, although the racism may not always be overt, statistical evidence on health care disparities for Black women demonstrates that gynecological health systems and prisons continue to perpetuate anti-Black practices. As a society, we need to become better at identifying and unpacking what it means to be anti-Black. Being anti-Black is not only overtly refusing someone service. It can take on much subtler forms, like dismissing someone's experience of pain or assuming they are drug addicts, based on the color of their skin. Being anti-Black can also be institutionalized; for example, when funding is consistently poured into Cystic Fibrosis research rather than Sickle Cell Disease despite its immense need for research and treatment. Being anti-Black is criminalizing Black women when they fall into drug addiction while simultaneously victimizing white people's addiction by declaring it an opioid epidemic.

²⁹⁸ Dorothy E. Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York, NY: Vintage Books, a division of Penguin Random House LLC, 2017), 295.

²⁹⁹ *Ibid.*, 295.

As mentioned before, in the U.S. Black newborns die at 3 times the rate as white newborns. However, new research from Dr. Rachel Hardeman, Associate Professor at University of Minnesota's School of Public Health, found that Black newborns' in-hospital death rate is lowered by a third when they are cared for by Black physicians rather than white physicians.³⁰⁰ Given this information, I ponder the positive impact placing Black physicians and Black doulas in prisons would have on Black infant and maternal mortality rates. Although some prisons have started using doulas for their incarcerated women, the research on the extent of these benefits are limited. Ultimately, within the current prison industrial complex, there is a clear inequity in how Black women are treated. In order to identify the efficiency of new prison reform, statistical evidence needs to be further investigated. And, although prison abolition may be required, reforming the current system now is paramount to improving the lives of Black women and their infants.

³⁰⁰ Brad N. Greenwood et al., "Physician–Patient Racial Concordance and Disparities in Birthing Mortality for Newborns," PNAS (National Academy of Sciences, September 1, 2020), <https://www.pnas.org/content/117/35/21194>.

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