Going in the back door: rural African American women's experiences with reproductive healthcare

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ABSTRACT

AFRICAN WOMEN’S STUDIES

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GOING IN THE BACK DOOR: RURAL AFRICAN AMERICAN WOMEN’S
EXPERIENCES WITH REPRODUCTIVE HEALTHCARE

Advisor: Josephine Bradley, PhD.

Dissertation dated May 2010

The purpose of this research was to investigate salient factors that contributed to the deficient levels of maternity care received by African-American women in Leake County, Mississippi. Utilizing Three Levels of Racism and Structural and Non-Structural Barriers to Care as the conceptual framework, this study examined rural African American women’s experiences with reproductive healthcare, revealing patterns and concerns related to the levels of care received by this community.

Narrative Analysis and Grounded Theory were utilized in exposing the development of belief systems unique to this population of rural African-American women. The results of this study reveal several ideas and cultural patterns that respondents demonstrated during this study. Using Cultural Environmental Conditioning as part of theory development also exposed culturally specific themes. One such
idiosyncratic theme is the Black Bottle Syndrome. This syndrome is prevalent as a means of explaining the level of care and suspicion that rural African-American women experienced in Leake County, Mississippi. This study provides a foundational background emphasizing the need for further research and model development relevant to specific minority populations.
GOING IN THE BACK DOOR: RURAL AFRICAN-AMERICAN WOMEN'S EXPERIENCES WITH REPRODUCTIVE HEALTH CARE

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF HUMANITIES

BY
LATESSA MARIE PEARSON

AFRICAN-AMERICAN/AFRICANA WOMEN'S STUDIES

ATLANTA, GEORGIA
MAY 2010
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Definition of Terms

**Black Bottle Syndrome**: A culturally specific syndrome which implies a deep and varied sense of mistrust with the medical community.

**Conditioning**: how cultural beliefs are demonstrated (behavior, attitude, and status).

**Culture**: the philosophy of a people whose perspectives are expressed through a variety of methods (ex. churches, schools, hairstyles, clothing).

**Cultural disconnect**: the divergences of cultural values based on dominate and subjugated communities' valuation processes.

**Cultural Environmental Conditioning** (Pearson-Bess): speaks to the ways in which a people are acclimatized into an environment and forced/persuaded to accept inferior or superior status with little or no resistance.

**Cultural integration**: open and willing to learn from the perspective of many, instead of espousing the world view of one culture with the acceptance of that culture as representing normalcy for all of humanity.

**Environment**: place where cultural ideologies are disseminated (social, and personal).

**Location prejudice**: refers to the discriminatory practices generated because of space and social position. (Example: sophisticated, wealthy, intelligent/urban, backward, ignorant, impoverished: rural).

**Medico-cultural**: a medical culture relevant to specific locations. (This definition explains the various idiosyncrasies expressed in particular locales around medical care and services).

**Personal accounts of care (PAOC)**: individual experiences working within/outside medical care (for this research the poac's will refer to reproductive healthcare encounters).

**Reproductive care**: provided to women during various stages of their life cycles.

**Rural**: a non-urban environment characterized by large parcels of land, agricultural work/setting and close family proximity.

**Socio-cultural**: the specific culturally social mechanisms prevalent within particular environments.
CHAPTER I

Introduction

The purpose of this research was to investigate salient factors that contributed to the deficient levels of maternity care received by African-American women in Leake County, Mississippi. One reason that may contribute to the parsimonious nature of healthcare in Mississippi could be the lack of metropolitan areas. In Mississippi, there are only four metropolitan areas. These areas consist of the northwest region (Metropolitan Memphis area), the Jackson metro region, the city of Hattiesburg and surrounding areas, and the Coastal Region. Mississippi is considered rural by the Federal Government due to this enormous collection of non-metropolitan counties.¹ This fact could play an important role in the level of disparities within the rural American South; however reproductive health takes on a different meaning, especially when addressing African-American women and maternity care.

African-American women are the only group of women systematically denied their right to parenthood. During American slavery, African women were not allowed to act as mothers or parents to their offspring as these offspring were classified as property by the landowning class, completely reconceptualizing motherhood.² Mississippi’s early

economy was undoubtedly connected to this system of reconstituted motherhood and intergenerational forced labor.

This "reconceptualized motherhood" was even more evident while examining eugenics on the developing American population, due to the acceptance of stratified value systems. This word and concept was coined by a cousin of Charles Darwin, Francis Galton, who derived it from the Greek word *eugenes* which means "well-born." African-American mothers were often portrayed as lazy, uneducated, and lacking the moral judgment to be good (acceptable) mothers. The idea of inadequate African-American motherhood has shaped many views in the dominant culture.

Unfortunately, this same ideology reigned supreme for a number of prominent African-Americans throughout our history. As such, Margaret Sanger presents an interesting paradox for the African-American community. Sanger is credited by some scholars for opening the way for African-American women to control their birth life course. However, some would argue against such accolades and instead focus on what others have called genocidal politics. Sanger was able to solicit the support of political and cultural giants of her time. W.E.B. DuBois, Adam Clayton Powell, Martin Luther King, Jr., African-American doctors and social workers joined in the efforts to eradicate unfit persons from parenthood. The impact of this depersonalized status on African-American rural women has not been explored as a possible hindrance to adequate

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4 Washington, 197.
maternity care and could explain some of the bleak present day statistics related to
reproductive birth challenges.

In Mississippi, the infant mortality rate is second in the nation only to Washington, D.C.\textsuperscript{5} The United States has a dismal ranking among other industrialized
nations when probing infant mortality, especially when investigating African-
Americans.\textsuperscript{6} Perhaps this tragedy is plaguing the United States because the present
system does not allow women, especially rural African-American women, to share their
stories related to maternity care.

**Significance**

The significance of this study rests in the lack of available research addressing
issues pertaining to rural African-American women and their birth stories. This study
expands the canon by presenting a different perspective regarding health services in rural
minority communities. By engaging the African-American women’s voice, a more
meaningful examination of cultural life emerged for consideration. Upon completion of
this study, it will be offered to the medical community in hopes of assisting in
understanding the disproportionate numbers of negative reproductive outcomes
experienced by rural African-American women in Leake County, Mississippi. Utilization
of results for training medical personnel and students on issues related to health
disparities and African-American women in rural America could also prove useful.

\textsuperscript{5} Kathy Lohr, Mississippi Grapples with Rising Infant Death Rate, *National Public Radio* June

\textsuperscript{6} Lester Spence, Infant Mortality Rate at Odds with “Culture of Life” *National Public Radio* June
African-American healthcare disparities are widespread and growing. According to the National Cancer Institute, African-Americans succumb at a higher overall rate to certain cancers. These cancers include, breast, prostate, cervical, and lung. African-Americans' poor experiences with healthcare services could be influenced by perceived biased treatment which, in turn, has been shown to contribute to the development of hypertension. Health disparities can be passed on to future generations continuing the health crisis within the African-American community. According to Vicki Mays, African-Americans' experience with discrimination results in the decimation of their health status. Hypertension, diabetes, and obesity are all effects of discrimination. This biased treatment has been shown to impact the rate of preterm births. In addition to preterm births, researchers have also found that African-American women are more than twice as likely as Euro-American women to experience infant mortality and sudden infant death syndrome (SIDS). Not only are African-American women at greater risk for suffering the loss of their infant, they are also at higher risk of losing their own lives to maternal mortality.

African-American women who have been exposed to racism are found to be more likely to deliver very low birth weight babies. Researchers believe that lifelong
experiences with racism have a negative impact on healthy reproduction. The type of racism most often experienced by African-Americans, according to researchers, can be divided into three categories: institutionalized, personally mediated, and internalized. All forms of racism have a negative effect on African-American healthcare disparities.

Researchers Mamadi Corra and J. Scott Carter have recently established that African-American women were less trusting of the medical and science community. African-American women were more distrustful than Euro-American women and African-American men. They concluded that African-American women were more guarded with medical personnel due to past experiences with medical care. The legacy of past treatment appears to impact present behaviors and attitudes. This belief is especially true in underserved minority communities. The insidious nature of racism continues to have a devastating effect on African-Americans’ ability to thrive.

Most of the disparities listed are more ubiquitous in Mississippi especially for rural African-American women. This situation could be due to the rural nature of the state coupled with limited or non-existent labor unions. Non-organized labor will not agitate employers to provide health insurance for the workforce. This condition, of course, will impact the percentage of people without healthcare coverage. Twenty-six


percent of African-American women are without health insurance compared to 17.9 percent of Euro-American women. African-American women are less likely to begin prenatal care in the first trimester than Euro-American women, even though African-American women are more apt to receive Pap Smears than Euro-American women. Yet in 2004, Mississippi had one of the highest death rates in the United States for both cervical (3.3 to 3.7 per 100,000) and breast (24.7 to 27.6 per 100,000) cancers. African-American women had a higher mortality rate with breast cancer than any other group of women. Although high cases of mortality plague rural African-American women in Mississippi, none of the researchers conducted a study that would allow for the women experiencing reproductive healthcare to provide insight into services, attitudes or behaviors that may influence their reproductive healthcare decisions and their willingness to adhere to prescribed modes of treatment.

**Political**

Unfortunately, African-American women also experience the agony of burying their infants more often than Euro-Americans. Infant mortality in Mississippi is

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egregiously elevated. According to statistics, infant mortality for African-American women was 9.7 per 1,000 in 2004, but increased sharply in to 11.4 per 1,000 in 2005. Some experts think this increase is caused in part to a marked decline in Medicaid services coupled with perceived lack of motivation some rural African-American women demonstrate while working to navigate services and social support.\textsuperscript{18} The increase in this vital health indicator exposes a marked area of concern for the populace. African-American women are more likely to have negative reproductive outcomes in the state of Mississippi. What could be the source this discrepancy? Previous studies concentrate on the pervasiveness of racism as a means of explaining the gap in healthcare.

Infant mortality in the four selected counties was excessive for African-American women compared to Euro-American women in 2006.\textsuperscript{19} In Leake County, five infants died before their first birthday. All five were African-American. A comparison of neighboring counties exposes the same or similar outcomes. Madison County had nineteen infants to die; fifteen were African-American. Scott County also reported seven infant deaths; all seven were African-American. Finally, in Yazoo County, four infants died; all four were African-American.\textsuperscript{20} While these numbers may appear low and inconsequential, African-American women experienced this distressing sorrow, in some cases, 100\% of the time. Rural African-American infants appear to suffer detrimental circumstances in greater


\textsuperscript{19} This state issued report was divided into two categories, White and Non-White, however for this research the terms Euro-American and African-American will be utilized instead of the state’s classification.

numbers than rural Euro-American infants. The answer could be found in the quality of care offered each group of rural women. Past experiences could also be the culprit that influences rural African-American women's healthcare behaviors which may impact infant health.

Furthermore, African-American women gave birth outside of Leake County. This occurrence is due to the shortage of obstetrics/gynecological care in the region. Some women must travel as far as sixty miles to see a doctor and in many cases, they may not have transportation or money.²¹ Perhaps this phenomenon can also be explained by probing the areas selected or available for Euro-American and African-American women to give birth. For example, hospitals, clinics, women's health centers and university hospitals need to be explored as possible contributors to this discrepancy.

There are several hospitals available to provide obstetric/gynecological services in the four-county area. Conversely, the level of care or quality is almost parallel prominently depending on race of clientele. Available statistics reveal that in Leake County, 430 babies were born in 2006. African-American women delivered overwhelmingly at the University Medical Center (UMC.) Seventy-five African-American women gave birth at UMC, while only sixty-one Euro-American women delivered at that site. In addition, the more prestigious centers or hospitals had much higher numbers of Euro-American women than African-American. Moreover, at St. Dominic, African-American women delivered 35 and Euro-American delivered 38, at River Oaks Hospital, 30 African-American women delivered compared to 49 Euro-

American’s, and the largest discrepancy, Women's Hospital Jackson with 5 African-American deliveries and 34 Euro-American births.22 This trend continues for the other counties as well.

Additionally, cultural environmental conditioning speaks to the ways in which a people are acclimatized into an environment and expected to accept status (inferior/superior) with little or no resistance.23 African-American women have been at the fringes of American society for many centuries. This marginalization at the hands of dominant Euro-Americans creates an environment replete with advantages and disparities. Advantages are provided to the Euro-American community while disparities continue to plague African-American communities. Cultural environmental conditioning gives rise to dismal psychological outcomes. As minority groups navigate within an oftentimes hostile environment, certain psychosomatic problems become prevalent (depression, hopelessness, etc...) which could also deter the help-seeking behavior of African-Americans. In this case, the number of physicians available for care still will not increase minority participation in healthcare services. Unfortunately for rural African-American women, this conditioning is proving fatal for positive reproductive outcomes. However, this assertion cannot be made without inviting rural African-American women to share their birthing stories and insight.


23 This concept is being introduced as a means of explaining some of the disparities prevalent in this study. A more detailed explanation is located in the theoretical framework section of this work.
Statement of the Problem

Disparities are a constant reminder that more impartial means of providing health care services are required. African-American women have not been afforded the respect or space necessary to share their birth stories, which could lead to reproductive healthcare advances. When examining the difficult circumstances ascribed to rural African-American women surrounding reproductive healthcare, it appears that African-American women are a third world populace within a first world nation.

This research focuses on both structural and non-structural barriers to healthcare by soliciting rural African-American women to contribute their reproductive healthcare experiences. Hospitals, quality of care, attitude of physicians, ability to pay, location, transportation and childcare are issues to be investigated from the perspective of the receiver community instead of the providers.  

Physicians often conclude that rural African-American women do not comply with reproductive healthcare because they lack motivation. Regrettably, physicians often stereotype rural communities and their denizens. The right to be heard is the most basic of human rights. Rural African-American women are no different. This research investigates the lived experiences of these women and their birth stories.

According to Mark B. Lapping, rural communities are often misrepresented. Many images of rural culture continue to hinge on stereotypes of farmers or a generally

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lazy, uneducated, unsophisticated populace. Frankly, less than two percent of the U.S.
population is farmers. Sadly, rural communities have suffered unjust ridicule due to
location and African Americans also shoulder stereotypes based on race. The
convergence of these two prominent components impact rural African-American
women's behaviors and accessibility for reproductive healthcare services.

Theoretical Framework

The race noted on a health form is the same race noted by a sales clerk, a police-
officer, or a judge, and this racial classification has a profound impact on daily
life experience in this country. That is, the variable 'race' is not a biological
construct that reflects innate differences, but a social construct that precisely
captures the impacts of racism.

The investigator shares the opinion of author Camara Phyllis Jones, surrounding
issues of race and its impact on the lived experiences of the masses, or specifically rural
African-American women. Racial bigotry, as it is attached to reproductive healthcare in
rural American communities, is disastrous if it is permitted to be the only indicator of
who should receive adequate reproductive healthcare. Assigned to the theoretical
framework employed for this study, are three levels of racism characterized by Jones and
structural and non-structural barriers identified by Jay and David Strickland. Structural
and non-structural barriers scrutinize the multi-faceted reasons for the lack of sufficient
healthcare services in rural communities. Both theories address pertinent healthcare

26 Mark B. Lapping, "Where Problems Persist: One-Sixth of the Nation is Rural-And Many Rural

27 Camara Phyllis Jones, "Levels of Racism: A Theoretical Framework and a Gardener's Tale,"
concerns for this population. The former analyzes the function of race and racism on healthcare, while the latter provides specific means of investigating facilities and attitudes of both providers and recipients of services.

Although structural and non-structural barriers identify more particular complications to services, three levels were constructed by Strickland and Strickland to further explain problems related to healthcare. Community level, Programmatic level, and Individual level are identified as areas of investigation. This theory is comparable to Jones' levels of racism. However, Strickland and Strickland examine these barriers from a community viewpoint, which was the focus of this research. Structural barriers are those effects that impede healthcare that can be adjusted. Transportation, childcare, available physicians, and time management are a few identified barriers to services. Non-structural barriers, including help-seeking behaviors, sense of empowerment, belief that services are obtainable, awareness of local programs and services, and awareness of baseline standards (understanding illness diagnosis), are recognized as inhibitors to services as well. 29

However, non-structural barriers are more difficult than structural barriers to correct due to the subconscious normalcy of racism in the African-American community's psyche. Many rural African Americans may not feel as empowered as others in terms of seeking services that would assist in managing their healthcare. They may also feel disenfranchised about seeking help due to countless years of oppression.


29 Strickland and Strickland, 215.
While both theories were utilized for this research, Jones' three levels of racism appear to address most of the barriers created and maintained as established racist policies. Institutional, personally mediated, and internalized racism individually and collectively illustrate the healthcare encounters of numerous minority citizens. This state of affairs is especially prevalent for those located in rural areas.\(^{30}\) Institutionally propagated racist policies impact the readiness of local governments to assist citizens in need of services. Perhaps, the most prominent example of this is the response to Hurricane Katrina. During that crisis, there were many instances that evoked painful reminders of just how blatantly negligent those persons in government positions tend to be toward some citizens. Thus, reproductive health services for rural African-American women are no different. There usually is no media frenzy, but the thoughtlessness could be just as lethal. Personally mediated racism is showcased by the attitudes and beliefs of medical personnel responsible for partnering with patients to ensure proper care. Medical personnel could be impacted by the negative imagery of both rural populations and African-American women. Once the images are authenticated, then the medical community/personnel will not provide the best care for all patients. Possibly, the most egregious level of this theory is internalized racism which completes the cycle of laxity. Disbelief of the importance of reproductive healthcare becomes perhaps the most noxious development in this succession of neglect. Rural African-American women begin to believe what has been stated about them. This internal conflict could create a populace simply not interested in assuring they maintain a healthy body, but rather accept the limited services provided. They have been the forgotten for too long thereby permitting

both governmental agencies and medical personnel to effectively write them off as patients not worthy of being saved.

In addition to Jones' levels of racism, the impact of location on reproductive healthcare was also examined as part of this framework which is substantiated by the Strickland and Strickland theory. Many minorities in rural communities are neglected by healthcare services, which can be particularly lethal when addressing reproductive healthcare. Additional clarity is offered by discussing institutionalized racism.

*Institutionalized racism* according to Jones is differential access to goods, services, and opportunities of society by race.\(^{31}\) This form of bigotry specifically references how and who is entitled to what services. If assistance is provided based on this model, large segments of the populace are left without a means of receiving the adequate care that is necessary for a healthy and productive life. Opportunities are relegated in society based on race; unfortunately, this form of discrimination is widespread and numerous. When reliable levels of support (reproductive healthcare) are accessible to only a few people, then they are left to fight for the comparable quality care provided to the dominant group Euro-American women. While the focus of institutionalized racism is on how goods and services are offered to groups based on race, personally mediated racism concentrates on how prejudice is exhibited in the medical community.

Jones' second category of racism is *personally mediated*, which constitutes prejudice and discrimination, while *prejudice* means differential assumptions about the

\(^{31}\) Jones, 1212.
abilities, motives, and intentions of others according to their race, and *discrimination* means differential actions toward others according to their race.\(^{32}\) This form of racism impacts delivery systems (availability of services, attitudes of healthcare providers, proximity of medical care, etc...). If a clinician perceives patients to be uninformed and apathetic, then the services may reflect this type of prejudice. Physicians who permit the evening news broadcasts to inform them about a particular community will probably inadequately serve this clientele. Stereotypical images of racial groups adversely impact more than just media outlets. Trite descriptions may inundate the quality of medical care afforded the scrutinized community. Similarly, internalized racism focuses primarily on the responsible medical personnel instrumental in showcasing these negative messages, which have a profound effect on the behaviors of receiver communities.

Jones' third level is *internalized racism*, which is defined as acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth.\(^{33}\) Internalized racism is pervasive. Once so many discouraging images penetrate society, the group harmfully portrayed may begin to believe what is being said about them. For example, the images of African-American women as "welfare queens" and "fertile myrtles" have permeated the media for several years. Some African-American women know these images are uncomplimentary and fictitious. If these stereotypes influence physicians who are responsible for this group, it is only a matter of time before the women begin to see themselves as a misleading representation of womanhood. Moreover, all three levels of racism constantly influence the level of

\(^{32}\) Jones, 1212-1213.

\(^{33}\) Jones, 1213.
treatment for African-Americans in general. These theories were applied to African-American women in Leake County, Mississippi.

Rural African-American women have been impacted by all three levels of racism. *Institutionalized* discrimination, is defined as the lack of commensurable reproductive healthcare in their community; *personally mediated* bias is displayed by the clichéd images of African-American women influencing the type of care offered by the medical community and *internalized* prejudice, the most harmful of the three, influence the manner in which rural African-American women see themselves as manifested by the low priority placed on their personal healthcare. The theoretical framework for research focused on the consequences of all three levels of racisms on the quality of care offered rural African-American women.

This theoretical framework categorized the levels of racism relevant to this investigation. The actions of hospitals, clinics, and number of physicians commissioned to provide services to rural areas are defined as a type of *institutionalized racism*. Stereotypical images that manipulate physicians' opinions of rural African-American women are defined as *personally mediated racism*. Low-value of self-worth demonstrated as missed appointments or non-compliance is defined as *internalized racism*. In addition, space and location were also important variables to scrutinize while exploring rural reproductive healthcare and are classified as part of institutional racism for this research. Critical Race Theory34 and Critical Social Theory35 also parrot many of


the concerns prevalent in healthcare. Formations of a theory created by the experiences of
the people who constitute the sample further the discussion of responsible and culturally
competent care. Although the previous theories address specific concerns with healthcare
and the availability of care, they do not address more explicit indicators that could also
play a major role in levels of maternity care. Hence, the researcher proposes a more
encompassing theory.

Methodology

The methods utilized for this study were narrative analysis and grounded theory. Both
necessitate a humanistic central focus. Grounded theory encourages an organic
development of theory. The purpose of this technique is to sanction the voices of people
under investigation to use their own words to enlighten others about a particular
phenomenon. This process encourages a focus on incorporating the experience and
influence of the researched group. Researchers such as Loretta Ross speak extensively
about the value of storytelling and oral history as a means to ensure more voices are
heard in order to provide a clearer understanding of humanity, especially when
addressing concerns of communities of color. A deeper appreciation of difference is
necessary to tell a more complete story of what it means to truly be human. This style of
research was beneficial because it allowed for the expansion of ideology surrounding an
event or time period. Daily ordinary living and surviving are the focus, instead of simply
utilizing numbers. This form of data collection is even more important for listening to the

36 Kathy Charmaz, Constructing Grounded Theory a Practical Guide Through Qualitative

37 Loretta J. Ross, “Storytelling in SisterSong and the Voices of Feminism Project,” in Telling
2008), 65-71.
voices of these socially invisible women. Narrative Analysis coupled with grounded theory was best equipped to answer the research questions of this study. Listening to the experiences of this population could improve the services provided by both medical personnel and the community under investigation; narrative analysis was the most efficient mechanism to do so. Maternity care was analyzed for themes related to cultural, personal, and societal values. These stories provided an exceptional narrative on the intersectional nature of rural minority culture and reproductive health.

Rural African-American women are central to this study, elucidating the contributions of an underprivileged community by sharing vital information. These reproductive health stories were explored to better understand the challenges and triumphs faced by this population of women. The women selected from this area share some commonalities based on location. Rural or urban environments create or implement characteristic levels of adjustments that are significant to the area under investigation. The focal point of this research area was no different. Many of the rural African-American women have been connected to Leake County, Mississippi for a number of generations forming social networks and friendships that are affiliated with their communal experience. One such commonality is the distance all the women travel to deliver their babies. This research will ask the women to share how this state of affairs shapes their views on personal and community sustainability.

More attention is shown to the daily struggles of African-American women in urban centers. Unfortunately, location is not given much credence when distinguishing the toil of African-American women based on community location. Concentration on rural culture and the African-American women that reside in these regions will expand
the dialogue. Childbirth stories for this research serve more than one purpose. The first is to establish a space in support of women from rural communities to share their personal experiences. Second, perhaps research can answer some questions surrounding the disproportionate number of infant mortalities occurring in rural Leake County, Mississippi and third, by encouraging women to express how pregnancy and childbirth impact their lives and community. There are purely utilitarian purposes for conducting this research, for example, by exposing the individual experiences of rural African-American women and birth, a better understanding of rural culture and empowerment will emerge. As this rural population of minority women is included in their reproductive healthcare, a more informed community will assist in understanding the problem of infant mortality and the importance of proper personal and collective care such as cessation of smoking, proper diet, exercise, adequate rest, and development of community support services.

Birth stories, for this research, were categorized into three parts: (1) emotional (mothers’ reaction once informed of pregnancy), (2) intellectual (how informed or willing the mother was about planning the actual birth i.e. prenatal care, medicalized or natural birth etc.,) and (3) spiritual (how important was faith as pregnancy progressed into the culmination of birth). It is assumed that race and racism impact how cleverly rural African-American women are able to navigate resources. Proficiency functions as insurance to ensure that both they and their unborn children are healthy and well supported.

Rural African-American women were invited to express their views on communal, individual and societal values linked to their maternal experiences. Their
knowledge provided insight into community acceptance or welcoming of the pregnancy, birth, and parenting. Rural African-American women shared their experiences in order to clarify pertinent issues, and to gauge the impact of race and racism on communal activities around childbearing expectations.

Data was collected and analyzed using a narrative analysis story map. This concept is introduced by Heather J. Richmond as a means of extracting information within stories provided to researchers. This type of story map further allowed the experiences of the women to be available for analysis and study. In conjunction with Cultural Modeling Framework, a culturally specific interpretation of the childbirth event was deconstructed to effectively portray rural African-American women in their own words.

Participants

This study investigated twenty-two rural African-American women from Leake County, Mississippi. This county includes a well represented African-American population. As stated earlier in this research, several of the families have resided either in Leake or neighboring counties for a number of generations. Leake County has several individual healthcare facilities.

The researcher solicited twenty-two participants from Leake County, Mississippi who agreed to participate in this study. The investigator utilized interviews as means of

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data collection. Interviews were employed to ascertain salient themes for rural African-American women participants. This concentration was paramount in establishing the influence of past experiences on present reproductive healthcare behaviors and attitudes (as displayed by three levels of awareness which include emotional, intellectual, and spiritual perspectives).

In order to participate in this study, rural African-American women should have received reproductive healthcare services from a Leake County, Mississippi healthcare system provider. Participants were from a diverse population encompassing age, income, religious affiliation, and educational levels which are just a few key components that emphasized diversity. The women were categorized into three sections. The first were the great-grandmothers or Sage Women. Their ages ranged from 61-83. The next group included the grandmothers or Wise Women with an age range of 40-60. The study concluded with the mothers or Renaissance Women, whose ages ranged from 20-39. Each group provided a different point of view on rural African-American women and maternity care. The interviews were conducted in several sites including the homes of contributors in hopes of decreasing transportation, time, and childcare constraints for the participants.

**Procedure**

Participants in this study were asked several open-ended questions to ascertain the levels of maternity care provided to their community. The interviews required approximately 45-60 minutes. The information was collected at various sites such as
homes, and churches. The sessions were recorded and transcribed for further examination.

Instrument

For this study, questions were arranged to reflect the emergent grounded theory Cultural Environmental Conditioning. Culture addressed the ways services are allocated based on various attributes such as class, race, gender etc. Environment could focus exclusively on the location of the study. However, for the purposes of this study, environment concentrated on the healthcare institutions in which rural African-American women gave birth and from which they received maternity care (hospitals, clinics, women's centers and University Medical Center) as well as their personal space (home). Conditioning reflected how the women internalize treatment.

Data collected articulated not only how they feel, but how those feeling impact their personal behavior and attitude. Interview questions were designed to facilitate this study. Participants were asked the following questions. Each provided insight into relevant themes. This research employed open-ended questions that encouraged the women to share their views of services.

General Questions/Demographics

1. How old are you?
2. How long have you resided in Leake County, Mississippi?
3. What is your marital status?
4. How many children do you have?
5. Are you currently employed? If so where? Is health insurance available to you?
6. Do you have a high school diploma or G.E.D.?
7. Did you attend college, if so where?
8. Did you complete your Associate's or Bachelor's Degree?

*Cultural*

9. What kind of services have you received at Leake County clinics?
10. How long have you received services?
11. Out of the services you received at the clinics, which ones did you feel were adequate or inadequate?
12. Describe your prenatal care? Do you feel this care was satisfactory? (Why? /Why not?)
13. How did you find out about your pregnancy? (asked family members, made appointment with healthcare provider, home pregnancy test be specific)
14. Describe your mood when you were informed about pregnancy (happy, excited, worried, sad, upset be specific).
15. How were you treated by family and friends once they were informed about your pregnancy?

*Environment*

16. Which clinic have you been satisfied or dissatisfied with? (Why?)
17. Describe the treatment you received at the clinic?
18. What do you think contributes to the type of care you receive? (Economics, quality of staff, lack of adequate technologies, etc.)
19. How do you pay for your services? Do you think how you pay impacts how you are treated?
20. How do you think your race impacts the quality and availability of care?
21. Where did you deliver your baby? (UMC, Women's Center, Madison County Medical Center etc.,) Were you induced? Was your water manually ruptured? Were you offered a midwife or doula in your birth plans?
22. How far did you travel to deliver your baby? (30 minutes, 60 minutes or more), do you have a personal car or did someone else provide transportation? Who?
23. How can Leake County Health Clinics assist in maintaining your reproductive healthcare?

*Conditioning*

24. How does this treatment influence your follow-up care?
25. Were follow-up appointments given by doctor or did you request them?
26. Describe the factors you think impact the type of care you receive? (Race, economic status, education levels, etc...)  
27. How does accessing reproductive healthcare in Leake County make you feel? (be specific)  
28. Do you consider yourself to be spiritual or religious? (Did news of your pregnancy cause you to rely more on prayer or other spiritual practices?)  
29. How would you describe your overall emotional state concerning pregnancy? (be specific. happy, joyful, sad, worried, undecided about state of emotions)  

**Research Questions**  
The research questions were:  

How does race and racism influence reproductive healthcare behaviors and attitudes for rural African-American women in Leake County Mississippi?  

What are the factors that contribute to the socio-cultural challenges related to the maternity care of rural African-American women in Leake County, Mississippi?  

Themes permitted the researcher to identify how rural African-American women experience reproductive healthcare within their environment. The topics created a means for further investigation concerning attitudes and behaviors.  

**Delimitations**  

Due to this type of study, the sample population was limited to rural African-American women residing in Leake County, Mississippi. Narrative Analysis or Grounded Theory does not require a large number of participants. Certain schools of thought emphasize quantity over quality making the inference that in order for research to be valid, there must be large numbers to analyze. Qualitative researchers are more concerned with the voices of the interviewed populace being heard and understood. Therefore, this research may not be as generalizable as larger studies, but will provide insight into a rural minority community.
Limitations

The focus of this research was on the experiences of rural African-American women and reproductive healthcare. For this reason, physicians will not be a focal part of this research. Many practitioners in rural areas are unable to allow interviews due to a lack of time and a shortage of assistants.

Data Analysis

Data was analyzed employing both narrative analysis and grounded theory. Both methods allowed for a better understanding of the women and their experiences. Code development was an important component of analysis for this study. Themes were formed with the intent of explaining levels of care received by this group of rural minority women. Narrative analysis was employed to extrapolate data from the stories or narratives. The technique engaged was Cultural Modeling Framework. This method of narrative analysis sanctions the cultural definitions of events or experiences. This process is carried out by utilizing a style of language that is culturally relevant and responsive to ethnically significant expressions.

Chapter Organization

Chapter I: Introduction established the problem to be examined which was rural African-American women's relationships with reproductive healthcare in Mississippi rural communities. Chapter II: The review of literature examined research already done relate to the problem under investigation. This chapter is divided into categories that

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address historical, psychological and political, as well as, personal experiences of rural African-American women on birth and motherhood. Chapter III: Context of the problem explored the strategies rural African-American women in Leake County, Mississippi currently utilized with pregnancy and birthing issues. Chapter IV: Findings related to data collection, which consists of interviews from rural African-American women who received reproductive healthcare services from Leake County Healthcare Services. Chapter V: Cultural Environmental Conditioning tenets and subsequent model. Chapter VI: Research conclusions and future research recommendations constitute this chapter.
Chapter II

Literature Review

The purpose of this chapter was to explore literature relevant to the experiences of African-American women. This exploration considers the liberation of marginalized voices by scrutinizing previous research. Several perspectives were investigated to provide a foundation for this inquiry. Results are categorically divided to ensure clarity. Historical, Psychological, Political and Personal experience work to create a map for the expansion of women’s studies and as such humanistic inquiries.

Rural African-American women’s childbirth stories (experiences) were investigated by reviewing literature relevant to this study. The literature was located in journals from a diverse field of interest; to include community health, rural health, and public relations. The reason for searching a diverse data base was to provide a balanced approach to the problem. Books chronicling personal experiences within the rural reproductive healthcare system worked to provide additional leverage exploring the information provided by rural African-American women.

Books further the balanced to the argument, although some were not as current as monthly or quarterly journals; they are useful and provide insight into proposed problems. Some of the text proved relevant to more than one portion of this review of literature as history impacts politics and politics weigh heavily upon both personal
experiences and the psychological well-being of humanity. Lastly, previous research conducted by the researcher on rural African-American women with reference to healthcare accessibility will be analyzed for this study. The previous study focused exclusively on the accessibility of healthcare services for Leake County, Mississippi African-American women.

**Historical**

African-Americans in rural America suffered vital health disparities from the start. In *Dying While Black*, Vernellia Randall discussed how the slave health deficit began for Africans forcibly moved to the United States by asserting:

> Slavery, segregation, and institutional racism resulted in the distribution of resources along racial lines, with whites being privileged and Blacks and other racial and ethnic groups deprived. In fact, race socially constructed all privilege or disadvantage from a past of slavery and colonization and a present built on neocolonialism, cultural imperialism, and racism.¹

Professor Randall associates the current status of indigenous African-Americans to the devalued ascribed position thrust up on them by unjust laws and government. She maintains that the current state of African-American health has been forever influenced by the slave deficit created during American Chattel Slavery (ACS). ACS included the forced and brutally depersonalized system of racial oppression. This explicit type of oppressive politics ensured that persons of African descent would remain fixed within a color based caste system for generations.

These disparities are blatantly noticeable while investigating historical connections between African-Americans and healthcare. Past discriminatory policies

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¹ Vernellia R. Randall, *Dying While Black* (Dayton, Ohio: Seven Principles Press, Inc., 2006), 21
exert significant authority over the present state of available healthcare. In *Medicine and Slavery*, Todd L. Savitt creates a vital piece of the puzzle regarding the care of enslaved Africans. His study focused on the many diseases prevalent in the old South, such as cholera, smallpox or yellow fever. Afflictions such as whippings also constituted a distinctively African health problem. In addition, the types of medical treatment/experimentation provided to the population of Africans at that time were dictated by the severity of the potential outbreak, and the value of the property. Marie Jenkins Schwartz continues to weave a tapestry of neglect in *Birthing a Slave*, which chronicles the type treatment (often informed by the distrust of white doctors), afforded enslaved African women in America, particularly in the South. During American Chattel Slavery, many African women were coerced into having large numbers of children to perpetuate white wealth. Especially with the legislative ruling in 1808, this concluded the importation of Africans into the newly budding American slave economy. Forced motherhood had perilous outcomes for enslaved mothers, but infants were also in grave danger of losing their young lives as well Schwartz notes that:

> Childbirth posed a danger not only for mothers but also for infants. Infant mortality ran high among enslaved people, and slaveholders hired doctors periodically to examine infants who were stillborn or who died shortly after birth.

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3 Savitt, 111-112.

4 Savitt, 130, 133.


Fanny Kemble's journal provides an even more provocative and distressing description of enslaved women and childbirth she states:

Here lay women expecting every hour the terrors and agonies of childbirth, others who had just brought their doomed offspring into the world, others who were groaning over the anguish and bitter disappointment of miscarriages here lay some burning with fever, others chilled and cold and aching with rheumatism upon the hard cold ground, the draughts and dampness of the atmosphere increasing their sufferings, and dirt, noise, and stench, and every aggravation of which sickness is capable, combined in their condition here they lay like brute beasts, absorbed in suffering.  

These descriptions in conjunction with the daily struggle for enslaved survival culminated into a prescription for current residual impact. These manifestations continue to plague the lives of indigenous black Americans (term used by Vernellia Randall). Infant mortality and other reproductive health disparities plagued plantation life and continues to pose a serious threat to the health of African-Americans today. The causes of the present day healthcare dilemma according to Vernellia Randall, has roots in the afore mentioned culture of neglect evident by historical maltreatment of people of African descent in this country.

According to H. A. Poindexter, infant mortality was higher among African-Americans depending on location. There was a higher rate of deaths in rural areas compared to urban areas in the 1930's. In order to better understand the politics of

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underserved populations, Susan Smith\textsuperscript{11} and Dorothy Roberts\textsuperscript{12} provide the background of policies that created healthcare disparities in the United States. Smith offers facts chronicling the historical significance of healthcare or the lack of healthcare in Mississippi. Her research centers on activism, Roberts considers specifically the political environments that gave birth to reproductive disparities. Smith advocates healthcare as a component of civil rights for African-American people. Roberts with her emphasis on activism, provides for this researcher the needed avenue by which to investigate the liberation of the African-American female body, and reproductive freedoms through education and legal scrutiny.

In \textit{killing the black body}, Dorothy Roberts provides insightful information about the legal system and how it works to contain African-American women's reproduction. Dorothy Roberts work complicates the role of women in southern culture especially related to the peculiar institution of slavery. Reproduction and production are explained as the basis for the abundantly wealthy historical southern culture. In current times the same disconnect is often presented when African-American women advocate for services surrounding reproduction. Dorothy Roberts holds to task the institution of slavery for its crimes against motherhood. Several examples were provided displaying the cruel nature of slavery and the lack of autonomy regarding African-American women's bodies and reproduction. Roberts posits:

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The story I tell about reproductive rights differs dramatically from the standard one. In contrast to the account of American women's increasing control over their reproductive decisions, centered on the right to abortion, this book describes a long experience of dehumanizing attempts to control African-American women's reproductive lives. The systematic, institutionalized denial of reproductive freedom has uniquely marked Black women's history in America.\textsuperscript{13}

Roberts presents a compelling argument introducing historical accounts of African-American women's labor on the plantation and how this work increased dramatically the wealth of southern white land owners. Work also provides the history of reproductive healthcare for African-American women.

Similar to Roberts's historical and legal account of harshness associated with reproduction in the American South, Harriett Washington's *Medical Apartheid* furthers the discussion by focusing on the systematic institution of slavery. Enslaved African women's bodies were used for research. Washington provides several examples of gross negligence at the hands of science.\textsuperscript{14} The mental anguish experienced by these women went unacknowledged during their lives and remain unknown today. What has been discovered is that modern science is indebted to the sufferings of these enslaved women for the many medical advances prevalent during that time. In congruence with the previous researchers, Deborah Gray White continues the discussion in *Ar'n't I a Woman?* of the political treatment afforded enslaved African women during slavery. This occurrence is significant because the American slavery system solidified the intergenerational stratification of values based on color, sex and ultimately privilege.\textsuperscript{15}

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Correspondingly, in *Women of Color and the Reproductive Rights Movement*, Jennifer Nelson broadens the dialogue concerning historical and contemporary reproductive issues by cataloging the struggle to secure reproductive autonomy. This text furnishes foundational information on the formation of several organizations dedicated to liberating white women. Women of Color forced many of these organizations to expand their agendas to include issues of class and sterilization abuse.

The personal account of southern culture during a pivotal time in American history is presented in *Mississippi Harmony: Memoirs of a Freedom Fighter*, Winston Hudson offers personal accounts of the repressive institution of sharecropping and white supremacy. Though her family was not sharecroppers, the brunt of racist politics shaped and contained her family’s ability to fully take part in America society. This biographical work assists the research in presenting a human face to the oppressive institution so well known in southern culture, as well as America. Hudson recalls efforts employed to ensure that all women in rural Leake County would have adequate reproductive healthcare. Hudson stated:

I remember when my mother was giving birth, the doctor insisted on keeping her propped up. He said to take the pillow out from under her and elevate her body with her head down. She said the she felt like she was smothering to death. I don’t know whether her lying down would have saved her, but the doctor would not let her lie down. . . two of my sisters, Willie and Ollie, died in childbirth too. Willie was only seventeen years old.

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This investigation into reproductive healthcare, though biographical, compels the researcher to understand the daily toils of women in rural environments by inviting others to understand, through voice transmission. *Mississippi Harmony* provides a personal account of the history of Leake County, Mississippi, from a rural African-American woman’s perspective.  

**Psychological**

The psychological understanding of culture as it relates to African-Americans is succinctly offered by Linda James Myers in *Understanding an Afrocentric World View: Introduction to an Optimal Psychology*. This work details the function of psychology in maintenance of the *self*. This body of research seeks to present a different method for understanding and appreciating the role of identity. (1) Rural African-American women are culturally astute in their distinct way of experiencing life. (2) Reproductive healthcare is essential to any culture, but particularly to African cultures. Children are praised before they are born and are accepted into the community with open arms. (3) Myers expresses the role of reproduction within the African consciousness as pivotal and of the highest importance. (4) This level of understanding is possible only as a collective cultural identity is created. (5) Only through self actualization and work can true health be attained. Myers’ research diversifies the method for interpreting the experiences of the population under investigation. Myers asserts:

> The conceptual system through which we relate to reality determines the way we perceive, think, feel, and experience the world...The depletion of our natural resources; pollution of our environment; increased incidence of catastrophic

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illness (e.g., cancer, AIDS, etc.); exorbitant healthcare costs; high rates of drug and alcohol abuse; family violence; teenage pregnancy and suicide; global conflict and the threat of nuclear holocaust--all these make imperative a close examination and careful analysis of socialization in U.S. society and the world view that becomes ours as a consequence.19

Myers clarifies the reasons for seriously investigating our socialization and psychological health as a precursor to understanding the role of reproductive healthcare in rural African-American culture. In addition, other researchers affirm the importance of providers becoming culturally aware of the communities they serve in order to improve the quality of healthcare.20 Cultural understanding of African Americans would prove beneficial to the medical community if they are charged with advocating for this population. In What Mama Couldn't Tell Us About Love, Brenda Wade and Brenda Lane Richardson discuss in depth the residual pain experienced during slavery, the era of Jim Crow and current issues of racism. Accordingly, What Mama Couldn't Tell Us About Love:

...examines our emotional legacy, a legacy of feelings and beliefs that developed from our collective experiences, beginning with the kidnapping of our African ancestors when they were dragged in chains to the "New" World, and continuing as their descendants suffered through the violence and humiliation of the Jim Crow laws passed across the South around 1914, and latter-day racism. All of this impacted us financially and socially. These historical events, fraught as they were with complex and diverse highs and lows, tragedies and triumphs, have cast a long shadow over our lives.21

The many occurrences that have shaped the lifespan of African-Americans continue to have a lasting effect on current value systems and the ability to cope with the daily


21 Brenda Lane Richardson, and Brenda Wade, What Mama Couldn't Tell Us About Love (New York:HaperCollins Publisher, 2000), xviii.
struggles of existing in a hostile environment. Psychological health is important for a viable pregnancy and an informed and active community. Psychological and spiritual healthcare also compromised by the insidious nature of slavery and racism. In *Stolen Women*, the weights of stereotypes are examined and Wyatt comments:

> In our neighborhoods and around the world, powerful stereotypes perpetuate the image of black women as sexually permissive. Society's message is that to be black and female is to be without sexual control, to be irresponsible about our sexuality. Regardless of the circumstance or our appearance, we may be presumed to be sexually available or for sale at some price. For so many years during slavery, we were bought and sold. It is hard for some people to believe that we can be anything else. Every other stereotype of the black woman springs from this one.\(^{22}\)

The institution of American Chattel Slavery and the subsequent eras that followed, created a people destined to define themselves through the eyes and cultural norms of others. A peculiar type of freedom ensued for many African-Americans at that time. The effect is still rampant within the community, and includes depression, obesity, drug usage, high school dropout rates and infant mortality.

> Prayer/Religion, value of reproduction, strong support systems are but a few dominant themes when considering rural African-American culture. Cultural health is maintained by acknowledging past events while being open to a redefinition of strength, hope and optimism. The medical community will need to acknowledge this crucial link to treat African-Americans.

> In *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950*, Susan Smith examines the responsibility of activism in healthcare. This body of research examines the beginnings of healthcare for enslaved Africans in the

southern United States. The work records the role of advocacy on the health and well being of African-American women. Surprisingly, Smith provides early prejudices concerning healthcare and enslaved Africans. According to Smith the plantation owners only provided meager health services to enslaved Africans as a precautionary means to curtail the spread of disease to the white slave owners. The largest concern for this class of "elites" centered on providing care for the sick only if there was a threat the sickness would spread to Christian white people. The book also examines the dynamics of reproductive healthcare by addressing the role midwifery played in early care. *Sick and Tired of being Sick and Tired* provides this research another historical account of reproductive healthcare as a form of activism.

While *Mississippi Harmony* provides a personal perspective on location and activism, it also assists *Understanding an Afrocentric World View* in creating the dynamics for culture becoming central for this research. In *killing the black body*, the historical examples of African-American womanhood and autonomy are addressed, as *Sick and Tired of Being Sick and Tired* examine similar issues registering the position of healthcare in America for enslaved and later freed African-Americans. All the books presented thus far advocate for more communal involvement to ensure a healthier African-American community.

In *killing the black body* economics is discussed as a major component directly affecting the well being of African bodies and reproduction. *Understanding an Afrocentric World View* does not explicitly undertake reproduction, but does address the psychological stressors of developing under tyrannical circumstances. The psychology of subjugation is an important factor to explore in hopes of understanding the
intersectionality of oppressive environments. *Mississippi Harmony* presents the role of rurality in assuring access to healthcare, while *Sick and Tired of Being Sick and Tired* presents the role of activism in demanding adequate healthcare services. As Mrs. Hudson advocated for care within the National Association for the Advancement of Colored People (NAACP), organizations such as Alpha Kappa Alpha (AKA) were also essential in securing services for rural African-American populations.23

All the issues presented thus far have evaluated the historical, political and social policies that have discriminated against African-American women's reproductive freedoms. While many of the themes touch on important aspects of African-American women's reproductive lives, none of the studies address specifically rural African-American women. This study will center research on the lived experiences of African-American women in an effort to supply omitted information in order to impact their level of reproductive freedom.

**Political**

Shortly after emancipation, the socially crippling politics of Jim Crow continued to exacerbate the frequently desperate conditions of African-American motherhood. Reproduction was as necessary during this era, as it was during the enslavement period. African-American women were still required to mother the productive labor force of the American economic system.

The assurance of African-American women's status in America has produced calamitous circumstances for African-American reproduction. African-American women

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are more likely to deliver very low birth weight babies as a result of perceived racism.\textsuperscript{24}

For African-American women, location and race continue to control the health of their babies. A study found that African-born African-American, American-born African-American, and American-born White women produced babies of significant varying birth weights. However, for African-born African-American and American-born White women, their babies weighed more than the American-born African-American woman.\textsuperscript{25}

These articles corroborate that the unremitting legacy of slavery stubbornly informs the American public's current social and political conscience, which is detrimental to African-American reproduction.

According to Strickland and Strickland the two major barriers that sometimes work to prevent rural healthcare are both structural and non-structural. Structural barriers include transportation, ability to pay, telephone, time and childcare, while non-structural barriers include empowerment, seeking services, awareness of services and the belief that services are desired or needed.\textsuperscript{26} Structural and non-structural barriers appear inclusive in scope. However, they do not specifically include the experiences of the persons receiving care. Though, non-structural barriers mentioned empowerment, the research did not delve into the psyche of persons receiving care, in this case African-American rural women.


Though African-American women are the focus of this research another vulnerable population was mentioned as lacking in care, the elderly.\textsuperscript{27} This study was valid as the researcher will also include elderly rural African-American women. One main reason for including this population hinges on the reluctance of this older generation of rural women to continue reproductive healthcare. Of course, maternity care is no longer an issue for this populace; however, it is still important for them to be empowered around their total health. The researchers did examine structural barriers to this population receiving adequate care. The barriers for this particular population were economic displayed by type of insurance coverage and Medicaid payments. While the researchers were specific and gave reasons for the gap in services, they did not include rural African-American women's experiences concerning reproductive health care.

Elderly rural African-American women are also in need of specific services. While the study provided some much needed insight into the overall population of elderly, they still did not focus on African-American rural women. The researcher included the elderly due to the diverse population of rural African-American women this study will involve.

Additional researchers focused studies on educational levels, number of physicians available to provide services,\textsuperscript{28} the ability of rural communities to access modern technology in clinics and hospitals,\textsuperscript{29} as well as racial disparity and lack of trust


\textsuperscript{28} Sharon K. Long and others, "Unmet Need Among Rural Medicaid Beneficiaries in Minnesota," \textit{The Journal of Rural Health} Vol. 18 No. 3 (Summer, 2002): 437.

\textsuperscript{29} Ira Moscovice, and Roger Rosenblatt, "Quality of Care Challenges for Rural Health," \textit{The Journal of Rural Health} Vol. 16 No. 2 (Spring 2000): 168.
experienced by African-Americans with health care services,\textsuperscript{30} ethnicity and socioeconomic factors.\textsuperscript{31}

Researchers continued to attempt linkage of services with racial make-up and lack of equality with reference to African-American populations. Though an attempt was made to explain disparities in reproductive healthcare services by Marilyn Therese, she still failed to specifically examine the experiences of rural African-American women by probing the local cultural norms that assist in developing the total picture.\textsuperscript{32} Rural populations are thought to be vulnerable to insufficient services. Civil Rights activists, such as Winston Hudson and Constance Curry, worked diligently to ensure quality services were provided to rural communities. One such example would be Mrs. Hudson. A pioneering rural African-American woman, she protested on several occasions to have quality health services in general and reproductive health care services in particular provided to rural women.\textsuperscript{33}

Other researchers chose to focus on length of patient/physician relationship and satisfaction as a means of discrepancy.\textsuperscript{34} While the study was able to establish a positive link between lengths of relationship, it left the question of patient responsibility and


follow-up for rural populations untouched. Studies show a connection between the perception of respect and medical treatment satisfaction. The study found that minorities are prone to feel that they have experienced disrespectful physician behavior. This experience then influences their willingness to comply with medical advice. The previous studies substantiated the necessity for patient/provider mutual respect, in order to establish quality healthcare. They provided the opportunity for patients to voice their opinions on the type of care desired for optimal medical benefits. The experiences of patients concerning healthcare is an important tool in creating a complete healthcare system. Though opinions were invited, rural African-American women were not questioned about their experiences with reproductive health care.

Educational levels, economics, insurance type, physician availability and other disparities were briefly explored to give a foundation to the validity of this type of research. However, the voices of rural African-American women will provide an insider view of experiences dealing with rural reproductive health care systems. The previously mentioned difficulties, which only included a few of the noted obstacles, are often investigated from the vantage point of the provider.

Additionally, the politics associated with reproduction must be examined. While historical and psychological aspects of reproduction have been explored, the influence of politics on reproduction is of equal concern. African-American women were not in control of their reproduction for much of the history here in America. When women (white) began to demand equality, a major vehicle of empowerment for this population of

\[35\] Janice Blanchard, and Nicole Lurie, “R-E-S-P-E-C-T: Patient reports of disrespect in the healthcare setting and its impact on care”. The Commonwealth Fund.
women, African-American women were not always welcomed to express their unique experiences or opinions. In *Pregnancy and Power, A Short History Of Reproductive Politics In America*, Rickie Solinger describes how American politics of reproduction was influenced by the presence of women of color.\(^3\) The ambition of African-American women regardless of location to control their birth rates is documented along with the desire for others to manipulate this basic biological process Rickie Solinger states:

Reproductive politics has been and remains one of the most fiercely contested and most complicated subjects about power in American society. I understand the term “reproductive politics” to refer most basically to the question, *Who has power over matters of pregnancy and its consequences?*\(^3\)

Power is certainly afforded those of privilege and status. African-American women have been ill afforded either class protection or the basic freedoms ascribed to the more affluent in American society. Motherhood continues to be described as an advantaged position. While Solinger focuses much of her argument on the position of power, *Undivided Rights* continues the discussion with a sharper focal point on women of color and their ideologies around reproductive rights and freedoms.\(^3\) When Fannie Lou Hamer declared that she was "sick and tired of being sick and tired," a nation of black women answered the call to action as described inside the argument established within this text. *Undivided Rights* presents the vehicle by which women of color defined for themselves the meaning of reproductive politics and freedoms, as an addition to the right to have an abortion or prevent sterilization. The women who shared their interpretations of self-determination also choose to include those cultural idiosyncrasies that are too

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\(^3\) Solinger, 3.

often overlooked. Environmental racism, poverty, inadequate education, having access to healthy food and support systems, are as much an integral component of their argument as access to methods of birth control.

Birth control and the protection of Roe v. Wade have become the defining victory for the women's movement, however in From Abortion to Reproductive Freedom; a much broader interpretation is accomplished through the analysis of women of color. Kathryn Kolbert comments that:

Reproductive freedom means the ability to choose whether, when, how, and with whom one will have children. Choice means not only having a legal option, but also the economic means and social conditions that make it possible to effectuate one's choice. Reproductive freedom is necessary if all persons are to lead lives of self-determination, opportunity, and human dignity. Because women have historically been defined by and valued almost entirely for their reproductive capacities, and all persons, especially women, have been expected to express their sexuality in ways that satisfy society's norms for childbearing and childrearing, the fight for reproductive choice is essential if women are to become full and equal partners with men in this society, and is a crucial part of a larger struggle for liberty and equality.39

Women of Color have been advocating for the inclusion of culturally relevant components within the fight for reproductive choice and access. Reproductive choice must be expanded to include more than just the most visual components of autonomy. The debate continues with the author positing:

Developing broader-based coalitions that reflect the diversity of women and wide spectrum of reproductive experiences will enable us to expand both our ranks and our success, and to nurture choice as a basic social value.40


40 Kolbert, 299.
The development of a truly liberal agenda within reproductive choice, which includes the many differences experienced by women, will enhance the scope of freedom for all women. Thus rendering the need for voice and listening in order to adequately provide services to communities under investigation.

**Personal Experience**

The importance of personal experience is the common theme among the previous texts presented. The experiences of rural African-American women concerning reproductive healthcare take on new and meaningful examples of resistance and culture. These personal experiences are a common topic due to perceived voicelessness of subjugated masses. By allowing a space for voice and culture a more comprehensive picture can be presented for women navigating reproductive healthcare services in rural locations. As mentioned earlier, Hudson’s personal accounts forced the researcher to value the importance of personal experiences in the margins of location and culture.

Clowers investigated the perceptions of young women regarding the type of physician they would choose. Experience as it relates to health care is very important and beneficial to both the patient and providers. Their ideal physician is understanding and non-judgmental, and willing to listen. These young ladies clearly defined the ideal provider for their populace.

Another important quality for this population was communication. The young ladies made another crucial finding. Vocalization is a central contributor to adequate care.

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If a patient anticipates a provider's inability to effectively communicate with them in a respectful manner, the service maybe wasted due to a lack of perceived mutual understanding. Clowers made it a point to inform the reader that voice development is paramount if empowerment and efficient medical care are the objectives. Medical Science is beginning to welcome this open style of communication between patients and physicians in Narrative Based Medicine (NBM). This form of medical care is more accommodating of patient input than Evidence Based Medicine which focuses exclusively on results. NBM is paving the way for a shift in medical care and practice by including the voices of patients as co-maintainers of their health. Empowered and well informed, instead of hapless subjects of the medical community. Voice creation is vital to effective communication.

A diverse collection of researchers agree this concept is not lost. Patricia Hill-Collins, a renowned black feminist, is adamant in generating conversation regarding black (African-American) women's voices. She contends that the African-American community remains incomplete until African-American women have found the courage and space to voice their unique concerns. Collins asserts in *Black Feminist Thought*:

Why this theme of self-definition should preoccupy African-American women is not surprising. Black Women's lives are a series of negotiations that aim to reconcile the contradictions separating our own internally defined images of self as African-American women with our objectification as the Other.

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Along the lines of Collins, bell hooks also a renowned black feminist, maintains that African-American women must be provided with adequate opportunity to express their distinctive experiences. She asserts this belief in *Ain't I A Woman*:

> The myth of the black matriarchy helped to further perpetuate the image of black women as masculinized, domineering, amazonic creatures. The black female was depicted by whites as an Amazon because they saw her ability to endure hardships no "lady" was supposedly capable of enduring as a sign that she possessed an animalistic sub-human strength.  

When rural African-American women are given access to provide their individual experiences with reproductive healthcare, changes should be inevitable. As Collins and hooks assert, once African-American women's experiences are acknowledged, many things will adapt to the "lived experience" and wisdom within the Africana community; instead of yielding to presupposed impositions of characterizations. A truly authentic representation of African-American womanhood will emerge especially in relation to reproductive healthcare.

This research is centered on rural African-American women and their personal experiences with local reproductive services. Researchers advocate for feminist methods to investigate and present how and why women study women's daily experiences.  

Too few studies are conducted from the position of the community under investigation; this study plans to create a space for the voices of the voiceless.

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There is a wealth of historical, political, and psychological research available that address some of the germane issues ubiquitous within the healthcare and African-Americans communities, however, few address the specific concerns presented by the investigated community. Vernellia Randall, Todd L. Savitt, Harriett Washington and Dorothy Gray White address many of the historical occurrences that created the disparities that currently are under investigation. Dorothy Roberts, Rickie Solinger, Jennifer Nelson and Johanna Schoen shed light on the political process assigned to African-American women and their reproductive capacity. Psychological implications are researched by Linda James Myers, Gail E. Wyatt, Brenda Wade and Brenda Lane Richardson by analyzing how the horrific actions customary during and after slavery impacted the psychological well-being of African-American women. While researchers have examined several social determinants in an attempt to better understand the residual influence of racism on daily purpose and maternity, a more in-depth explanation can be ascertained by questioning rural African-American women. Although some of the arguments may appear divergent from the main topic, they are nevertheless significant in this study.
Chapter III

Context of the Problem

In talking about the context of the problem, we begin with a history of Leake County, Mississippi. An inquiry into the unique cultural and medical context to be explored will highlight this area of research. A more discerning probe into Leake County will undoubtedly provide a more complete portrait concerning the culture in this rural Mississippi area. By examining the history of Leake County, a comprehensive picture will be presented on the treatment of African-American women and their families on the topic of healthcare.

Class conscious reproductive healthcare as a consequence of malicious neglect, has warranted an investigation. People with money are provided the best medical care. Leake County is not unique, in those regards. Residents, who have access to capital, enjoy the benefits of preferential treatment. Those persons who live on the fringes are neglected the basic consideration of healthcare. Unfortunately, this belief system contaminates reproductive healthcare systems as well. Women, who have access to resources, are given special considerations. The preeminent hospitals and women’s centers are frequented by Euro-American women. A small number of African-American women are able to access these benefits. For the few women who are able to do so, some of them reported unpleasantness and prejudicial treatment, even at the most prominent locations.
All this negativity is continuously perpetuated, while the African-American mother to be navigates cultural landmines. Invitation into a particular environment does not indicate acceptance. These environmental stressors are plenteous prior to pregnancy. Certainly, the impact has proven quite powerful and insidious. Manufactured superiority is truly nefarious in nature. Its ilk has poisoned generations of well-intentioned people. African-American women survive this corrupt environment daily. Imagine how this situation complicates the delicate budding life in her womb. The stratified power of proclaimed cultural normalcy penetrates the safety of expectant motherhood. Imaginary separation and protection diminishes. African-American maternity is a complex and rewarding cycle of life. Studies have shown that the perception of racialized care induced stress which encouraged the development of other complications.\(^1\) Illnesses such as preeclampsia, diabetes, heart disease and pre-term delivery are exacerbated by hostile environments. These types of environments are navigated by African-Americans daily.

Essentially, this study examined personal stories. Every woman was afforded the opportunity to share her narrative of care. This proved inspirational, as they educated all willing parties. Today, it is important to be vocal about common life issues. The menacing nature of race must be investigated as an inhibitor to qualified reproductive healthcare. Location may also prove problematic. Rural environments are particularly susceptible to medical technology and insufficient staff. The historical ramifications of differential treatment continue on a destructive path. Today, that course is linked by intergenerational wealth building and intergenerational poverty. Leake County has a

unique history all its own to showcase. From the original inhabitants, new settlers, and enslaved Africans, the story of this rural community has yet to be revealed.

**Historical Context**

*Brief History of Leake County, Mississippi*

Leake County is the only perfectly square county located directly in the center of Mississippi. It was founded on December 23, 1833. The researcher found a discrepancy in the dates as some documents record the founding as December 25, 1833. Regardless of the exact date, Leake County has been one of the more rural areas of Mississippi since statehood was granted in 1817. The county consists of exactly 24 square miles of land.

The county was named in honor of Walter Leake. Mr. Leake was the governor of Mississippi from 1822 to 1825. Mr. Leake was not the only notable politician with ties to Leake County as Ross R. Barnett, who also governed the Great State of Mississippi from 1960 to 1964, was a native of the county as well.⁴

The county seat is located in Carthage, Mississippi. The small town was established as a gift from the Harris Family on July 31, 1834. The county seat is approximately 40 acres. Though the name appears to have North African ties, it was actually named in honor of the first settlers who migrated from an area which shared the same name in Smith County, Tennessee. The state allowed Carthage to become a town on May 12, 1837. The small town has managed to attract industry in the form of manufacturing. Carthage, to this day, has remained diminutive with an interesting mix of

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people from various backgrounds. While some persons will see the benefits of progress, other citizens interpret change of any sort as an affront to southern traditions.

*Brief History of Race Relations*

The Choctaw Nation

Leake County, as mentioned previously, is a rural area in central Mississippi. The past and present are linked to the gruesome stratification prevalent throughout American history. The residual impact of such treatment influences cultural conditioning in this area. Mississippi’s sordid history did not begin with the mistreatment of enslaved Africans. Instead, many of the grievances can be found with the treaties provided to the native population of Choctaws. This Nation was present when Europeans began to populate the “New World.” Differential treatment was a primary element in the settler’s ideology. It is important to visit some of these interactions in order to understand local patterns of cultural conditioning that continue to permeate this small southern town. Agreements were fostered by the two nations in hopes of ensuring partnership and brotherhood. Initially only small parcels of land were given to the new settlers. This pattern of course changed. Several treaties ensued replacing the native Choctaws as land owners, with white land developers and farmers:

People ask how the United States Government came to own all the Choctaw land in Mississippi, Louisiana, Alabama and Arkansas. It might be best to enumerate the various treaties and give the names of the approximately 146 Indians who signed away forty-four million acres of Choctaw land in Mississippi alone.

1. The first treaty between the Choctaws and the United States Government was a general treaty with all the tribes east of the Mississippi River and south of

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3 Spence, 132.
the Ohio River. It reaffirmed the boundaries described in a previous treaty with his Britannic Majesty, King George III. It was held on January 3, 1786, at Hopewell, South Carolina on the Keowe River. It set aside three tracts of land, six miles square, for trading post, to be used by the United States Government. These were usually run by half-breed Indians. It was signed by agents for the Choctaws.4

As the treaty states in the previous passage, The Choctaw Nation provided land for the development of what is currently the Mississippi along with a few neighboring states.

Though the initial treaty was for a small area of land, many more acquisitions allowed for the creation of several present day southern states as a result of treaty agreements.

However, while it may appear that the Choctaw Nation was naïve, a leader of this Nation spoke eloquently about his encounter with Europeans, Colonel Samuel Cobb states:

Brother, we have heard your talk as from the lips of the father, the great white chief at Washington, and now my people have called on me to speak to you. The Red Man has no books, and when he wishes to make known his views like his father's before him, he speaks it from his mouth. He is afraid of writing. When he speaks, he knows what he says; the Great Spirit hears him. Writing is the invention of the pale faces; it gives birth to error and feuds. The Great Spirit talks—We hear him in the thunder; in the rushing winds and the mighty waters—but he never speaks. When you were young, we were strong. We fought by your side, but our arms are now broken. You have grown large. My people have become small.5

The differential treatment of the native inhabitants of Leake County speaks volumes about the type of people who desired local governmental (white) control over all facets of wealth in this region. Though the native Choctaw possessed legal contracts, those agreements were often violated. Distrust among the nations grew. When the Choctaws became aware of what was happening, it was too late. They were already in the process

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4 Spence, 4.
5 Spence, 5.
of being relocated. The previous speech solidifies the notion that words can be manipulated, especially when written in a foreign language.

When cultural conditioning is present, actions are ordered and expected to be carried out for a particular goal. Settlers desired land for wealth creation. Native Americans perceived land to be sacred, living and wise. Wealth development was not a priority for Native Americans; in contrast, that was the founding philosophy of the settlers. Native American cultural conditioning was foreign to the new settlers and the settlers’ were outlandish to Native Americans. Differences ranged from the native inhabitants’ reliance on nature, ancestral worship, the sanctity of land, connection to all living beings and honoring their right to exist. There were many differences between the two cultures. These differences cultivated a strained relationship, Colonel Samuel Cobb states:

We do not complain. The Choctaws suffers, but he never weeps. You have the strong arm now and we cannot resist. But the pale faces worship the Great Spirit. So does the Red Man. The Great Spirit loves truth. When you took our country, you promised in the book. Twelve times have the trees dropped their leaves, and yet we have received no land. Our houses have been taken from us. The white man’s plow turns up the bones of our fathers. We dare not kindle our fires; and yet you said we might remain and you would give us land. Is this truth? Native Americans were distressed by the actions of the new settlers. Land they once inhabited was now being infested by foreign entities. Honor, respect and equality were not considered for the native population. Laws, books and moral judgment became the managing system, even for a culture whose priority was not wealth creation. Native Americans continue to reside in Leake County, in an area called the reservation.

6 Spence, 6.
Slave Ownership

As stated earlier, Mississippi’s economy was linked to slavery. Leake County also participated in the institution of slavery. It is important to re-examine these events as they are vital to understanding the socio-cultural lineage of prejudicial policies. African-Americans, who live in this area, continue to be impacted by these unreasonable regulations borne of this era. Even if only a relative few Africans were in bondage, oppression was a foundational underpinning of local politics; a cultural policy which encouraged a continuation of differential treatment for African-Americans in Leake County, Mississippi. According to Mac and Louise Spence:

Leake County was not one of the large slave-owning counties; and not being one of the large cotton-producing areas, Leake’s slave ownership was held to quite moderate limits . . . among the slave owners were some of the preachers of the county, indicating that they had no opposition to the system of slavery. . . . The total number of slaves in the county in 1850 was 1,549. . . The total number of slaves in the county in 1860 had risen to 3,056 a number almost twice as great as that reported in 1850.7

Past cultural politics encouraged the depersonalization of enslaved Africans. Marginalized and maligned, African-Americans become disengaged and angry. Regardless of the era, African-Americans in Mississippi have dealt with many devastating situations. The continuation of the past belief systems has an impact on the conditioning of the present. Though the number of enslaved Africans was kept at a minimum, they were the backbone of the local economy, Spence comments:

Leake County had escaped the devastating raids of the war, but many of its homes had fallen to wreck and ruin. Most of its wealth had been in slaves or land. The more wealthy men, however, held between fifty to seventy slaves. After the war, most negroes (sic) left their old masters and those who remained refused to work.

7 Spence, 145.
The (sic) were waiting for the "forty acres and a mule" from the Federal Government.8

According the passage, once the war ended, the newly freed African-Americans refused to resume work on plantations, due to the promise of economic freedom. The utilization of the American government to assist the newest Americans proved devastating to the masses waiting patiently for change. Rural culture continued to perpetuate the perverted, and deeply entrenched, cultural stratification. This belief system survived to influence subsequent era’s in American history.

Uppity Negroes

Unfortunately, the history of Leake County proved violent around race relations and elections. Intimidation was a tactic utilized by those in power to control the African-American vote. Several prominent African-American preachers were threatened and beaten (given a red shirt) by local white men. The incident according to Spence:

Ned Rushing, a colored Baptist Preacher, who had made himself obnoxious to the the white people by taking too prominent a part in the elections. He would stand by the ballot box and show his “brothers in black,” how to vote. The white people found that he was voting the Negroes (sic) on the Republican side and they decided to wait on him. They were not masked, but they told him that if he knew any of them any time after that they would kill him. They proceeded to give him a “red shirt,” by the use of long hickories actively applied. The negroes (sic) at that time had a superstition that the judgment day was near because of the action of a certain star. While the white men were whipping Ned asked if judgment day had already come, for he declared that he seen many stars.9

Though the recollections of such heinous actions are disheartening; they must be

examined through the cultural lens of African-American residents. Fear, a successful

negotiator, was used frequently to maintain order in Leake County. African-Americans

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8 Spence, 158.
9 Spence, 160.
were afraid to vote. The community was strongly persuaded not to participate in any elections. Consequently, the violent behavior of some white citizens restrained African American’s opportunity to positively change their circumstances. These stories are copious, many African-American narratives center on violence at the hands of white southerners. Moreover, another assault transpired with a far graver outcome according to Spence:

Fears of a negro (sic) riot, led by a negro (sic) Noah Dismuke, caused the people to organize for protection. Noah was a bigoted freedman, and at times made himself very obnoxious to white people. It was reported that the white people were preparing to “wait upon him.” He got his gun and said he wished they would come, he was afraid of no white man. He waited sometime for the coming of the whites, but as they did not appear, he returned to his home. As he was going through the door, it is said that his gun in some way fired and he fell dead. Some think it was not his gun that emptied itself into his head but a shot from some member of the klan. Several negroes (sic) were killed by outsiders and the blame was unjustly put upon the Ku Klux.10

African Americans in Leake County, Mississippi are accustomed to differential treatment. Slavery, Jim Crow and current states of problematic wealth distribution continue to penetrate the fibers of this rural southern community. Healthcare is one of many areas in need of investigation. The past and its less than ideal standards of community development informed this disengaged populace of rural African-American women. However, in order to change and correct historical wrongs, examinations of those culturally sanctioned policies are paramount.

_History of Healthcare services in Leake County_

According to hospital administrator, Robert Faulkner, Leake County has one hospital which was founded in 1949 and is located in Carthage. Leake County Memorial

10 Spence, 161.
Hospital was created to provide general medical services to the rural citizens of Leake County Mississippi. The services, they provide are emergency care, inpatient/outpatient, and they are responsible for the operation of a rural clinic established for Leake County residents. The hospital provides a 44 bed nursing home.\(^1\)

In spite of all these accomplishments, Leake County continues to be deficient in providing sufficient reproductive healthcare services. One major reason as expressed by Winson Hudson in *Mississippi Harmony Memoirs of a Freedom Fighter*, many of the widespread obstacles prevalent in this area are caused by a rural location and the paltry economics located in this region.\(^2\)

Winson states the following:

> Those radicals out West wanted to organize a big march on the Nixon Administration. *That's when I raised sand, and told them that people were dying where I come from, and we had lost faith in this society.* (Researcher's emphasis)
> When I made national headlines again and got home, couldn't get nothing in the paper here that I wanted to say. The big to-do was "stop this woman from going north, we must ignore this woman," and some even threatened to sue me to stop me from going to these meetings. See, I had testified also at Meharry Medical School in Nashville, Tennessee, about the lack of health care for black people in Mississippi, and I had gone other places across the state talking about this terrible situation, and they just wanted to stop me from spreading the word about what all we needed for black and poor people.\(^3\)

Rural African-American women are not provided enough freedom to share their reproductive health experiences. As Winson Hudson so eloquently stated "*people are dying where I come from, and we had lost faith in this society,*"(Researcher's emphasis)

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\(^1\) Robert Faulkner, Leake County Hospital Administrator, Personal Communication, Spring 2005.


\(^3\) Winson, 108.
sums up what has been the experience of many people searching for adequate care. That people not familiar with rural culture assumed marching would eradicate the multilayered conundrum of rural healthcare, makes clear the importance of more people living these experiences becoming vocal. This lack of inclusion could continue to prove fatal as it relates to maternity care systems in rural communities. Again, Winson Hudson shares a story of personal tragedy in relation to rural maternity care:

My mother, Emma Laura Kirkland Gates, died at the age of forty-four here in Leake County when I was still only eight years old. She died from a lack of medical attention while giving birth. This was common back then. People had nothing like birth controls. It was just no other choice but to have children. Her death could have been prevented if the doctor had put her on a diet instead of letting her eat fattening food. She had been in labor so long at the time she passed. She was at home and had complications and it was just no way to get that baby from her but to let her die. There wasn't no hospitals for blacks in those days and no funeral homes. The baby lived to be fourteen. My grandmother Ange was the midwife, but the baby was so large that she couldn't handle my mother's delivery. They had to call in a white doctor and wasn't nice (researcher's emphasis).  

Women were forced to delivery large numbers of children as cultural residue associated with the enslavement period. Mrs. Hudson's mother succumbed from several complex problems that continue to permeate black American culture. The medical community's perceived lack of compassion and cultural normalcy around health and the need for better care (ex. Diet, exercise, and communal support around fitness prior to and during pregnancy). Unfortunately, rural African-American women are subjected to others perceptions without compassionate understanding around issues of location, gender responsibilities, and culturally significant social networks (ex. fish fries, barbeques, and other activities replete with poor food preparation and choices, but central to socializing activities). This lack of specific cultural knowledge ostracizes the medical and African-

14 Winson, 24-25.
American community from each other, and consequently proper care. More native populations most become active in providing outside communities with proper cultural information that will assist in providing adequate services.

Most perceptions of healthcare services in this area come from an outside external source and not an internal personal perspective, which was discussed earlier in this research. This outside (provider) observation may make it appear that rural African-American women are not supportive with their reproductive healthcare needs or solutions. The reasons for such an appearance are multifaceted.

**Cultural Context**

Many researchers are concerned about the number of physicians or the type of environments (hospitals, clinics, women’s clinics) available to rural women. These researchers are disturbed by the number and types of structural barriers to services. Unfortunately, they do not focus as strongly on the cultural relevance of medical care. The individual customs and expressions intricate to every culture are sometimes overlooked. A more humane approach must be implemented. Annette Dula, a medical ethicist, is extremely creative in crafting a story that summarizes the plight of many in the African-American community surviving valiantly with devastating health dilemmas. Annette Dula’s heart-wrenching portrayal of an elderly African-American woman operating/advocating within the dominant (medical) community to provide care as she died from cancer. Communication style and type were examined as well as the instrumental role of the African-American community in maintenance of health. Diet, exercise, levels of responsibility and communal knowledge of health were also analyzed.
through the lens of Mildred’s struggle to maintain life while addressing her intersectional oppression (race, class, gender).15

Analogous to the story conveyed by Dula, this researcher became interested in African-American women and reproductive healthcare in a drive to the Leake County Health Department. The researcher’s grandmother offered a story of indignity in relation to rural reproductive healthcare services. She spoke defiantly about being forced to walk up two flights of stairs (around the back entrance of the state supported county hospital) while in labor to give birth to her son. Further stating that he was the first Negro [sic] born in that hospital in 1951.16 Remarkably, those services have since been eliminated in rural Leake County, Mississippi. Now women must travel at least one hour to Jackson (state capital of Mississippi) or Madison County to deliver their babies.

The outside/dominant community (white) was even less welcoming of black motherhood, than the medical community. So entrenched was this southern culture that violence often found a permanence replicated in daily living. The researcher’s grandmother remembered a disquieting event, which occurred when she was much younger. A usually pleasant trip to Carthage (town) turned into a terribly nightmarish venture. As she and her older pregnant sister walked around the town square, an angry white man began screaming debasing racial slurs, “what you niggers doin’ round here,” He shouted as he assaulted her by slapping her on the shoulders and beating her in the back. This battering, both physical and verbal, continued until they managed to escape,

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the year was 1946. African-American soldiers were bravely serving this country risking
their lives for an ideal that America herself had not matured to understand, even as
pregnant African-American women were openly attacked in broad daylight. The
assaulted young woman’s husband was, at that time, enlisted with the Navy. This
malicious attack centered on the politics of social position and (un)common freedom.
Carthage, Mississippi, where this atrocious assault transpired, is a southern town
permeated by old traditions. Although some express joy in the maintenance of traditional
southern life, several of these customs would be best served if left in the annals of
history.

If the reader presumes, well, that happened a long time ago, those beliefs and
cultural approaches were common back in the days of widespread legal segregation,
unbridled in the Jim Crow South, will find that, in fact, it is still a contemporary problem.
Another relative provided a story of prenatal care just as heartbreaking, painful and
perhaps more devastating than the previous accounts. While waiting for the doctor to
examine her, a nurse came into the room to take her blood pressure and perform other
routine medical responsibilities. An additional nurse joined the exam process after many
of the tasks had been completed. The first nurse asked how many children were already
born to the woman. She replied that the child she was carrying would be her fifth. To that
the second nurse insolently added “and you’re pregnant again?” The lady
communicating the narrative did so with much anguish and frustration. Not only did she
have to endure the humiliating examination performed by doctors who many women only

17 Ruby Pearson, Personal Communication, spring 2005.
meet for monthly check-ups, she also had to endure disrespectful insinuations from the staff. The experience conveyed in this paragraph took place in 1986.

Over a period of several decades, the general acceptance and availability of services have varied remarkably, yet the general atmosphere of care has changed little. African-American women are allowed to frequent the same institutions for care as Euro-American women, but the type of service they receive is irrationally dissimilar. The cultural context is important to dissect as it reveals the value placed upon the communal activity of childbirth. As demonstrated in this portion of research, the cultural milieu is swayed in an unfavorable direction for African-American motherhood and pregnancy. The stereotypes of “fertile myrtles” and “welfare queens” continue to wreak havoc on the mindset of not only the service providers, but African-American women as well. The relative who was asked to justify her pregnancy recalls the story sympathetic to the rationale employed by the white middle-class nurse. A white nurse who felt privileged to determine an appropriate number of children practical for her, a rural African-American woman receiving welfare benefits. Treatment or care must be more expansive. Medical care has far reaching implications for well-being. The circumstances that have hindered adequate care for some in the past must be acknowledged to provide a better system of services in the future. One method was to allow the women accessing services to tell their personal accounts of care (PAOC). These personal stories become a model for ways to improve healthcare by listening to marginalized populations.
Medical Context

It should be noted that for this body of research, perceptions were defined as the stories related to the researcher by rural African-American women. These narratives created a disturbing picture of rural life in this environment. In addition, these personal accounts provided sacred space for voice and recognition; from a population often regarded as invisible. Coupled with the biased perceptions of rural African-American women, location prejudice also warrants an explanation. Rural cultures are sometimes regarded as outdated, old-fashioned and backwoods. This unfair labeling cultivates a cultural lens which favors one environment over another. People in urban locales are often portrayed as hip, cool and tolerant. While people in rural areas are represented as slow, dumb-witted and intolerant. Location prejudice impacts medical services and obstructs proper care.

For these and many more reasons, healthcare in America has become an increasing concern for many, in particular, rural African-American women. The lack of care assigned to citizens is creating an atmosphere of despair. Though approximately 21 percent of Americans reside in rural communities\(^\text{18}\) these communities receive only 10 percent of graduating medical doctors to provide care to this population\(^\text{19}\). These numbers take into consideration the elderly, children, and minorities. Studies show that women are far less likely to request medical care even if plagued with serious health problems\(^\text{20}\). It

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\(^{18}\) U. S. Census, 2000

\(^{19}\) National Rural Health Organization

becomes problematic that more research has not been conducted addressing the reasons for such discrepancies.

Healthcare in America is in greater demand than ever before in history. America currently ranks 37th in providing healthcare plans to its citizens.\textsuperscript{21} The inequality currently reflected in the healthcare industry is cause for concern. This increase could be due in part to the type of health services (inadequate) available in rural as well as urban areas. However, the focus of this research is to take a closer look at the reproductive health care experiences of rural African-American women.

Women are often neglected in the healthcare system.\textsuperscript{22} As expressed earlier in this research they are less likely to seek medical services, even if they are seriously ill.\textsuperscript{23} This deficiency forces women to single-handedly negotiate their healthcare needs. The reasons for this, studies show, are economic. A majority of women have a yearly income under $10,000.\textsuperscript{24} The problems of acquiring adequate healthcare become evident as women age.\textsuperscript{25} African-American women are not invited or provided liberty to express their experiences with reproductive healthcare in Mississippi.

\textsuperscript{21} David Hammeistein, Mary Clement, and Steffie Woolhandler. "Healthcare for All NOW!" \textit{The Nation} Vol. 279 Issue 7 (September 13, 2004):2.


African Americans as a community are in need of adequate healthcare. African Americans experience disparities at a greater level due to historical socialization. This socialization created an environment that developed along with a system of discrimination. This point of view has been examined in this research. While, the issue of access affects all races, it becomes more devastating for African Americans. African Americans are more likely to experience poverty in comparison to Caucasian Americans. Rural African Americans suffer from complications born of health disparities and location prejudice. Many African Americans are less trusting of medical services, than Caucasian Americans.

Healthcare issues are still exceptionally prevalent within the American landscape. Rural areas lack the resources to establish modern clinics and hospitals. Many residents of these areas are forced to drive long distances just to access healthcare. This becomes more problematic for rural African-American women. Women in general are more likely to experience poverty, lower education levels and depend more heavily upon government assistance, which could impact care.


Women are often not properly informed of services and are less likely to adhere to physician recommendations.\(^{21}\) This problem may be rectified if healthcare providers allowed rural African-American women an opportunity to provide answers for some of the questions surrounding the quality of healthcare in rural environments. African-American women could prove beneficial to the healthcare system if given an opportunity to voice concerns focused on creating a more "user-friendly," healthcare industry.

The reasons for investigating rural African-American women in regard to reproductive healthcare are complex. The most important is to allow for the voices of rural African-American women to be heard regarding their experiences with reproductive health care services provided to their community. There are several factors that may influence healthcare providers in general and African-American women in particular into being passive about health services. This research will attempt to uncover the reasons by asking the women receiving care to provide insight into their experiences. African-American Bioethicists are another voice of reason in the discourse surrounding personal experience as educator. In *African-American Bioethics, Culture, Race, and Identity*, different researchers maintain the importance of understanding the culture of people seeking care as a means of changing the quality and availability of healthcare.\(^{32}\)

Total community health would be a benefit of creating an opportunity for this populations experience negotiating rural healthcare systems. However, the focus of this


\(^{31}\) Alyson Reed, "Women's Healthcare Disparities and Discrimination" *Civil Rights Journal* Vol. 4 Issue 1 (Gale Group, 2002) 42.

research is to address rural African-American women about received reproductive healthcare. The most important aspect of this research is to allow the voice of these women to become the guiding force in creating a more complete system of healthcare. African-American women are thought invisible, and as such appear irrelevant. However, by allowing their opinions to influence healthcare providers a more humanistic approach can be made in supplying an efficient model for health services.

Similarly, reproductive healthcare in America has been under increasing scrutiny. Researchers armed with statistics espouse disparaging information regarding the present state of the American reproductive healthcare industry. According to Jennifer Block in *Pushed: the Painful Truth about Childbirth and Modern Maternity Care*, American women are the least autonomous regarding their reproductive experiences. Hospitals have completely eliminated independent care for women forcing all mothers to deliver babies under the guidance of the medical community, increasing the rate for unfavorable reproductive outcomes. Correspondingly, rural African-American women are proscribed by the intersectionality of their oppression. Race, gender, class and for this study, location all create a fascinating phenomenon around birth stories, access to care and value.

The distinctiveness of this research will be in delivering to the world the experiences of rural African-American women. Not exclusively because they have experienced disparities or economic limitations, but because they can provide insight into how personal experiences impact reproductive healthcare behaviors and attitudes. They

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will share what it means to be rural African-American women negotiating reproductive healthcare services. This research focused on knowledge from this population. The questions to be employed provided this population an opportunity to put in their words, the experiences and possible barriers of received and credible reproductive healthcare. The significance of this study was in providing space for rural African-American women to communicate their personal accounts of maneuvering reproductive healthcare services in a rural environment.
Chapter IV

Findings

The purpose of this chapter was to report the findings gathered from the twenty-two rural African-American women participants from Leake County, Mississippi. The conceptual framework employed Three Levels of Racism\(^1\) and structural and non-structural barriers.\(^2\) Women in this community have a particular expectation of care; these limited expectations are manifested in the type of care provided to them by the local government. CEC allows for the common people under investigation to provide intimate knowledge of their individual and collective experiences. The main focus of CEC is to uncover and understand important information about healthcare in rural minority communities, with unambiguous intentions of finding a plausible improved system of care.

Data Analysis

Information gathered through interviews and transcriptions were utilized to answer the following research questions:

How does race and racism influence reproductive healthcare behaviors and attitudes for rural African-American women in Leake County Mississippi?

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What are the factors that contribute to the socio-cultural challenges related to the maternity care of rural African American women in Leake County, Mississippi?

Data was reviewed rigorously by reading each section of the transcribed interviews, and subsequent lines for theme creation. Rural African-American women were central to the expansion of this research as their stories developed the following prevalent themes and thus, assisted in organizing investigation of research materials.

Study Participants

This study was centered on developing research resources to understand the event of rural birth stories. Interviews were conducted to capture the experiences of these women in “their own words.” The participants were assigned to a group after listening to the women and reading the transcriptions. Themes were assigned to each group based on categories described by the investigator. Each woman was placed into an appropriate classification based on age. The groups are as follows: Sage Women, Wise Women and Renaissance Women.

The group with the strongest voice was the Renaissance Women. This group of women provided the largest number of interviews. It should be noted that both Sage and Wise women were solicited but many declined participation. Though the heated healthcare debate prevalent in both local and national news was one possible reason for the limited number of older participants, it is still likely that some were suspicious of the interviewer’s intentions. Many of the women in these groups (Sage and Wise) received governmental assistance and were concerned that their support may end if they provided a less than favorable view of local reproductive healthcare. Normal cultural suspicion of medical inquiries coupled with the historic healthcare debate culminated into a
population of guarded women. Also, women of a certain age consider talk of pregnancy and birth to be a private matter not open for communal discussion. Again, local cultural practices influenced this study of rural African-American women, from its inception to the conclusion.

Sage Women (great grandmothers)

This collection of women represented the eldest women of the study. All of these women gave birth during the segregated system of Jim Crow. Their experiences provide valuable foundational knowledge into this rural culture’s response to African-American women and birth practices. Their voices and unique stories are the cornerstones by which the researcher was able to build the study. The SAGE women were aged 61 to 83. While each woman’s story is her own, several themes emerged as interesting facts.

In their own words

Respondent 9

Words to remember

When asked about her overall emotional state during her pregnancy, she replied

Hungry!!!!!! . . Starving . .

The interview was conducted in the home of respondent 9. Located at the kitchen table, questions were read to ease nerves and suspicions. There were few interruptions, so the session was relatively straightforward. The home was warm and filled with family photos and trinkets such as small glass figurines that people collect over the course of a lifetime.
Respondent 9 was an eighty year old widowed mother of two, who has lived in Leake County for seventy one years. Prior to the recording, she was vocal about the level of care provided to her during her pregnancies. She stated that her pregnancies were complicated due to a lack of resources. Stress was a chief problem while she was “in the family way.” Her husband was not able to work and because of that, money was scarce to non-existent. A member of the sharecropping South, this survivor spoke bravely about the circumstances that were overcome. Though education was a personal priority, she was not able to complete high school, a common theme for older women in this study. Hard work and determination along with a strong faith in God has propelled this Sage woman forward. Yet, she is scarred by the level of care available to her, but remains positive. The fact that she was so impoverished during her pregnancies is a life event that continues to haunt and distress her, even now.

Respondent 15

Words to remember

I had insurance...yes that makes a difference.

This interview was conducted in the home of this participant. Initially, the interview was taking place in the living room, but was relocated to another room for reasons of privacy. The conversation was engaging. At first, the respondent was hesitant about being documented. Finally, after reading the research material, consent was gained. The interview progressed without any further interruption.

This respondent was a sixty-nine year old married mother of five, who has resided in Leake County all of her life. She is presently unemployed and receives Medicare. A
high school graduate who reports not attending college, she, instead, devoted her time to motherhood and marital responsibilities. When asked about her care during the recorded sessions, she replied that all was well. Once the recording was over, she admitted how much she despised the examinations. Upset that the exams required the doctor to observe her when most vulnerable. Culture does impact care, in subtle and obvious ways. Many African-American women have expressed distaste for certain medical procedures. Perhaps if women were more empowered in regards to their care, the system would adjust and incorporate those concerns. A male doctor examining a woman, especially during this timeframe, was a thing of discomfort. This respondent reported being uncomfortable, even though she was insured.

Respondent 20

Words to remember

I had good treatments carrying my children.

This interview was conducted in the home of this respondent. A neatly manicured lawn surrounded a small wood frame house. The researcher was informed to set up in the living room. The entire house held memories of children and grandchildren and great grandchildren. Pictures covered the walls of every developmental stage. From childhood, to adult and so on, it was almost like a still picture show of her family.

This respondent was an eight-three year old widowed mother of nine. She reported living in Leake County, all of her life. The most interesting, participant, having experienced midwives, homebirths, and doctor facilitated home births and hospital births. Her reproductive life course was filled with many different experiences. The one she
most wanted conveyed was that she received good treatment while she was pregnant. No mention of social or cultural problems colored the story she shared.

**General Characteristics of Sage Women**

Home births were common. Women were central to birth. After receiving care, hospitals, as a place for birth, were a comparatively new development. While some women were quick to state how “good” their care had been, others were just as unwavering about expressing what it truly meant to be black, of the female gender, rural, and poor. All factors contributed to the dismal care provided to this population of women. However, perhaps the most perplexing answers were those given by the women that felt their care was adequate. Particularly when understanding the historical times and the racialized system prevalent throughout the South and possibly most notable in Mississippi, one finds it hard to believe that care was better and more accessible to women during this Sage period as opposed to the other groupings of women. The candor with which the women explained their unique acquaintance with both the medical and family structures provides cause for even more interest.

**Wise Women (grandmothers)**

This group of women is the first generation of African-American women to have legal access to all services provided by local and federal governments. The ages for this group of women were 40-60. Jim Crow, while still fresh in the minds of these women, was not as integral to their lives as it had been for the previous generations. That being the case, women in this group were still quite dissatisfied with the type of care they
received. The themes provided by this group continue to inform the angst of the previous SAGE Women.

**Respondent 2**

**Words to remember**

I would say that things would have been better if I would have had private insurance instead of Medicaid cause on Medicaid it’s like a A like you’re in a class A and then a B by us being on Medicaid sometimes I really don’t think they would want to work on you.

The location for this interview was the bedroom of a very small, but well furnished house. This space was chosen because it offered a diminishing degree of privacy. With constant phone calls and inquiries about local affairs and happenings (gossip), this respondent was well liked by her community. Initially, interview questions were asked prior to taping. This adjustment was made because the first interviewee wanted to see the questions prior taping. Once all concerns were answered, the taped interview began. The one thing that stood out the most was the extremely high volume of calls. The taping was interrupted several times.

This respondent was fifty-nine years old who has lived in Leake County for most of her life. She reports being divorced with five grown kids. She currently does not receive insurance coverage from her job at Ability Works. A high school education concluded her formal educational aspirations. The link to class is one made by many women in this study. Insurance type is the easiest indicator for these women of status. The belief that having access to private insurance as a status raiser is not unique. The differential treatment experienced by women with Medicaid is a real occurrence. As long
as insurance is granted to those with “benefits,” the level of apprehension assigned to class will only become more and more noticeable.

Respondent 5

Words to remember

Well, my main thing is family planning. You know if, when I was younger if they would have told us more about this when we was younger and I guess if you would get more education you know and how to family plan adequately . . . they wouldn’t have so many children. But by them not getting enough education on it I think that is a big problem. You know they should sit down and have a little class and do that but they really don’t do nothing like that in Carthage or Leake County.

The last of three interviews located in the formerly mentioned apartment. There were fewer interruptions during this interview. The respondent was apprehensive to have her input documented. She read the questions and was prepared to begin the recording.

There was a delay due to a family obligation halfway through the process. Once the matter was handled, the interview continued without and further distractions.

This respondent was a forty-three year old single mother of six, who has made Leake County her home for nine years. Employed with Friends of Children, she does have health insurance although she states it is not the best. A high school graduate who attended college for a while, she also enjoys spending time with her grandchildren as often as possible. Family planning was a serious concern for this woman. Her alarm was intuitive because she wanted to see young African-American women avoid making the same mistakes that disrupted her path to accomplishment. Aware of the many pitfalls and landmines, she adamantly believed that Leake County should implement an educational program focused on family planning and reproductive health.
Respondent 10

Words to remember

I had a lot of questions for them. Especially with my first pregnancy, I was very very questionable then cause, I wanted to know everything and about everything.

The interview was conducted at a local beauty salon in Tuscola, Mississippi. This small town is about fifteen minutes from Carthage, Mississippi. The location of the beauty salon assists in the enjoyed popularity. Many women frequent this particular shop. The high traffic area makes it an idyllic site for this research. Even though only a few women agreed to participate, the location remains ideal.

This respondent was forty-four year old married mother of two, who has made Leake County her home for most of her life. Initially apprehensive, once researcher read the interview materials, nerves were eased and she willingly participated in this study. Employed by Tyson Food, Inc., health insurance is available to her. A high school graduate with an associate’s degree, she reports dropping out of college due to her first pregnancy. Questioning health care providers is a positive step toward empowerment. Several women in this study were compelled to mention the importance of engaging the medical community around personal care. This respondent was very informed and because of her interest in her individual care, reports being pleased with the local health clinic.

Respondent 11

Words to remember
One thing I think they need to do to improve is get their time schedules a little bit better and how they arrange their, their people to come in.

The location of this interview was the same the previous contributor. Both ladies were accessible and participated at the beauty salon. In addition, respondent 11 is also the proprietor of the hair salon.

This respondent was a forty-four year old married mother of four, who has resided in Leake County all of her life. She is currently the owner of a hair salon, but also works part-time for another agency. Health insurance is unavailable. She is a high school graduate, and reports having some college credits. Lively and willing to help the community, her salon is always a place that people gather and share information. Again, time management rates high for discontented customers. One small improvement with schedules could result in a better local clinic and increase the number of satisfied customers.

Respondent 14

Words to remember

. . . the doctors I mean umm actually I think, I know Carthage was better than Jackson. Carthage was better than Jackson by delivering my baby it was better than Jackson cause Jackson have so many and they give more personal care in Carthage than they do in Jackson.

The interview was conducted in the same location as the previous respondent. The party was subsiding, and everyone had eaten. A master bedroom was the site of this interview. Everyone else is curious about the tape recorder. After nerves were soothed, the session was carried out as predetermined.
This respondent was a fifty-eight year old married mother of four, who has resided in Leake County all of her life. A Leake County correctional facility is her employer, and health insurance is available. She completed high school and did not attend college. Locally provided care can sometimes improve the level of participation. Satisfaction was higher for women when the local hospital was able to deliver babies. Now that service has been discontinued, women must travel at least an hour to the nearest women's center, clinic or hospital to deliver their babies. The community is forced to relocate, and thus hampers the communal celebration of new life. The pressure to secure transportation is problematic for some families. Not every family can afford a car. This only increases the distress of rural women as they try to access reproductive health care outside of their community.

**Respondent 17**

**Words to remember**

Yeah it would help a lot of people and more people would get a mammogram done if the health department had that in there. Now we can get it did like in Philadelphia or somewhere like that . . .

The interview was conducted at a family member's house at the kitchen table. The participant was anxious about being recorded. So, the researcher worked to reassure her about the purpose of the research project. Once all questions were answered, the interview proceeded as planned.

This respondent was a forty-eight year old married mother of five girls, who has resided in Leake County all of her life. Presently, she is unemployed and has no health insurance. She dropped out of high school and has not pursued her Graduate Equivalency
Degree. A more comprehensive system of care informed this participant’s comment.

Accessibility is an important theme to mention. Mammograms are not performed at any Leake County clinic. Women must travel at least an hour, again, to access the vital preventive measure. Reproductive healthcare does include preventive treatments. Though this study focused more on maternal care and pregnancy, the local clinic must work to make health screening more accessible.

Respondent 19

Words to remember

Because they had some good, well at the time they had some good nurses and stuff over there at the time, but the way they talk now they ain’t got nothing over there. . . they don’t do what they supposed to do, so a lot of people leave there and go to Jackson and stuff when they come up pregnant.

This interview was conducted in the respondent’s home, a nice residence she shares with her disabled son. There was a pleasant, but rushed atmosphere. Reticent initially, this respondent quickly warmed up and began to chat and open up a bit more.

This respondent was a forty-eight year old single mother of three, who has resided in Leake County all of her life. She is currently employed with Tyson Foods, Inc., and reports having health insurance. She did not complete high school. During conversation, respondent was candid about some gynecological problems she has been dealing with for years. To access a qualified doctor, she must travel to Jackson, Mississippi, an hour away from her home. She remembers when the local health department was adequate. However, she acknowledged that many other women are displeased with the clinic and are now accessing care in other areas.
Respondent 22

Words to remember

I would go again, cause I’ve taken my grandchildren out there and they are pretty much updated. We have black and white working in there . . . when I was going in the early days; I think one lady might have been a cleaning lady.

This interview was conducted at a retail shop in Carthage, Mississippi. Due to the high volume of customers, the interview was recorded in the storage room.

This respondent was a fifty-three year old married mother of four, who has resided in Leake County all of her life. She is currently employed with a local retail shop and health insurance is available. She attended college but has not been able to complete her degree.

This respondent recalls the climate of the local clinic earlier in her life. There were no black doctors or nurses working out of the health department. The only black person employed by the facility was a female custodian. This woman was allowed to witness the performance of pap smears on black women. Now there are a few black nurses, but no black doctors.

General Characteristics of Wise Women

The intimate nature of poverty politics and the intersectionality of their oppression (race, gender, class, and location) are true testaments to the peculiar nature of the era during their reproductive period. Birth control was finally available to women during this group’s fertility phase. Women were able to control their births. This invention of course, allowed more women to become active planners of their reproductive capacities. African-American women were able to delay becoming mothers
and focus on careers and other personal goals. Birth control and legal integration both provide interesting backdrops to the stories of the women in this group.

**Renaissance Women (mothers)**

This group of women represents post-integrationist American society. These women benefited from birth control, delayed motherhood and a progressive era of women in business, medicine, education, and sciences. There is no doubt that this group of women has benefited most from reproductive technologies and other medical advancements. The overwhelming stories of dissatisfaction and racialized care are not too far removed from their great-grandmothers’ and grandmothers’ generation of economic deprivation. The recounts continued to be a matter of grave concern. Joblessness and basic economic security quickly became a theme of concern for these women. Education as a category made some improvement with care options but not in overall satisfaction. This group represents ages 20 to 39.

**Respondent 1**

**Words to remember**

Well the only thing that I would like to state is number one, don’t have a baby if you are not ready. There was a lot of things I found out on my own of course the old saying is true that every pregnancy is different, but I’m pretty sure that somebody could have told me that you get indigestion at the beginning and the end of your pregnancy. I could have been warned about that or that you swell up from your face all the way down to your ankles. I didn’t know about that or you can’t eat as much at the end of your pregnancy, these are all things I found out on my own.
This interview was conducted in the bedroom of her mother’s home. A small intimate space that encouraged a sense of calm, the room was an ideal setting for this inquiry. Initially timid, she rapidly warmed to the process once the questions were read prior to taping. Nervousness set in during the preliminary taped questions, but quickly subsided. Each section was read and explained to this respondent until she was finally comfortable enough to begin the process. As she sat casually on the bed, the process began.

This respondent was a twenty-three year old who has lived in Lena or Leake County, Mississippi her entire life. Currently, she is single with one child, a boy. Employed (enjoying insurance coverage) with Bank Plus (a local bank), she feels confident about her future and states that she plans to finish her bachelor’s degree at Jackson State University. Only fifteen hours short of graduation, she understands the need to complete this important milestone.

Respondent 3

Words to remember

They could hire more courteous staff, they could treat people better, and since it’s a free clinic (they may feel like) “well you getting this for free so just be satisfied with what you have you could (not) ask for more,” so the whole thing could be re-staffed, scheduling, it could be more up to date with the technology cause they are very behind in lotsa areas.

The setting for this interview was the local projects or Section 8 housing development. The interview was conducted in the living room of a very clean and sparsely decorated space. The women in the house were very nice and polite. More than a few people constantly came into this room, which was directly in front of the entrance.
Several women were interviewed at different times at this location. For the initial respondent, there were very few distractions. Prior to taping the interview, the questions were read and all concerns answered prior to recording the responses.

This respondent was a twenty-two year old single mother of three. She reports living in Leake County for approximately 6 years. Currently unemployed, she is eligible for Medicaid and reports being insured by this agency. A high school dropout, this respondent has recently received her Graduate Equivalency Degree and plans to continue her education. Extremely intelligent and open about her experiences with the local health clinic, most of her angst is geared toward the discourteous staff and rude treatment customary at the clinic.

Respondent 4

Words to remember

It hurted me the whole time I was pregnant I didn’t have nobody besides my doctor and *****, and my baby daddy one day he started running out on me and my mama she didn’t, she didn’t really stay at home so what made me mad was my first pregnancy she went out. I was in labor and she decided to go out and I have to make it to the emergency room on my own... I started out walking and lucky I thought about my cell phone and I could dial 911 regardless if I have any minutes or not and that’s how I could... called 911 and told them I was crawling on the ground... trying to make it to the emergency room in the back road up there by **** Store...

As mentioned earlier, this interview was conducted in the same apartment as the previous respondent. Although, there was a considerable increase in traffic for this interview, it was an entertaining experience. The types of distractions ran the gamut, from neighbors knocking on the door, to the police arriving to arrest a domestic violence
situation. The entire apartment building was awake and full of energy. This respondent is very interested in the subject matter and quickly moved the interview format to recording.

This respondent was a twenty-three year old single mother of one, a girl. Currently unemployed and insured by Medicaid, she was eager to answer any questions related to her maternity care and treatment. She reported residing in Leake County for 8 and half years. Unable to complete high school, she recently received her Graduate Equivalency Degree. This respondent admitted to surviving homelessness during her pregnancy. Disappointment drove her honesty, as she confessed to losing two children to miscarriage, even though the pregnancies developed for at least eight months. The major culprit, according to her, was the tremendous stress of living on the streets while being pregnant. One friend was her beacon of hope as she provided support, comfort and assistance.

Respondent 6

Words to remember

Okay, alright the doctors they they’re nice. I don’t think they I think the doctors come through its better they know more than the others. They don’t take precautions like they don’t take the extra restraint precautions like the hospitals do but they, they get you seen not to the, not to the best of their ability I don’t think.

The interview was conducted in the home of this respondent. Comfortably situated, the interview took place in the living room. There was a storm rumbling in the background and this, of course, made all parties a little nervous. The room was cheerfully decorated with portraits and other family paraphernalia. The storm woke one of the respondent’s young children. The session continued once the child was comforted and calm.
This respondent was a twenty-five year old married mother of two, who has resided in Leake County all of her life. She even states that she has lived in this particular house, all of her life. She currently works at the Pearl River Resort, a local casino that employs a large percentage of area residents. Health insurance is available to her through her job. A high school graduate who is currently attending a community college, she anxiously awaits and anticipates her graduation. Though time management was a concern, she shared a dislike toward the level of care available at the Leake County Health Department. She believed that the health care providers do not take care of the patients well. Mistrust encourages the perception of ineffective care. Healthcare workers must become aware of this cultural trend in order to deliver the best care. They must be engaged and helpful to every patient at all times.

Respondent 7

Words to remember

The only thing I don’t like at really about the clinic is and you might have heard this from other people, but . . . when you go for your doctor visit you have to, it take you the whole day to be seen and I don’t . . . it’s a lot of time walking around and a lot of personal stuff going on in there that you know. I think I was told one time that I may have a limited time . . . but as many going on . . . as many women that it is that’s pregnant you know you call and can’t never get in to get a doctor’s appointment because they see maybe so many people a day. If they would go ahead and see their people like they’re supposed to and get them in to be seen so you know that’s . . . my main problem. That I had and I felt uhhh uhhh a little the nurses some nurses were not as you know they didn’t treat you with dignity and respect. They just treat you like oh here come another little black girl that’s pregnant. You know kinda see ahhhh a little bit of ahhhh racial still tension still in this in this county. You know so that was one of the other things and you know I just didn’t like that. I go to other doctors and you don’t have to be there all day for them to see you and they be private doctors . . . even though I still had Medicaid.

The interview was conducted at a local retail shop where the respondent is working. This store is very popular and as a result, there are a lot of patrons roving
around looking for items on sale. When there is a break in customer demand, we begin the interview. More than once, the recording was stopped so that she could take care of the many customer requests.

This respondent was a thirty-five year old single mother of three, who has lived in Leake County for about twenty-two years. She is currently employed, with the company mentioned previously, but reports health insurance is unavailable. A high school graduate, respondent 7 has attended college, but reports leaving school due to a pregnancy. The decision to end her educational aspirations weighs heavy upon her conscience. Throughout the interview she remained fixate on returning to school and completing her education. She feels duty-bound so that her children will see that hard work is its own reward.

Respondent 8

Words to remember

...when I went in to see the doctor or whatever they explain everything to you. And they real, real nice people they so they explain everything to you. They told me to you know for instance when I was pregnant I had to watch my salt intake and they gave me a little list of things to eat and not to eat and how to prepare them or whatever and I I like them.

Another interview that was conducted on a work site, in Carthage, Mississippi respondent 8 was open to questions and very cordial. She was able to provide time to participate in this research during her lunch break. Several people continually requested assistance during the interview. We were positioned in the front of the store on shopping carts but, we were able to persevere.
This respondent was a thirty-year-old single mother of one, who has resided in Leake County for about six years. She is currently employed by the retail store mentioned in the previous paragraph. Health insurance is provided through her employer. She was working to complete her Graduate Equivalency Degree at the time of this interview. This respondent accessed a different clinic for her prenatal care. She was pleased with the clinic that provided her services. The reason she choose not to attend the Leake County Health Department, was their poor time management skills. Informative service also enhanced her satisfaction with her prenatal services.

Respondent 12

Words to remember

I was satisfied to an extent umm like I said they busy. You know it would be much better if they had other physicians or umm clinics or hospitals around that umm did prenatal umm that way you wouldn’t have a full clinic and everybody there for the same reason and it make the time much longer for you waiting...

The interview was conducted at her mother’s house, in a small room. There were a lot of people in the house and extra measures were employed to ensure privacy. Even with all the precautions, the session was interrupted several times. Children are running around the house playing and preparing to eat their dinner. The environment is pleasant, but very busy and chaotic. Despite the high energy location, the participant calmly prepared for the recorded interview.

This respondent was a thirty-four year old divorced mother of two. She has lived in Leake County all of her life, except when she and her husband resided in Jackson, Mississippi. Walnut Grove Youth Correctional Facility is her employer. Health insurance is available. Respondent 12 is a college graduate. Open and engaging, this participant was
willing to voice her opinion about the level of care provided to her community. Well informed, she forced the researcher to revisit some preconceived notions about the local health care provider dilemma. A clear, simple suggestion was made by this respondent, which could eliminate a number of highlighted concerns. Create more than one location to provide maternity care, or hire an Obstetrician/Gynecologist to care for the women in that area. One of a few participants to think along these lines, her response was welcomed and solution oriented.

**Respondent 13**

**Words to remember**

Why, cause my experience I think that if you have your insurance you go and you know they treat you better and nicer and you know they want you there. But if they see that you don’t have any insurance and you probably can’t be able to pay your bill, they kinda really just have I don’t know they don’t treat you as good.

The interview was conducted at the home of this participant. A birthday party was taking place, but the respondent welcomed the interview questions. There were other women at the celebration, but only a few qualified. The home was filled to capacity with people joining in on the festivities. A small number of women, that were not eligible for this study, questioned the purpose of the research. Once the interview began, things moved along rapidly.

This respondent is a twenty-nine year old legally separated mother of three, who has called Leake County home for all twenty nine years. She is currently employed at the local hospital and has health insurance. Presently enrolled at a community college, she looks forward to completing her associate’s degree soon. Insurance type as a universal remedy became a prominent theme for this research. Women in this study believed that
insurance type determined the quality of care. Many participants were receiving Medicaid at the time of their pregnancies. They were convinced that a different insurance would increase their level of satisfaction, and relieve their anxiety about accessing the local healthcare clinic. Insurance type for this study proved beneficial to the women, even if the benefits were perceived and not real.

Respondent 16

Words to remember

Hire more workers . . . because they had that one woman go in there and weigh us, take our blood pressure, do this and do that and it was like twenty-five more pregnant people there.

The interview was performed at the house of this participant. Permission was granted once the research materials were read. Unlike the previous contributors, this young lady was not at all apprehensive or shy about being documented. The session space was pleasant, with children preparing for bed. All together an enjoyable interview, executed without any delay.

This respondent was a thirty-three year old married mother of three, who has lived in Leake County all of her life. She is employed with a local manufacturer. Health insurance is available. A high school graduate with some college credits, this participant was charming, engaging and honest about her received reproductive healthcare. Again, time management was the major concern for this woman. Personal experiences with being “stuck” at the clinic inform this interview. The need to increase the number of workers was proposed solution. However, she still felt displeased with the local health
care clinic. Her disdain was justified by a lack of consideration common when
frequenting the local clinic.

Respondent 18

Words to remember

Equipment, staffing ahhh courtesy, they really didn’t treat you nice. Well some of
them, I will say some of them. Employees don’t really care and I feel like that if
you’re in the you know environment you should at least care about what you are
doing you know they decide the kind of mood you put your patient in cause you
look and they like and you I don’t know I don’t think I need to be in here you
know they handle needles and everything.

The interview was conducted at a family member’s home. The actual session was
relocated to a bedroom. The participant was excited to assist in research project and
asked a plethora of questions. The hope of this respondent was that something could be
implemented to improve the level of care available to women in Leake County,
Mississippi, especially high risk pregnant women.

This respondent was a twenty-four year old single mother of one, who has resided
in Leake County her entire life. Tyson Foods, Inc. is her employer and she reports
receiving health insurance. A high school graduate, the contributor reports having
attended college, but she is currently not enrolled. She postponed her college education
due to pregnancy and has not returned. Though she is very interested in continuing her
education, she believes that being a mother is of the highest priority. She believed that
patients are reflections of the healthcare providers. Attitude is an important asset when
working with the public, especially for healthcare. Once a community losses confidence,
reassurance is difficult to achieve. Black Bottle Syndrome manifests in situations where
the appearance of differential treatment is present. Minority communities are already
afraid to trust outside sources to manage their personal care. Intergeneration fears must be remedied in order to create a holistically inclusive medical system.

Respondent 21

Words to remember

They need to add more clinics they would need to move into the hospital a prenatal area and to educate every culture woman in terms of what they need to know. I understand that they have an early start program in Walnut Grove that is trying to make some impact and teach the young mothers. But they don’t teach the rest of the mothers so they have a program set aside for the new mothers. But it doesn’t cater to everybody. So its limited, if you are a part of their expectant program with a child already being a part of that then you can’t receive those services. So they’ve made a small impact in trying to help at risk young mothers but they have not helped over all in terms of making it available for any mother any mother so the county needs to improve in terms of more clinics in Leake County in terms of more education, as far as the health department, as far as the hospital prenatal teams as far as the clinics prenatal teams and bring in more qualified doctors that can actually deliver these babies without taking the risk of the mother’s life.

The interview was facilitated in the home of a family friend. The kitchen table was the place chosen to carry out the task. Food was cooking on the stove and the whole atmosphere was family oriented. The respondent was engaging and asked many questions about the research before sharing her story of sorrow associated with reproductive healthcare. The more interest was shown, the more obvious that something extremely painful had taken place in her life.

This respondent was a thirty-nine year old married mother of two, who reports living in Leake County all of her life. She is currently employed with a local business and does have health insurance. A college graduate, she has a Masters degree from Jackson State University. The connection of care to community is vital. Healthcare must become more inclusive of all communities, and work to alleviate the appearance of differential
treatment. This respondent was adamant in demanding the creation and implementation of an educational program that would teach total body care.

**General Characteristics of Renaissance Women**

Technologically savvy and comfortable with the status quo (success defined narrowly by western standards), these women were the most vocal about levels of care and areas that are in dire need of improvements. A sense of historical significance ran throughout the explanation of care. While Renaissance Women are thought to be capable of handling multiple identities i.e. mother, wife, girlfriend, “baby mama,” sister, entrepreneur, college professor etc., a space for personal development and growth outside of the confines of motherhood was absent when they were asked about support systems or methods of relaxation.

**Commonalities**

Again, each grouping provides a means of extrapolating relevant information that is based on age and perception of experience during different time frames. An example of this is the segregation group’s (Sage Women) stories. These women remember explicit details of life during that time of American history. Separate and (un)equal was more than a slogan for them, it was a way of life. While some scholars are quick to demonize this time period, the women were not as vocal about the racist nature of their lives at that time.

The Sage Women were more impressed by the amount of communal support and care during their pregnancies. The oldest woman in this group was adamant and determined to express how her treatment was reasonable. The only one to experience
both home and hospital births, she stated that she received “good treatments” when she was pregnant. That statement coupled with basic knowledge of that time period would make most people think twice about what she may have meant by “good treatment.” According to this respondent, she was treated “real, real nice by the doctors and nurses,” and that was the basis for her evaluation of services. Sage Women, or at least this particular one, was satisfied with her services because the healthcare providers treated her nicely and respectfully. Perhaps the treatment she received while pregnant was better in comparison to when she was not with child. Maybe she was able to rest more or have others take some of her work burdens and care for her household and children.

Another member of this group was just as unwavering in her opposition to having received good care. She repeatedly stated that she was inadequately cared for despite her satisfaction with her doctor’s care. Poverty, lack of employment, and family support coupled with the stress of the times (segregation, sharecropping, and underlying racial violence) worked to create a time of dismal need and distress for this woman. Given the state of her support and health, stress was a major culprit prior to and during her pregnancies. Perhaps her daily life produced an environment that encouraged the occurrence of C-Sections as she was the only woman in this group to have experienced such an invasive medical procedure. Today, the correlation between proper care and support during pregnancy and positive reproductive outcomes is widely known if not completely understood. Low birth weight babies are more likely to be the normal experiences of women who unfortunately live in stressful environments.

The respondent imparted universal understanding and interpretation about what has been acknowledged in the healthcare community. If women are not supported during
pregnancy, then both the woman under stress and her child are in danger of negative reproductive outcomes. African-American women are more likely to experience negative outcomes for reproduction, in part, due to the varying degrees of stressors in their lives and environments. Studies have been conducted that substantiate the claims, yet very few have investigated the women who live, overcome, or succumb to demands exerted by outside conditions (low employment, lack of insurance, and racialized treatment).

The youngest respondent for this group was just as submissive to her treatment as the oldest respondent. They both believed they received very kind care from healthcare providers at the clinics. However, economics was also a major contributor to her level of care. Although she reported being happy with her pregnancies, she also reported having a very strong family support system that included a husband. All of the women in the Sage group were or are married. None of the women mentioned having children outside the confines of matrimony. This was the case even if being married did not provide any substantial financial support as was reported by the second respondent.

The governing expectations of women in this group were similar, they all wanted to be mothers and have healthy children. While one of the women in the group experienced extreme intervention, the majority of women were not encouraged or forced into harsh measures of medical management. A woman's body was permitted to process gestation with a discernible degree of freedom, enviable by today's standards of care.

Cesareans were not as popular for this group of women. The single woman that found this intervention medically necessary was compelled to have this procedure because of information provided by her doctor. She was unable to dilate and her children
had to be surgically delivered. Motherhood was rewarding to this group of women. The opportunity to mother was a gift and they valued the experiences regardless of the type of environment, in which they were living, loving, and surviving as a community.

The second group of women, the Wise Women, was pregnant during the integration of American society. Their stories vary as to the amount of support they received and the reasons for the level of care they were allowed to partake in during the newly forming open social integration period. This era of American policy and politics is marked by vast improvements in birth control and legal abortion. For the first time in America, women were permitted, and encouraged to orchestrate their reproductive power ensuring a newfound sovereignty.

Freedom was a culturally defined term for African-American women, which inevitably included the gift of motherhood. African-American women were just as pivotal in the expansion of women's rights that included reproductive justice. As expressed earlier in this research, this group of women had been one of the most controlled around reproduction. The system of American capitalism had inextricably attached its assets to the fecundity of African women's wombs. A relationship built on the necessity of control and promulgation around cultural normalcy. While white women were the socially and legally accepted mothers, African women could not legally be defined as such. Sage Women were still restricted by the ungodly creation of power brandished by the American slavery system. Jim Crow was the unadulterated amalgamation of the Industrial Revolution and the previously mentioned system of American slavery. Sage Women survived the unconditional control system put in place by both federal and largely, local governments.
Wise Women were able to observe this structure collapse under the weight of new federal legislation produced to demolish the previous system of oppression. Birth control and access to reproductive justice and care were hot button issues for this group of women. A new day was dawning in America and women were at the forefront of a massive paradigm shift. The level of influence this shift has been in the reproductive lives of rural African-American women is still a mystery.

Perhaps the last group of rural African-American women could answer the before mentioned conundrum of determining how instrumental the shift in American politics regarding reproductive justice has changed the lives of women in rural communities. All of the women in this group were born after integration, thus providing the categorization of post-integration era motherhood. Yet, the treatment most of them expressed was less satisfying than the previous or earliest groups. Sage women as a group had higher levels of satisfaction (though the sampling was smaller than the other categories) with care.

The majority did not mention the racist policies that were signatures of the Jim Crow Era as major contributors of or to their pregnancy experiences. According to them, they were treated as well as could be expected or good in various situations. Renaissance Women were the least satisfied with care. They cited level of treatment, rushed staff, rude staff, unpleasant environments, feeling talked down to, and being linked to the label that all black girls do is have babies so the government can take care of them.

The Renaissance Women were not entirely unlike the Wise Women who did cite examples of feeling as though they were forgotten about while waiting for care, and having the mistrust factor weigh heavily upon each groups conscience. A number of
women declined services for pregnancy care at Leake Memorial Hospital even when the facility provided delivery services. Wise Women were more likely to go to the clinic and work through the rude and distant treatment meted out to them by staff. Many of the women thought that they were being treated fine and were not inclined to speak to their healthcare providers much during their pregnancies. Their collective issue regardless of age (this applies to all the groups) was the inconsiderate time management of the local clinic. Every group provided detailed information around long lines and rooms filled to capacity with pregnant, hungry, depressed, angry, and economically deprived African-American women waiting for services.

The women for this study represented a diverse group of rural African-American women. A deeper understanding of them as individuals, and as a group was desired. Location, setting of interviews, and town customs were all important characteristics of this study. By bridging the gap between academia and everyday living, the humanities are entrusted with the creation of a more fundamentally tolerant and assorted world community to engage. The more interaction and networking, the stronger are our ties that bind us to this planet and consequently, to each other.

The appreciation of other persons and their struggles, triumphs, and reasoning are paramount to explaining what and how we constitute our humanness. Space, along with cultural norms, impacts the stories these women tell. While the emphasis or central theme was pregnancy and the related narrative of that experience, the lens by which these women gauge their world was also open for a cultural peek inside the inner workings of this distinct and common rural environment. Each woman was encouraged to be empowered by sharing an intimate portion for life experience. While some may view
pregnancy as a personal event, this is not the case for African people, especially in the United States. The culturally relevant aspects of child birth, family continuation, and reverence for spirit constitute a large component of life and the rich rewards from within this sacred space.

The researcher thought it necessary to go further and incorporate more details about not only the women, but the setting of the interviews. This process entailed a descriptive and humanistic inquiry into the lives of these very brave and ordinary women. The interviews are ordered by groups. Each provided a learning experience for the researcher by increasing the knowledge base of woman stories and the value of living.

Eligibility

Any rural African-American woman who was pregnant and gave birth while residing in Leake County, Mississippi was encouraged to participate. The women represented a diverse group of rural African-American women. Age, education levels, marital status, and employment produced an assorted collection of knowledge which enhanced the voice of this populace.

Location of Interviews

Interviews were conducted at several sites. The researcher was mindful that many of the women had busy and demanding schedules. Interviews were conducted at employment sites, beauty salons, and personal homes. The participants authenticated the research by agreeing to assist in this study. All of the interviews were conducted in Leake County, Mississippi. The comfort level of respondents was a continuous priority throughout the duration of data collection. Women were encouraged to select a place
where they would be most relaxed. This situation produced various locations for this study as mentioned earlier. The researcher avoided clinical settings, preferring a more natural and undisturbed locale of the women’s choosing.

Once women were identified and accepted an invitation to participate, a scheduled time to conduct interviews was established. Prior to each session, the researcher explained the purpose of research. Time was allotted to answer any questions that the participant identified. When all inquiries about the study had been satisfied, consent forms were read, explained, and signed. A signature was required before any questions connected to the research were asked. Each woman was informed of her individual right to withdraw from the study any time during or after the session. Interviews were recorded and transcribed by the researcher.

**Instrument**

A qualitative approach was utilized for this study. Voice and appreciation of experiences were the main reasons for applying a “person-centered” structure to this research. Several open ended questions were employed. Questions were arranged into various categories: Culture, Environment and Conditioning. Sections facilitated the organization of both questions and responses.

**General Questions/Demographics**

1. How old are you?
2. How long have you resided in Leake County, Mississippi?
3. What is your marital status?
4. How many children do you have?
5. Are you currently employed? If so where? Is health insurance available to you?
6. Do you have a high school diploma or G.E.D.?
7. Did you attend college, if so where?
8. Did you complete your Associate's or Bachelor's Degree?

**Cultural**

9. What kind of services have you received at Leake County clinics?
10. How long have you received services?
11. Out of the services you received at the clinics, which ones did you feel were adequate or inadequate?
12. Describe your prenatal care? Do you feel this care was satisfactory? (Why? / Why not?)
13. How did you find out about your pregnancy? (asked family members, made appointment with healthcare provider, home pregnancy test be specific)
14. Describe your mood when you were informed about pregnancy (happy, excited, worried, sad, upset be specific).
15. How were you treated by family and friends once they were informed about your pregnancy?

**Environment**

16. Which clinic have you been satisfied or dissatisfied with? (Why?)
17. Describe the treatment you received at the clinic?
18. What do you think contributes to the type of care you receive? (Economics, quality of staff, lack of adequate technologies, etc.)
19. How do you pay for your services? Do you think how you pay impacts how you are treated?
20. How do you think your race impacts the quality and availability of care?
21. Where did you deliver your baby? (UMC, Women’s Center, Madison County Medical Center etc.,) Were you induced? Was your water manually ruptured? Were you offered a midwife or doula in your birth plans?
22. How far did you travel to deliver your baby? (30 minutes, 60 minutes or more), do you have a personal car or did someone else provide transportation? Who?
23. How can Leake County Health Clinics assist in maintaining your reproductive healthcare?
**Conditioning**

24. How does this treatment influence your follow-up care?
25. Were follow-up appointments given by doctor or did you request them?
26. Describe the factors you think impact the type of care you receive? (Race, economic status, education levels, etc.)
27. How does accessing reproductive healthcare in Leake County make you feel? (be specific)
28. Do you consider yourself to be spiritual or religious? (Did news of your pregnancy cause you to rely more on prayer or other spiritual practices?)
29. How would you describe your overall emotional state concerning pregnancy? (be specific... happy, joyful, sad, worried, undecided about state of emotions)

**Conclusion**

As the women so eloquently stated, more care is needed. Culturally competent and relevant care is desired to alleviate some of the mistrust held in this minority community. All of the major themes were prevalent, culture, environment, conditioning were all a part of these women’s personal accounts.

In Carthage, Mississippi, there is a physician’s office where the patients automatically separate upon entrance. There are no signs instructing individuals about this age old custom. It is simply adhered to with little or no resistance. People assume their place within a culture and maintain that station until they are empowered to change.

African-American women are a diverse group. Many women have concerns about their ability to access and maintain healthcare. This disparity is even more problematic once a woman becomes pregnant. Rural African-American women are survivors of a particularly sinister circumstance. The intersectionality of race, location and economics work to ensure a disparaging phenomenon for these rural women. Low birth weights,
premature, births, miscarriages, preeclampsia, limited funds and resources, low employment are all impacted by the intersectionality of their unique oppression.

Mississippi’s history runs rampant with stories of intimidation and race stratification. Socially arrested, rural African-American women have survived and thrived through challenging events. The role African-American women were forced into during the era of Enslavement continue to permeate the collective conscience of the community.

Jim Crow segregation developed a Code of Ethics so nefarious, rural African Americans continue to perpetuate that heinous experience. Earlier in this section, an example of a doctor’s office was discussed. Presently, if an African-American patient visits that office; they automatically go to the waiting room on the right. Euro-Americans go to the left. There are no identifiable differences between the two sides, but as long as residents can remember, that has been the order of service, one side black the other white. One group welcomed into the facility, the other tolerated and provided with minimal service. Surprising still, African Americans continue to patronize this establishment. The cultural conditioning is stronger than simple logic. Oppression is a sinister inhibitor to equality. Those in power are reluctant to give up their perceived advantages, while those disadvantaged give up hope of ever witnessing any meaningful or lasting change.

Perhaps the most impressive aspect of this continued segregation is that people assume their position, without fail. Some African Americans refuse to patronize this doctor, while others seem to not care. According to the research findings, that people are uninterested in change validates the proposed theory. Individuals demonstrate their cultural conditioning through their actions. Patients without instruction, enter with intergenerational Southern Civilities intact. Who may enter a space is understood,
accepted and carefully navigated. Many people in this rural society are instinctively aware of these unspoken cultural normalcies.
Chapter V

Cultural Environmental Conditioning

This study examined social and political discriminatory policies and their responsibility in determining (the experiences of this rural population of women) Cultural Environmental Conditioning. An exploration of maternity care could allow revelations of behavior and attitudes which would lead to the exposure of reproductive cultural healthcare disparities; which, in turn, may lead to improved services, an empowered populace of rural African-American women, and healthier communities for example, a decrease in low birth weight and very low birth weight babies. While examining African-American women's birth experiences in rural America, the researcher sought to uncover the impact past encounters have on present behavior and attitudes. This fact could be a primary cause for some of the health disparities experienced in the American South.

Cultural Environmental Conditioning works to explain the way culture interacts with environmental conditioning. Rural communities are purveyors of a distinct cultural world view based on both environment and location. This concept furthers the discussion by addressing the conditioning or training of a populace to accept status (value) based on racist rhetoric (bigotry). In this case, location impacts culture, which in turn insists on conditioning a general population to accept worth based on biased premises. For this study, the culture is the rural location, the environment includes the hospitals, clinics, and
women’s clinics and conditioning alludes to the behaviors and attitudes shared or introduced by the participants when dealing with levels of maternity care.

**Tenets of Cultural Environmental Conditioning**

CEC was utilized in this study to examine the various reasons for the type of care received by rural African American women. Each domain addressed a specifically identified concern. Culture was investigated by examining how each woman was able to navigate within this specific culture. Rural cultural norms were deconstructed and reconstructed from the vantage point of African American women. Environment was studied by examining both the usage of public and private self-advocacy. Public spheres included hospitals and clinics and private, home life and community. Again, addressing this pivotal component from an African-American woman’s perspective was useful. Finally, conditioning was analyzed by investigating the behavior and attitudes prevalent within this community of women. Personal or Social motivation was the major divisions within this segment of the theoretical domains.

They are as follows:

**Culturally maladaptive:** constitutes an inability to adjust thinking, conditioning or behaviors to ensure positive reproductive outcomes. This group appears to succumb to the outside pressures exerted by the perceived dominant culture...complete cultural environmental conditioning.

**Culturally adaptive:** conducive to progressive thinking and the ability to adapt conditioning to facilitate healthy reproductive outcomes. Adjusts to outside influence of dominant culture ...partial cultural environmental conditioning.
Culturally holistic: the ability to incorporate both medical and culturally relevant influences during pregnancy. Optimal phase, individual is able to self-advocate and adjust to outside influences, yet maintains strong sense of self and communal value... resist cultural environmental conditioning due to level of awareness.

Environmentally maladaptive: the ability to properly navigate public (hospitals, clinics, or women's centers) or private (home life, kin, support) areas to ensure positive reproductive outcomes. This person does not self-advocate for better services/treatment for herself or child.

Environmentally adaptive: the ability to navigate successfully to ensure proper services in both areas publically and privately. The individual is easy going and not interested in causing any trouble, thus, she will go along even if things appear odd.

Environmentally holistic: the ability to navigate both public and private areas and to create space to voice opinions about pregnancy. This person is dedicated to positive reproductive outcome and will advocate (for better doctors, referrals, complain to authorities when things appear odd, are offsetting and uncomfortable, because she understands her rights).

Socially motivated: more aware of what others think and believe about them and their current condition whether or not they are seen as fertile myrtles, welfare queens, and or lacking intelligence. The individual exhibits complete submission to external pressure/forces.

Personally motivated: this individual is more concerned with her personal value and is able to rebut any or most negative influences from outside dominant culture.
This person is at peace with herself and this confidence is reflected with her successful navigation of pregnancy. The individual can exist outside of external pressures.

**Scale**

*Optimal* is defined as the most advantageous position to occupy. An optimally thinking person is one that is capable of agency. In accordance with the framework, a person who is optimally defined has mastered all levels of distinction in this study. They are well adjusted in all areas. Culturally holistic, environmentally holistic and personally motivated are traits that govern such individuals.

*Average* is defined as a common or general position. It is assumed that most people usually fall in the average category. The individual basically indicates that they are adaptive to whatever the culture, environment and conditioning bestow. While this position may not be the most desired, it still occupies a place of responsibility and empowerment.

*Sub-optimal* is defined as the least advantageous positioning. This person is completely disconnected from responsibility or reasoning around reproductive care. There is the absolute consumption of distasteful information that impacts the thinking and competency of this individual. They are at the complete and utter control of others, both in their public and private spaces.

Rural African-American women are often times at the forefront of disparaging treatment. Misguided policies continue to prove disadvantageous to the progressive

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1 This term is introduced by researcher to mean less than average and in fact represents the lowest state of engagement by a respondent to the medical community.
policies needed to understand this group of women. Cultural Environmental Conditioning\(^2\) sought to provide a model of explanation and understanding for this population. As a concept, there are eight phases that were utilized in this study to gauge the related stories/data provided to the researcher.

Each previously espoused section or phase constructs an organized framework to investigate the pregnancy knowledge acquired by this population of women. All the phases allow for further investigatory development into the daily experience of rural minority communities and pregnancy.

Several themes were prevalent during the analysis of this research. Placed within a larger framework, each of them benefited the overall organization of the study. Pregnancy Stories, Childbirth Stories, Healthcare Stories, and Economic Stories complete the premise for analysis. Culture, Environment, and Conditioning are the elements of a larger framework established to analyze specific aspects of the participants' stories. The following section will allow for the unpacking of personal experiences of rural African-American women and reproductive healthcare. The previously mentioned components will be defined and explored in the following segments.

**Culture** is the philosophy of a people whose perspectives are expressed through a variety of methods including valuation of reproductive healthcare.\(^3\) Just how this culturally relevant challenge manifests was analyzed utilizing the vocabulary of

\(^2\) Cultural Environmental Conditioning, this concept is defined as the ways a people are acclimatized into an environment that expects absolute acceptance of social status (inferior/superior) with little or no resistance. This concept is particularly useful when investigating rural environments which tend to have accepted norms and ways of being less likely to translate seamlessly into other environments.

\(^3\) The definition of culture is created by researcher.
participants. Significance placed on the process for rural African-American women were defined in terms of time conscious care and attentive informative staff. Preliminary assessments by the women will be investigated as access to reproductive healthcare in Leake County, Mississippi. Subtitles are provided to indicate which aspect of preferred care was repetitively mentioned during interviews. Time and Attentiveness are the two of the most common themes prevalent in the answers. Culture for this study was utilized to discuss Pregnancy Stories. In addition, the response from the community once they were informed about the pregnancy was also examined. The responses are not organized according to group, instead they are ordered according to severity of reaction.

Time

Respondent 1: .., at Leake County um at the Leake County clinic their services could be a lot better um, if you have an appointment at 9 o’clock you may not be seen until 11 or 12 um there they have really poor time management.

Respondent 2: Uhhh, well a typical day was be prepared to stay there for awhile because the doctor would have to go to the hospitals before he could come back to serve the umm pregnant women...

Respondent 3: The first thing is because the waiting period that they have in Leake County is extremely too long...

Respondent 4: I first was going to Leake um the Health Department of Leake County and then I didn’t like it so...
Respondent 5: Ohh you went in there you was supposed to have an appointment at 9 you may get out of there at 4 because they was it was so many people there.

Respondent 11: Uhhh, a long day. I mean it was just it they took they time as far as getting you back uhhh and it was a lot of people there too you know.

Respondent 16: Because the wait was too long.

The majority of the respondents were dissatisfied with the low priority placed on time conscious care. Long days and problematic scheduling contributed a great deal to the low level of satisfaction experienced by the women in this investigation. Another area of concern is that high priority family responsibilities are not considered when healthcare representatives are providing care to these patients.

*Attentiveness*

Respondent 7: Cause I felt that the process I just felt that like you don’t have any one on one at Leake County. I wanted someone that was gone really care about me and not just get me in there see me and send me home. You know, I wanted some special attention.

Respondent 9: I loved Mallory Clinic..., when I went in to see the doctor or whatever they explained everything to you. And they real real nice people they so they explain everything to you....they told me for instance when I was pregnant that I had to watch my salt intake...,

Respondent 12: Yes it could be better if we had a prenatal umm doctor’s office or hospital you know around it would be the system would be much better.
Respondent 21: I did first from Leake County Health Department ummm there prenatal services, but they could never pick up on the fact that I was pregnant. So we had a miscarriage.

Respondent 22: In my earlier days I would say that the Leake County Department of Health was not good in probably the 70’s and 80’s they had one local doctor that uhhh did the pap smears and we all we most of us black women felt that we didn’t get good care...

The significance of thoughtful care is priceless. Several women acknowledged their personal preference for attentive and understanding care. Special considerations were sought by more than one respondent. The cost of non-attentive care proved deadly as one respondent articulated the loss of her first pregnancy. She assumed that it was prompted by the failure of the local clinic to adequately and attentively diagnose her condition, endometriosis.

Responsive of family and community to pregnancy

Respondent 1: My family are my friends they (laughter) were very supportive which I am extremely grateful for cause a lot of people don’t have that and I don’t think I would have made it without then and that kinda support.

Respondent 3: Well, my immediate family I mean like my mother and my sisters and brothers on my mother’s side I mean they, we love kids so it was pretty good but as far as my father’s side of the family they do not know until this day.
Respondent 4: My mom was disappointed said that she was too young to have grandchild but she already have one by my younger sister, she frowned. The only person was happy was my friend and my baby daddy some people was upset and some people was upset, but he was okay.

Respondent 6: Ahhhh, they was real caring and in shock.

Respondent 7: Ummm some family members with the first one, they were kinda disappointed. I would guess because I was in college and everything but everything else they were fine.

Respondent 8: They were, they were good to me.

Respondent 12: They were very very excited. Ummm very excited.

Respondent 13: Oooh they was okay, they was fine with it.

Respondent 16: I was pretty good.

Respondent 18: They were shocked (laughing) so it was like “are you really pregnant”? Every time I looked up I was like yeah (laughing) up until I started to get bigger they didn’t really believe me (laughing) so that was strange.

Respondent 21: Oooh, gosh they were so overwhelmed and excited everybody wanted to know what I was having and when was the baby shower. They were very excited.

Respondent 2: Oooh everybody was okay with it. My mom was okay because she loves kids.
Respondent 5: They were disappointed. Yeah they were disappointed because they say I know better so yeah…

Respondent 10: They were disappointed that I that I got pregnant. Cause there were choices other choices that I could/should have made but didn’t. But they were pretty much disappointed (laughing).

Respondent 11: Well my family they was there for me. They actually was there for me and you know umm my mom was there and she let me know “you can do this” she was letting me know about the do’s and don’ts about what I can do and don’t do they was there for me.

Respondent 14: Fine, they was all treating me the same.

Respondent 17: Ummm they some was happy some was what you call it redundant (laughing) they was alright.

Respondent 19: They was fine with it.

Respondent 22: They were excited.

Respondent 9: Some pretty good and some didn’t feel so good about it. Because I couldn’t give birth, they said it was because of my health said that was the cause.

Respondent 15: They were happy.

Respondent 20: I was treated fine, good real good.

Communal acceptance of pregnancy sustains the mother, and alleviates various stressors exerted by outside sources. Family and friends are important assets any time in
life, but they are indispensable once a woman is informed of pregnancy. The amount of support provided by the community, especially in the beginning, will make a significant difference in the stress levels experienced by the expectant mother. The next section will investigate the environment where services are offered.

Environment is space where cultural ideology is disseminated that includes hospitals and clinics. Acknowledgement of both the Public and Private sphere is crucial to any noteworthy system. For that purpose, Healthcare Story recollections are explored by probing clinics. Childbirth memories are examined by dissecting responses associated with personal hospital care. Reproductive healthcare combines both public and private domains as a prerequisite to receiving service. As a consequence, each area is heavily scrutinized. Public space, clinics, and hospitals are purveyors of cultural norms. Stereotypes and misinformation could permeate this territory. No place is sacred from irrationality. Privacy is positioned on the back burner for the purpose of delivering or giving birth to a healthy child. Women are expected to sacrifice their better judgment and desire to maintain confidentiality for the sole purpose of birth. Sacrifices are too costly for some of them as the two areas are not always properly integrated.

Clinics

Respondent 1: The doctors are poor because they have poor time management. They are always in a rush there is never that personal care that everyone deserves..., yeah that’s not really the case with Dr. ********* office she was very...I mean because of the you know don’t nobody like to sit around especially when you pregnant.

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4 Definition of environment is created by researcher.
Respondent 2: Ahhh, how do I say this, some days it was fine and then umm some days it was okay I guess because sometimes they was tired and uhhh it's a heavy load sometimes, I guess at times everybody has their days.

Respondent 4: Because Leake County is very slow and then they have all us packed up on there (a room) and then somebody could walk in white and they can go right in without no problem go tell them what they need and they tell them to go to the back and no problem it all depends if they know them or not…,

Respondent 5: Yeah, the wait yes. They they look like they woulda had a better they shoulda they shoulda not scheduled everybody at 9 o'clock and its 20 people waiting to see the doctor at 9. As a matter of fact they still do it that way. So they shoulda had smaller you know how, they shouldn’t scheduled so many people at once and it would have been more easier for everybody.

Respondent 6: I was dissatisfied about the services because it took too long. I hate waiting all day when you have to go and do something especially when you have to go to work. You still be waiting for all day. Like when I was stuck over there (Leake Clinic) one day when a tornado came through and I was supposed3 to have been in and out and going to work afterwards. Then a tornado came through and then we had to wait up in there a whole lotta extra time I could have been long gone on to work by then instead of waiting around on them to call.

Respondent 7: Some nurses were not as you know didn’t treat you with dignity and respect they just treat you like ohhh here come another little black girl that’s pregnant. You know kinda see ahh little bit of ahhh racial still tension still in this in this
county. You know so that was one of the other things and you know I just didn’t like that...  

Respondent 12: I was satisfied to an extent umm like I said they busy. You know it would be much better if they had other physicians or umm clinics or hospitals around that umm did prenatal umm than way you wouldn’t have a full clinic and everybody there for the same reason and it make the time much longer for you waiting. . .  

Respondent 16: I think they need more people because we had to wait and wait and wait.  

Respondent 18: By choice I didn’t want to be at umm Leake Health Department. Because ahhh the first part of my pregnancy when actually I found out I was pregnant when I almost lost my son probably a week after so I didn’t I went to somebody that I felt was you know, more capable of handling a situation like that. I referred myself to River Oaks.  

Location and satisfaction of care are another crucial component of adequate care. Many of the women repeatedly mention time management as an inhibitor to services. Racial discrimination was also explored as a possible cause. The lengthy and arduous legacy allocated to social stratification continuously plagues this rural county. The environments these women must navigate become one of hostility and hopelessness. Communal distress aggravated by historical wrongs is present. The women also experience a lack of complete environmental transformation. The lessons learned through the experiences of each woman reveal a shameful story of much more than purely contemptible time management and perceived bigotry.
**Hospitals**

Respondent 3: I delivered all my children at Madison County Medical Center...all were born naturally.

Respondent 4: Well it was supposed to be at River Oaks but they was full so they switched cause my doctor also work at St. Dominick’s...on that first one it was an emergency C-section and the next one it was not an emergency they just they just went ahead and got her out while she was in good health...because they didn’t want me to miscarry so they went on ahead and did what they had to do.

Respondent 6: At River Oaks Hospital...it was scheduled I was supposed to be there at 6 o’clock in the morning I didn’t like I was in there for about 5 hours before something happened. They broke my waters like about an hour after I got there. He still didn’t come down so I was still there about 5 or 6 hours and they finally said well he not coming down so they went ahead and cut me open.

Respondent 7: Madison County for the first two and St. Dominick’s for the last one...I was induced two times and one time it was natural. It happened on its own. ...At Madison General it was okay. It was uhhhh. It was a little (pause) it wasn’t comfortable because then they would move you from one room to another every procedure. Ummm that’s a part that wasn’t upgraded. Well you know like the hospitals now where you can be in the same room that you deliver in and on and so forth. And umm the uhhhh its just that the uhh the facilities weren’t upgraded it seemed. ...old fashioned...

Respondent 9: At the hospital...Kosciusko that was the first one and the one the one Carthage Leake Memorial Hospital....C-sections with them both.
Respondent 11: I delivered at Kosciusko... Well actually my water broke that morning at 7 and I didn’t have her until like 7 o’clock that evening so I really didn’t have to rush. I wasn’t feeling a lot of pain. But I knew I was having some contractions.

Respondent 13: I delivered one at Mumford Jones, I delivered one at River Oaks and one at UMC... they broke my waters... cesarean with the last two.

Respondent 20: At home... uh huh midwife and with my oldest children I had a doctor.

Respondent 21: I delivered my babies at Anderson Regional Hospital... I was induced at 38 weeks... I was considered a high risk mother at 35... they did indeed rupture the waters and it was about 12 hours before I had the baby... I had no cesarean... I was I actually had a midwife to deliver my baby and the doctor and the midwife delivered my second baby and the doctor was the person that delivered my baby the first time.

Hospital births are more often than not an utterly orchestrated event. As the expectant mother becomes an ostensibly insignificant part of the ritual. According to the respondents, many of the women were induced with a small fraction going into labor organically. Induction is usually enacted to speed up the delivery process. Another noticeable occurrence was the number of cesareans performed and low participation with midwives and doulas. When the medical establishment offered this service to the women, they declined. The rationales were plenteous, and the most frequent was unfamiliarity. Education appears to be the reason so many women refused to access doulas and midwives for service.
Conditioning determines how cultural beliefs are demonstrated. The expressions of principles are established by attitudes and belief systems. The psychological importance of healthcare is evaluated in this segment of the study. Whether or not an individual feels valued or insignificant becomes the impetus for contentment. A community that has traditionally been unjustly stereotyped will pass down knowledge of this marginalized treatment. Discussions around healthcare and service continuously provide countless points of discord for such a people. Encouraging a community to partner with medical institutions becomes challenging if not mission impossible. The dissensions articulated by the underserved community are historically correct and leave very little space for important points of interest to be discussed. Trust of service providers and medical institutions become central to the debate. Once this vital element of care is desecrated, then the entire interaction between the two communities becomes laborious. Rural African-American women’s word will convey the depth or lack thereof concerning the appreciated status of reproductive healthcare provided to them by local governments. The segment simultaneously probes healthcare stories.

Trust

Respondent 1: I normally tried to eat the things that I was asked to. I wasn’t always the best patient but when she um would tell me something that I needed to do like if I needed to take an iron supplement cause my prenatal vitamins weren’t giving me enough of the vitamins that I needed you know I incorporated that when I was told my blood pressure was too high and that I needed to cut back on my salt I tried real hard to do that and I did exercise toward the end of my pregnancy.

5 Definition created by researcher.
Respondent 2: …it was a lot of um that would call in to see which doctor was on at the clinic and they never liked him (a particular doctor) cause… most of them wanted a um lady doctor and I guess that’s why most of them waited until there was a woman on.

Respondent 4: Cause my doctor if he was there with them then they was fine. He made sure that they talked to me and explained stuff…,

Respondent 5: I guess because I really had a good relationship with some of the nurses that worked for Leake County Health Department… they real helpful and I think that if you go in with a certain amount of respect that’s how the kind of treatment you gonna get…,

Respondent 11: I think they really really umm took their time to just really check and see was I in good health was the baby in good health…,

Respondent 13: Well, I kinda dreaded going anyway but they care it was okay. I mean at Leake Memorial. I choose not to go back to them the second time because I had my own private doctor. But if I didn’t have my own private doctor, I probably would have gone back.

Respondent 21: Oh my God ummm, when I went in to an appointment at Dr. ***** office it was like going to Kirkland’s or Pier One. It was very relaxed. There was plenty of resourceful magazines to read while you were waiting for either your appointment or they were very respectful… it was a very relaxed setting. I didn’t have the stress.
Responses of the women were very diverse with some being satisfied with services offered and others despondent. One participant was skeptical of the doctor on call at the clinic and decided to leave that facility. Gender appeared to be the biggest culprit in that case. Some of the women were satisfied and therefore, raised no complaints concerning actions by staff. CEC explores the cultural conditioning that creates specific environmental impediments regarding reproductive care. Deliberation is critical to understanding current conditioning of rural African-American women in consideration of healthcare issues. Conditioning was so complete in some cases the women, even when mistreated, worked to justify the unacceptable behavior of the staff. The practice of placing less value on oneself is a major premise of CEC. One might ask how this manifests in the lives of everyday people surviving. Self-esteem and the lessened significance provided by the women in the community relates to their personhood. Depersonalization is a broad term that could include the deliberate readjustment of previously valued activity based on the desires of those outside of the trivialized population.

Whether or not an environment is friendly or hostile, adequate or inadequate, become markers for differential treatment when addressing the designated care assigned to minority rural communities. This prejudicial treatment causes both individual and collective health distress. Reproductive care as expressed earlier in this study requires women to collectively merge both the private and the public spheres. Essentially, while preparing for delivery, women are mandated to become less engaged with natural procedures during birth while granting permission to an outside source to monitor and regulate the process of birth. While for some women, power structures have ensured they
be given autonomy, though marginal, over their reproductive facilities, subjugated populations have not been granted access to that level of importance based on stratification.

This perspective was evident when participants were probed about their individual birth plans. In cases where doulas were offered, many of the women declined the service, admitting that they were unfamiliar with the role or the necessity of hiring a birthing coach. It became clear that women were not educated about their options. The lack of information provided by medical institutions exhibits another basic level of CEC. These manifestations take place most frequently in common situations such as questioning doctors, demanding time conscious care, having access to snacks and other amenities while waiting for services, having transportation provided to important appointments. Trust is compulsory for positive healthcare experiences. Both the medical and receiver communities must become aware of this important partnership. If this joint venture is not established or not allowed to erode misconceptions, then distrust becomes more prevalent while lessening the opportunity to create a beneficial system of care.

**Black Bottle Syndrome**

Black Bottle Syndrome⁶ was common in this rural community of African Americans. It includes the manner in which cultural conditioning imposes and explains medical circumstances that are highly problematic. More than once during this research, participants demonstrated apprehension toward medical institutions. Attitudes such as

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⁶ Black Bottle Syndrome according to participants figuratively connotes a lethal combination of mistrust and under appreciation experienced by African American communities in Leake County, Mississippi. Several people, again according to participants, have been killed or severely injured at the hands and direction of medical care providers.
suspicion and annoyance were evident while speaking with participants about services. As a result of the previously mentioned problem, behaviors were also modified to reflect a lack of interest or absolute detachment from medical communities. Perhaps this behavior became prevalent as a result of transpired and culturally specific stories. As one participant explained, people die when they go in for services. The Black Bottle Syndrome is a means of connecting the proverbial dots as it relates to care and trust within a marginalized community. Though this concept is figurative, the impact is real and continues on a devastating course throughout this rural minority community. Any medical phenomena too complex to be explained in simple terms, take on the sinister Black Bottle Syndrome. It is a culturally specific syndrome which implies a deep and varied sense of mistrust, with added degrees of dissent. Black Bottle Syndrome is a devastating inheritance of the squalid historical past of discriminatory policies. Though problems continue to manifest as a result of prior maltreatment, Black Bottle Syndrome continues to permeate the very fabric of this rural community’s conscience.

Respondent 2: …my mom would have to go to the hospital and she would have to sit outside and wait before they would wait on her. Then I think this one lady umm she had asthma and she died out under the tree because they wouldn’t take her in the hospital they would give her a shot for her asthma… and she died out under the tree.

Respondent 3: …it could be somebody up on there with a disease they ain’t gone inform you but like two months later and then they tell us I need y’all to come in so that we can check your blood counts to see if to come to find out that y’all in here with somebody that has some diseases and y’all might have been around them and I didn’t like that cause I was scared for me and my baby lucky we didn’t have it but I was I was mad.
Respondent 5: ... all everybody had to be looked at the same way. And I just asked please don’t don’t do me like that. You know your body you’re very private about your body. Okay I done just had a baby. So why do you and 6 other people got to mash on my stomach. Or why do you and the rest of them why y’all gotta look at me when I don’t need but one person to look and you know see what’s goin’ on. So that was a bad thing. It made me feel baaaad. I didn’t like that... all of us were black in there. Let me think uh yeah all of us were black.

Respondent 6: ... some how I trusted them but I didn’t trust them that much (concerning dietary changes)

Respondent 13: But you know they asked questions, it was just, maybe it was just me but you know they asked about me I just..., didn’t.

Respondent 14: ..., I didn’t never try to talk to them it was just I didn’t feel like I needed to.

Respondent 18: Yeah, they sitting up there looking like, I want to kill you or something so that will make you uncomfortable..., 

As reported by participants, Black Bottle Syndrome politics inclined much of the accepted wisdom to include horrible and agonizing recollections of loss on some level. Several women were reluctant to speak with their doctors, feeling that to answer questions about their pregnancies was tantamount to a privacy incursion. After labor, one participant reports demanding personal privacy, she stated that the whole process made her feel like a guinea pig. Possibly, the most impressive responses involved someone in the community being killed, murdered by local medical personnel. CEC explores how
this level of conditioning impacts interactions with medical care. For these women, the historical significance of their place within this rural society provides an unwelcome backdrop to the expected vulnerability experienced during maternity care.

These historical wounds have not been redressed or even acknowledged. As far as hospital and clinic administrators are concerned, those atrocities were committed in the past or are non-existent (untrue). It seems as though they are unaware of present day scarring symptoms prevalent in the receiver community such as anger, lack of interest, inability to effectively communicate, unfriendliness, and doubt. Countless medical staff members never learn to relate or adequately extinguish these seemingly meaningless fears. Behavior modification is possible once, and if, both communities come together and build a significant expectation of equality.

**Race**

The most vital component of readjusting belief systems is a better understanding of how race and racialized care impacts marginalized communities. Some of the women in this study were very open and honest about how they perceived their treatment. A few of them specifically stated that they believed racism was the major deterrent to adequate, considerate, and welcoming services. As long as this behavior continues to permeate medical systems, “marginalized” populations will continue to feel like destitute guinea pigs, even if only a few speak out against such differential treatment.

Respondent 2: They would put us in a room and you would stay there for a while but, I guess it went on for so long too umm we umm just accepted it because at the time there was nothing we could do about it not as compared to now because its, I think now
it's somewhat better, but I think it could be better now...the majority of them (patients) was black they just didn’t attend to us...because it’s always, this is Mississippi its always been racial.

Respondent 4: The only thing I didn’t like about River Oaks was that my doctor was not there for me because he is a lovely doctor and the doctor he had on call was a rude, he was prejudice and the way he cut me. Like my doctor said, the way he cut me he didn’t have to cut me that way but he did, but like my doctor said the only thing he could do was try to stitch together better but besides that I was okay with it...it was because of my race.

Respondent 7: ...like I said uhh race and kinda like poverty issues. That was something else we coulda I coulda added back in the earlier statements that I made too. I see that being a problem. Too umm people not having as much money as or in the lower class of standards or living you know I see that that was the main things that impacted on it.

Respondent 9: There was difference between the races. The blacks didn’t get the treatment the whites did get in the hospital or where ever.

Respondent 21: ...race as far as demographics as far as black women you are going to have a large number of that like in any county and Leake County does have its share of the numbers. Culture wise we do things a little bit differently. We eat differently, we exercise differently, we parent differently those things are limited in Leake County with our women. Leake County does not accommodate culture wise the blacks as they do
Hispanics and Caucasian women. But it should be improved and like the fact that being that Meridian is a city it catered to every culture... Every Culture Woman,

Respondent 22: I would say a little bit of race...,

When the women were asked about the number of black women in the clinics they responded with the following:

Respondent 16: Oh about 90 to 98 percent.

Respondent 2: Yeah, yeah the majority of them was black they just didn’t attend to us.

Respondent 5: It was two women; it was four women in my room. It was four... all of us were black in there. Let me think uh yeah all of us were black.

Respondent 18: More than half were black.

Respondent 19: Most of them, most of them. It might have been two or three white.

Respondent 21: There were probably a percentage of out of 100 percent, you might’ve seen a percentage of about 60 percent and the others were other minorities.

Respondent 17: Oooh you want to see that was about maybe 2 or 3, probably all of them except maybe 2 or 3...

Race and racialized care was a part of the discussion for a few women. A number of women attributed their inadequate care to other factors. The most prevalent was income. However, in a state like Mississippi, wealth or the ability to acquire employment
that is adequate enough to maintain a family is very much tied to race. CEC examines not
only how the women responded, but some of the reasons for their responses to certain
issues.

Racialized care is ubiquitous in Leake County and Mississippi. The climate of
racism is just as poisonous now as it was during the other timeframes in this old southern
state. Social stratification was the norm and continues to bear unpleasant fruit in the form
of reproductive healthcare disadvantages. Conceivably, the most disastrous
demonstrations reside in the emotionality attached to pregnancies. Many of the women
were unhappy with news of pregnancies as verified by their responses and the following
chart (page 103).

Respondent 1: I was ecstatic, scared. I was happy because it was planned and it
wasn’t a mistake and I was scared because it was a whole other person that I had to take
care of.

Respondent 3: I was very shocked um when they told me I was pregnant. I was
kinda looking forward to being put on birth control.

Respondent 4: Well with my last pregnancy I was sick I thought I had the flu and
I was goin back to get on my depo and she told me I was pregnant and once again I
fainted because I am high risk and I had already had like two miscarriages and I was
there again and they asked me if I wanted any prenatal care and I said no I’m gonna go
back to my same doctor while I’m pregnant.

Respondent 6: Denial
Respondent 7: Sad, upset….my first child I was. That was a sad day. I was sad. My second one I kinda actually planned him so I was excited about that one. And the last one I was very upset about that (laughter).

Respondent 8: All (laughter) all if it hit you at one time. Nawwww, ummmm really, I was kinda upset. I was upset because I had. I was pregnant before and I lost it so I was upset because I was nervous...

Respondent 12: Excited.


Respondent 16: I was…ummm…I kinda figured. I wasn’t happy (laughing) I wasn’t sad.

Respondent 18: Shocked (laughing) shocked.

Respondent 20: Happy!!!!, Excited I was pregnant the second time the first time we had lost it was a gift for me to be pregnant again because I had problems getting fertilized and we had undergone some enhancement there to get me fertile and finally a year later we found out we were pregnant.

Respondent 2: Ahhh, I was hurt because I was uhhh, me my husband and I was separated and I already had four kids.

Respondent 5: I passed out…I was ummmm I was sad. Yeah because I had already had 5 kids and I was wondering how I was gonna take care of another one. So it was kinda sad.
Respondent 10: I wasn’t happy because at the time I was in my basketball career and that basically umm discontinued it one I found out that I was pregnant.

Respondent 11: Actually at that age I was I really didn’t know how to feel. Ya know cause I wasn’t really ready or expecting to hear that answer ya know I just really didn’t know I was missing a period. And when I went to the doctor that’s when I found out. So I was like ooooh my mama gone kill me (laughing) that’s how I was thinking but it wasn’t nothing like that they they was just really there for me.

Respondent 14: Well neither one I was just…. I was just pregnant.

Respondent 17: I cried like a baby, I don’t know why, but I cried like a baby multiple times.

 Respondent 18: Mad.

Respondent 22: Happy.

Respondent 9: I was happy.

Respondent 15: Oh I was happy.

Respondent 20: Well, my first children I was proud but after I got..., so many I was unproud I was unhappy about that (laughing).

As demonstrated by the following chart, the majority of women seventy-three percent were displeased due to multiple implications of maternal and social expectations, leaving only twenty-three percent of the women happy. Several women were un/underemployed at the time of pregnancies. Another significant portion had to drop out
of school as a result of pregnancy. Unfortunately, the women who left school due to pregnancy have not returned to complete their education.

![News of Pregnancy](image)

**Figure 1. News of Pregnancy**

The emotional toll of expectant motherhood coupled with other responsibilities creates an environment replete with hard decisions concerning personal growth and development. Perhaps the previously mentioned dissatisfaction with pregnancies somehow impacts the manner in which women engage medical communities. Another assumption for the emotional state of the women could just as easily rest in the valuation of race and ability to secure the basics of a desirable life. Despite the ability to access the amount of care most desired at all times, African American women survive and thrive in some cases based on community support.

One of the most respected characteristics of African cultures is the strong valuation of community and belonging. Rural African-American women are engaged in producing a culture of support and in some cases resistance against a sometimes
unsympathetic and imperfect world. In Mississippi, family and community support has often been the one thing that maintains a sense of peace and progress. Sufficient support systems enable a sense of survival and perseverance while insufficient support systems create dejection and painful separation.

Respondent 1...I was supported by my family and fiancé. Whenever I had a doctor’s appointment I never went alone so like my family or my fiancé...I never went to any of my doctor’s appointments alone.

Respondent 2: My mom and my kids.

Respondent 3: Friends and family.

Respondent 4: I guess not besides my friend and her mama is basically all I have I mean I have family but, they don’t support me it’s hard for them to do anything especially my mama’s side she ain’t never been there for me.

Respondent 5: ... it was mainly my grandmother. That’s the only person I really had to stand by and who stood by me. She loved me. She made sure I went to the doctor. She helped me financially. That’s it she was the only person that was there all the time constantly. So that’s how I made it. Through the love of my grandmother.

Respondent 6: ... My cousins, I’ll just say my family.

Respondent 7: Friends and family members.

Respondent 8: I would say my family.

Respondent 9: I was stressed ... noooo, neighbors and my mom.
Respondent 10: Baby daddy.

Respondent 11: Yeah, the Dad did a lot the Dad was there too but my mom was there for everything.

Respondent 12: . . . my mom she was so supportive I was living in Jackson Mississippi umm but when I found out that I was pregnant and I wanted to move home so I could have that support from my mom cause my husband he worked away. He worked what they call offshore so it was like he was working out on the upper Mexico and having my mom support helped it really did for me I needed that at the time.

Respondent 13: everybody . . . friends

Respondent 14: I didn’t need nobody to help me, I am a reliable person.

Respondent 15: My husband.

Respondent 16: My family.

Respondent 17: My sisters . . . my boyfriends.

Respondent 18: My family . . . friends.

Respondent 19: My family.

Respondent 20: Yeah, my sister, Evelyn cause she was there any time I called she was there.

Respondent 21: . . . My family immediate family, mothers and father, brothers and sisters and my husband and his side of the family as well.
Respondent 22: Family.

Family support was essential for these rural African-American women. African cultures cultivate significant family bonds. Kinship becomes the comfort that soothes and heals tribulations experienced by this minority group. Marginalized communities learn the value of networking with others by incorporating supportive and meaningful traditions. Pregnancy requires the assistance of many kinship bonds those of blood and those of circumstance. The majority of women in this study reported that family and friends provided crucial support and encouragement. In fact, the women that reported less family or communal support reported a noticeable increase of stress. In addition to high levels of stress, these women also experienced difficult pregnancies and miscarriages. All the previous responses demonstrate the need for a more culturally comprehensive method of ensuring proper care.

Manifestations

As a means of explanation and establishing a measurable system, several sections are utilized to provide further investigation of responses. The organization is based on the framework for this study. CEC explores how differential treatment manifests in the lives of people impacted by perceived biased policy. To the extent that this internalized belief system becomes an intergenerational practice, it has been most noticeable in the introduction of the Black Bottle Syndrome concept.

Once stories such as those which transpired earlier are circulated, establishing trust becomes even more arduous. Even though the women did not mention stories of blatant misgivings, the healthcare community must be made aware. Healthcare
proponents must be made aware of these culturally unique traits, if they expect to eradicate mistrust in some communities. A means of explanation will be presented in the next section of this research. The Scale consists of three degrees of care. They include Optimal, Average and Sub-Optimal care distinctions established by the responses of the participants. Charts will also facilitate clarity in this section of the research.

Scale

*Optimal* is defined as the most advantageous position to occupy. An optimally thinking person is one that is capable of agency. In accordance with the framework, a person who is optimally defined has mastered all levels of distinction in this study. They are well adjusted in all areas. *Culturally holistic, Environmentally holistic, and Personally motivated* are traits that govern such individuals.

*Average* is defined as a common or general position. Most people usually fall in the average section of this study. Basically indicating that they are adaptive to whatever the culture, environment, and conditioning bestow. While this position may not be the most desired, it still occupies a place of responsibility and empowerment.

*Sub-optimal*7 is defined as the least advantageous positioning. This person is completely disconnected from responsibility or reasoning around reproductive care. Absolute consumption of distasteful information affects the thinking and competency of this individual. They are at the complete and utter control of others, both in their public and private spaces.

7 This term is introduced by researcher to mean less than average and in fact represents the lowest state of engagement by respondent to medical community.
Optimal

The women located at this level of empowerment are at the highest echelon on all areas of investigation. While some may have demonstrated empowerment earlier during gestation, all the women in this section were prepared to navigate healthcare services adequately. The majority of Optimal ranked participants were represented in the Renaissance Group.

Average

The majority were well represented in this group. The average section represents how various women were marginally satisfied with the level of care received at local clinics. A small number of women were so dissatisfied with the levels of care that they relocated to another site for maternity services. While this was common for some women, they were unwilling to operate at the highest level. Similar to the previous group, there are various degrees within this section. Differential treatment was acknowledged but not enough to become an impetus for movement.

Sub-Optimal

Though some of the women appeared to be disengaged during their pregnancy, all women in each category were very clear about the benefits of prenatal care. According to their responses, though the slow discourteous service made them want to reconsider, they kept every appointment. One of the markers for sub-optimal ranking would entail chronic tardiness and missed appointments. That did not appear to be a concern with this group of women. However, once the environment and staff were noted by the women for being inadequate, their reasons for staying could qualify them for this categorization.
The following section consists of charts which demonstrate the levels of care received by women participants of this study. The majority of women were average in overall response to services. A few would be considered sub-optimal due to their general lack of interest in both the environment (hospitals, clinics) and conditioning (personally motivated or socially motivated). For clarity, each section will be divided to provide clearness with responses and assist the researcher in crafting a measuring instrument.

![Culture Chart]

**Figure 2. Culture**

Respondents were sufficiently represented in the adaptive sector, which comprised of sixty-four percent of responses. The majority of the women were willing to adjust to the confines and strictures dictated to them during gestation. A very small number of women, twenty-three percent were disinclined to adjust to the culturally normalized treatment of African Americans and decided to adapt to a different system of care (changed location). The least represented group was the maladaptive sector representing thirteen percent of respondents. Women in this group were completely
disengaged during gestation. Privacy was a major concern and they maintained inflexible conduct while engaging the medical community. No questions, limited answers, lack of concern for possibly obtaining services if those services required engagement outside of their preconceived comfort levels.

The reasons for such sheltered responses are historical. Some marginalized communities of color are apprehensive about sharing personal information with medical institutions. These fears are grounded in historical maltreatment and perceived malicious actions of the dominant community, often represented by medical personnel. Unless real efforts are made to understand the repercussions of past discriminatory policies, rural African-American women will continue to disengage from forging a true partnership with the medical community around reproductive healthcare.

Respondents were well represented in the holistic forty-five percent and adaptive sectors forty-one percent with a small number 14% in the maladaptive sector. The majority of respondents were capable and willing to relocate to an environment more fitting to their aspiration of care. The holistic women changed environments early on during their gestational processes. Aware of the limited care available to them by the local clinics, they made the best decision available to them and acquired improved care. Adaptive women were more likely dissatisfied with the obtainable local care, but in some cases were unable (transportation, income, time, inability to drive, and other restrictions) to access care outside of the local clinic.
Figure 3. Environment

Awareness of limited care was a major concern for these women, however due to a plethora of outside influences (intersectionality), they were unable to relocate to access the most satisfying care. Maladaptive women were not willing to relocate, even when they identified unpleasant treatment. Most of the women in this section noted they did not feel it necessary to speak with or question healthcare providers. Privacy at all costs seemed to be the prevalent thinking within this group of women.

The majority of women in this sector fifty-nine percent were socially motivated. Socially motivated women were more likely to be overly concerned with the norms of society. One example of this would be the low number of women that accessed midwives or doulas as part of their birth plans. Many of the women were not introduced to birthing coaches (doulas) prior to delivery and were generally unprepared. When they were in active labor or in place for induction, they were not equipped to access this vital component of care. Personally motivated women forty-one percent were more likely to
work with non-traditional alternative care workers. One woman was able to have her baby delivered by a midwife and some women were provided maternity care by a local midwife.

![Conditioning Chart]

**Figure 4. Conditioning**

**Scale Chart:**

Sixty-four percent of respondents collectively represented an Average level of conditioning, Optimal twenty-three percent and Sub-Optimal thirteen percent encompassing a much smaller percentages of responses. Many of the women were adaptable to treatment even once they identified problematic delivery processes (long and delayed care, rude and prejudice treatment). Of the women that made a significant change, few of them were inclined to return to the local health clinic for services. Perhaps the most interesting faction within this research was the Optimal group. As stated earlier, Renaissance Women were prominent in this assemblage.
Figure 5. Scale Chart

Optimal women were able to navigate within a dissatisfying system and make decisions to ensure the best reproductive outcome. They were reluctant to remain in a situation deemed unsafe or lacking satisfactory outcomes. Unfortunately for some, this empowerment came at a price. Three of the women in this group reported losing children while in the care of the local clinic. Their experiences compelled them into action. This exceptional group of young women became advocates for personal health and well-being. Self-advocacy within the Optimal group was at the highest echelon in comparison to the other women. All of the women in the Optimal group were prepared to take matters into their own hands and on many levels, were able to access the desired care they required. Diligence and self-promotion was justly rewarded as each woman was able to deliver healthy babies, even as the odds of doing so were stacked against them having productive pregnancies.
Discussion

The links between prenatal care and positive reproductive outcomes has a long history that support preferred results. However, if women are encouraged to participate in these services a less stressful environment would greatly benefit the outcome. This research explored how women in a minority and rural environment were able to evaluate the level of care they received during their pregnancies. The women were divided into three categories. Each group presented various issues surrounding care and valuation.

The oldest group (Sage Women) was charged with surviving the rigors of the Jim Crow South and motherhood. The demands placed squarely on their lives were great. However, according to the majority of women in this group, only one was completely dissatisfied. This woman also experienced the greatest level of poverty. Her children were born underweight due to the immense and varied nature of poverty she confronted during her pregnancy. Hunger was a constant companion for this woman as community support was limited or non-existent. The lack of communal support was a surprising find. Most people assume that rural communities are very closed knit and supportive. This respondent noted that people gave what they could, but everyone struggled and had nothing extra to provide.

The next group (Wise Women) of women was just as engaged and provided another level of understanding concerning rural healthcare provisions. Birth control and family planning were major victories for women during this group’s reproductive life cycle. That being the case, women were still displeased with care provided to them by the county. Some women expressed a complete disengagement with the process, admitting
that they never really solicited advice or provided insight into their pregnancies. They were not allowed to care very much about their situation.

Doctors, according to the researcher, were outside public influences. The woman in this study felt they had no business in her business. No additional information was provided to her healthcare provider. If something significant developed, she felt justified remaining silent and trusting other sources outside of the medical system if additional care was needed. Needless to say, this participant was sub-optimal. Although her responses were not in the majority, they were significant in exploring how women in rural communities adjust to family growth and responsibilities.

The last group (Renaissance Women) of women perhaps benefited the most from previous generations’ family planning agendas. Career development, medical interventions, and cesareans were prevalent occurrences for this category of women. Challenging and changing American norms, women were at the forefront of progress with respect to reproductive policies. Renaissance Women are certainly positioned to carry the advances of previous women forward. African-American women, while often thought to be disenfranchised, worked tirelessly to ensure all women had access to medical improvements and career opportunities. As this has been the case for many in America, African-American women continue to place a very high priority on the monetary necessities of life.

Most of the women in this section continued to proclaim similar disadvantages around securing proper monetary means. Insurance type was the most prevalent indication for this school of thought. It was assumed by the majority of women in this
group that if they had access to better insurance or paid insurance, they would have been treated much better by medical staff at the clinic and hospital. They also proposed that paid insurance as a status symbol would ensure more choices around accessing reproductive care.

Education ranked very high for this group of women, but only one completed college and only one had an advanced degree. Several women in this group received a Graduate Equivalency Exam or G.E.D. Perhaps, adding to the assumption from higher paying jobs, job security and good benefits, women in this group were adamant in their belief of money as panacea. While this last group of women was still actively in their reproductive life cycles, many continued to feel that the care offered to them was racialized and sub-standard. Education, as mentioned earlier was introduced, but insurance held the highest significance according to women in this group.

All the women in this study were mothers. Motherhood developed for each in a unique and engaging time of America’s history. Perhaps the most fascinating component of study for this researcher rested in how pregnancy changed and challenged each section of women. Renaissance Women were the most influenced by media and other responsibilities, while the Sage and Wise groups were consumed by the pressures exerted by the demands of their prospective time periods. America as a whole changed significantly from the oldest to the youngest woman’s experiences. While change is factual, rural African-American women continue to struggle with the least amount of allocated resources coupled with an endless list of responsibilities. Such a combination creates a less than desirable reproductive healthcare outcome. However, this level of care
generates a possibility for other venues to develop capable of concentrating on some of the issues elucidated in this study.

The use of Grounded Theory assisted in the creation of a theory designed to assist the study of rural African American women in Leake County, Mississippi. Cultural Environmental Conditioning encouraged voice development of a marginalized community of women. Each section provided a different perspective on the type and level of care available to them at the time of their pregnancies. An exploration of cultural values was paramount in understanding the role and responsibilities of local influences on reproductive healthcare. Culture, is a popular term with a multiplicity of meanings. For example, one definition includes civilization. If that is true, than the type of treatment, differential or otherwise, provided to African Americans is problematic. The lack of consistently attentive and adequate reproductive care is less than civilized. However, culture for rural African-American women assumes a less than pleasant imposition of devaluation. Especially when interacting within the dominant cultural systems. A new model of care would assist in easing some of the mistrust, by empowering both the receiver and provider community.

A Model for Change

As a result of establishing a number of issues prevalent within rural reproductive healthcare, as demonstrated by the creation of Cultural Environmental Conditioning, a different approach for future practice is offered by the researcher. *Q.U.I.L.T. C.A.R.E.*, a nine point model, was created by the researcher to further assist the medical sciences’ ability to provide care that will meet the needs of a broader population of people. Each
letter represents a recurring desire of participants in this study and is established as follows:

- **Quality** (qualified permanent staff)
- **Unbiased** (lack of differential treatment)
- **Informative** (communicates with receiver community respectfully)
- **Life affirming** (positive re-enforcement of healthy lifestyle)
- **Time-conscious Treatment** (conscientiously schedules patients and informs receiver community of scheduling conflicts)
- **Culturally Competent** (Aware of the unique attributes and tribulation within African-American community)
- **Attentive** (listens to patient and patients listen to medical staff)
- **Reformative** (educated about culturally competent care with a shared interested in restructuring how care is provided)
- **Educational** (both medical staff and community work together in establishing a working relationship around reproductive healthcare)

Participants of this study were focused on accessing quality healthcare. Many of the women felt that they were not treated as well as Euro-American women. This belief system stymies any progressive assistance that could eradicate the perception of inequality within reproductive healthcare facilities. The following are suggestions to eliminate mistrust and possibly forge a true partnership to adequate reproductive healthcare services.
QUILT CARE NINE POINT SCALE

For provider community

Quality

1. Friendly cordial staff, smile and make small talk (ask about family, kids, etc...) and informs patients of new activities keeps mood light and educational.

2. How do you greet your patients?

3. Is your facility comfortable? (clean bathroom, waiting area, snack machines, magazines, toys for children)

4. Is the doctor a permanent member of the staff or are they on rotation from another clinic?

Unbiased

1. Patients are not treated differently based on color or economic status.

2. Perception of differential treatment should be eliminated or minimized (no one should be allowed to walk in and receive services, if the waiting area is noticeably full of restless tired pregnant patients)

3. Community forums should be planned often to encourage communal feedback and support. (Church, community center, sponsors a spring picnic, organize at a local school)

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8 This system is being offered by the researcher to assist with rural reproductive healthcare practices; however, it could be applied in other areas of healthcare to ease apprehension and suspicion for African American communities.
Informative

1. Patients should be made aware of any changes to staff or services. (newsletter)
2. Doctors should be made aware of the need for them to properly inform patients about their reproductive care (Conduct test, explain why they need the test and what is implied by the test).
3. Keep an open dialogue about treatment, care, and risk (do not leave patients in the dark about their care).

Life-affirming

1. Praise your patients when they are doing well, explain to them the risk of ignoring medical advice in clear concise language that is easily understood. *Do not talk down* to or belittle patients, this behavior only intensifies the mistrust evident amongst communities. (Medical and African American)
2. Find ways of incorporating stress reduction classes or provide the information in a relevant way for patients to engage.

Time Conscious Treatment

1. This cannot be emphasized strongly enough. Do not leave patients to decide the reasons for slow care. Inform them of schedule conflicts.
2. Institute call center to inform patients hours or days ahead of time to either reschedule appointment or be prepared to wait for no longer than 2 hours.
3. When patients are seen in a timely fashion, this service adds to their level of satisfaction and encourages them to continue receiving care.
4. No one likes to feel maligned, when patients are forced to wait without explanation, they are bound to interpret the incident in the worse and less effective way.

Culturally Competent Care

1. Speak to patients.

2. Be genuinely concerned for their care.

3. Educate yourself and staff about the norms and expectations of the community you are providing medical care.

4. Understand the mistrust do not judge or dismiss it, work to understand the cultural disconnect\(^9\) so that better more efficient care is provided. This is especially important for African Americans. A health model geared toward creating comfort will ease the intergenerational mistrust of the medical community.

Attentiveness

1. Work to be engaged and engaging listen to what patients are saying. Watch their body language, because they are watching yours. People can tell if they are being rushed or disregarded. Have a mirror in the exam room look at your disposition are you smiling, do you look at the patient or are you afraid and prejudicial toward them because of misguided information. Re-educate

\(^9\) Term offered by researcher to explain the divergences of cultural values based on dominate and subjugated communities’ valuation processes.
yourself about the importance of courtesy when interacting with people who have a strong historical mistrust of medical sciences.

Reformative

1. Be an agent of change.
2. Incorporate culturally competent care.
3. Reorganize priorities to include proper care for patients.
4. Disregard the misguided information.
5. Leave your prejudice at the door.

Educational

1. Educate the community about the benefits of healthy bodies prior to pregnancy.
2. Create workshops and stage reproductive healthcare fairs to engage community outreach to churches and organization.
3. Stay physically healthy (exercise often).
4. Stay mentally healthy (find ways to relax).
5. Stay spiritually healthy (incorporate a belief system that reinforce your value as a person).

For receiver community

Quality

1. Understand the limits of local reproductive healthcare facilities. If you require more detailed services, find a way to access proper care for your condition.
2. Take responsibility for your health.

Unbiased

1. Be open to medical advice.
2. Question the doctor about side effects of medication or other concerns you may have. Do not assume that medical personnel are not interested in your concerns.

Informative

1. Come to the doctor's office well informed and with plenty of questions. Do not assume the doctor will understand where you are coming from; be willing to assist in your care.

Life Affirming

1. Visit your doctor's office with a positive attitude.

Time Conscious Treatment

1. Be mindful of the time constraints.
2. Reschedule appointments ahead of time if necessary.
3. Bring books, magazines, or other things to entertain you and your child (ren) if necessary.
4. Prepare snacks for you and your child (ren).

Culturally Competent Care

1. Engage you medical care provider about topics relevant to you.
2. Be open to sharing important information about you and your desired care.

3. If your local doctor decides not to assist you with incorporating relevant (safe) culturally specific request, then relocate or find a physician that is more open to your needs. Be empowered about your personal health care.

**Attentive**

1. Pay attention to medical personnel.

2. Listen to medical advice.

3. Be a partner in your healthcare.

**Reformative**

1. Change your attitude about healthcare.

**Educational**

1. Be informed about your body. Attend as many community health fairs and events as possible.

2. Stay informed...you only have one body take care of it!!!!

In conjunction with the proposed model of change, there must also be a way to incorporate people from the receiver community to be reproductive healthcare advocates. Familiarity with the local norms and expectations could bridge the proverbial gaps. A more holistic approach is necessary and required, as demonstrated by this research. The humanities encourage the appreciation, study, and understanding of what constitutes
humanity. The willingness to connect all aspects of community, support the expansion of cultural integration.\textsuperscript{10}
Chapter VI

Conclusion

The purpose of this exploratory research was to investigate salient factors that contributed to the levels of maternity care received by rural African-American women in Leake County, Mississippi. This research utilized a qualitative method of analysis to ensure the voices of the women would be the major focal point of the research. The research questions were adequately addressed as follows:

How does race and racism influence reproductive healthcare behaviors and attitudes for rural African-American women in Leake County Mississippi?

According to respondents, race does influence reproductive healthcare behaviors and attitudes by creating a sense of class stratification. One respondent spoke defiantly about being treated as a Class B citizen. The expectation for care was decreased as a marker for behavior modification as some of the women refused to meaningfully engage the medical community in their reproductive needs. Several women were dissatisfied with the level (value) of care provided to them. They were not able to relocate to different clinics due to a lack of insurance coverage.

Insurance type appeared to be more of an inhibitor to care than race or racism. For a state with a history as soiled as Mississippi’s regarding race, it would not be inappropriate to assume that the quality of employment is predicated upon race. Succinctly, employments that provide good insurance (private insurance) are mostly held
by European Americans instead of African Americans. Therefore, even as the women identified insurance as a sign of a provision of superior service, race and racism cannot be factored out of the equation as it relates to care. This psychological development imbues the whole operation with key points of interest. Firstly, private insurance ensures high-quality care. Secondly, private insurance provides a status symbol for better care. Thirdly, once private insurance is obtained, equal treatment is a natural outflow of good employment with excellent benefits. Again, while some women were quite adamant about racial issues, the majority believed they received the level of care based on insurance and indirectly, income.

What are the factors that contribute to the socio-cultural challenges related to the maternity care of rural African American women in Leake County, Mississippi?

One of the most frequently presented concerns for this group of women was time conscious care. Many women were responsible for a plethora of other obligations. Long delays in care and insufficient staff became a major concern for the majority of women who participated in this study. Hours “stuck” in waiting rooms, questioning staff about reasons for delay, and dealing with rude and inconsiderate staff due to Medicaid participation are major culprits in their inability to receive satisfactory care. Socio-cultural challenges include the lack of consideration provided to women of color and their many communal responsibilities. Several women commented that they were treated as if they were just another black girl pregnant with the expectation of governmental support. The medical mentality dictated that the women deserved the level of care provided to them. They should take it and be glad that anyone would work to provide the marginal care received by this community of women. Race and ability to acquire good employment could also significantly intensify the challenges in this area.
Cultural Environmental Conditioning

The framework for this study consisted of cultural environmental conditioning. CEC provided a means of extracting the most important issues prevalent in levels of care from personal experiences of this population of rural African-American women. Psychological impairment was a major inhibitor to care. The perception of differential treatment guaranteed dissatisfaction among participants. The imprint of dissatisfaction weighed upon the quality of care. Since the majority of women fell into the Average classification, a small percentage was actually Optimal or Sub-optimal. Average categorization was the most prevalent due to the adjustment women made to navigate the quality of care provided to them by the county. Average is not indicative of satisfaction with care, but rather illustrates the ability of women in this rural environment to adjust in order to survive. Culturally speaking, survival is a necessity for African Americans. As a community, bigotry has been a long acknowledged point of contention. The adaptability of the women complements the framework as it lends competence to the culturally specific modes of engagement most distinguished in this rural group of African-American women.

Sub-Optimal ranking as a group was very small. Several women provided insight into this stage of disengagement around reproductive services. While this was a prevalent means of providing insight, women even in this group, made prenatal care a priority in spite of long lines, inconsiderate staff, outside responsibilities, and work. None of those most noted reasons prevented them from accessing care. Members of this group were most noticeable because of their general disengagement from power. They did not leave
an environment they classified as problematic. Instead, they remained, received care, and moved on or out of services.

Previous research provided a means of explanation for the type of care most received by African Americans. Past discriminatory practices as well as epic or intergenerational knowledge of medical and social disparities, create a virulent environment for care. Yet, very few women sought to understand how the residual impact of differential treatment manifests today. When a young rural African-American woman enters a medical institution, more than just her current state is in question. Many times, a history predetermines the experience both she and the healthcare attendants employ. To understand how a person comes into any socially framed institution, the provider of care and services must be informed and properly educated. Humanities and medical sciences should forge a partnership to ensure every person is provided considerate, culturally competent, and time conscious care.

Recommendations for Future Research

One means of assisting both humanities and medical sciences in ameliorating the racialized care so explicitly stated throughout this study, would be to employ a multi-disciplinary system of medical engagement. Doctors or other medical staff could be educated and trained to accurately pay attention to patients. Culturally specific courses could also be created in medical schools that would prepare physicians for work in diverse communities. Prior to this research, studies have proven that language specific care and inclusive immigrant education assists doctors in providing satisfactory care. However, African Americans in general, and specifically, rural African Americans, are
not considered a special group which demands a culturally distinctive approach to care. African Americans are the only group of Americans with a history so profoundly linked to legal and social discrimination. Humanities, as a field, could create a system of care that would eliminate some of the historical issues prevalent in current healthcare.

Implementing QUILT CARE MODEL

Healthcare providers once they are made aware of the alienation some African-American women feel when accessing reproductive healthcare could become more aware of ways to alleviate the issues prevalent within this marginalized community of women. Environment is very important to development and progress. To begin with, staff could be trained to become more responsive to the needs of each particular community. Given the history of African-Americans struggles with accessing equality, a different approach would serve the provider community with outreach programs and services.

Outreach fosters a sense of community involvement. Churches, organizations and educational facilities could work as beneficial liaisons between both communities. Schools could develop programs that will inform students about the importance of reproductive healthcare, prior to pregnancies. A healthy start is paramount to a healthy gestation and birth. The younger this process is emphasized, the better for the overall community and medical institutions. Churches as community centers have proven invaluable in assisting people with empowerment. The church community remains an essential force within the rural African-American community. Services geared toward health awareness, improvement and empowerment will also be beneficial to both
receiver communities, by minimizing the perceived mistrust that continues to trouble any true and lasting progress.

Receiver communities must also take the lead if they desire to become true partners in their healthcare needs and assessments. Through the community liaison programs, a more open dialogue could be nurtured and respected. Communication within both communities is another very important aspect of care. Receiver communities can become more vocal about issues surrounding care. An organic development of receiver question and answer sessions could alleviate some of the fear and apprehension experienced by some persons in this community. Instead of assuming that all is well, each participant will have an opportunity to work for the level of care deemed important by involvement. No longer can respective communities only voice discontent without feeling ownership of the process.

Each area mentioned is abundant ground for brokering broader understanding and acceptance of minority communities. Quality care translates to mean not only highly trained medical personnel, but a well-educated and engaged community. That reflects the other components of this model. Unbiased care is central to overall improvement of services. Receiver communities must feel certain that they are provided the best care available, regardless of race, social economic status, or gender. Informative medical staff will ease concerns of some patients. An open and inviting environment fosters honest communication instead of deepening an already vast language and attitude disparity. Life affirming, which includes a more hands on approach for both communities, would work to enhance satisfaction with services. By emphasizing the importance of self-care, women could become empowered around their own reproductive healthcare needs. Time-
*conscious Treatment* would re-enforce the value placed on patients and their responsibilities. Not over scheduling visits and creating a system that would be considerate of the participants/patients time, would certainly raise the level of satisfaction for this receiver community. *Culturally Competent Care* is much more than simply language considerations. To truly be cognizant of others culture, the providers must be willing to truly listen to what recipients' are saying. If there are a plethora of missed appointments, the culprit could be a lack of transportation or baby sitters. The medical community must become more knowledgeable of possible barriers to care for each community. *Attentive*, encompasses a willingness from both communities to work toward an agreed upon communal goal. *Reformative* care involves dismantling preconceived notions and working toward a new agenda of care. *Education* is vital for both communities, ensuring the development of a community based system of care. One service could involve outreach and adequate communication.

The proposed model would work to remove some of the barriers to care highlighted within this research. Community involvement and assistance can only enhance levels of reproductive care for this community. The more involved both communities become, the better the services. Citizen organizations for medical care could organize and provide grassroots outreach for patients accessing care. A system of rating communal satisfaction with medical institutions and doctors could also prove beneficial to both communities, creating a better system of reproductive healthcare for all.
Conclusion

The women in this study were adamant in their demand for equal treatment. The unsavory historical residual impact, associated with generations of differential treatment produces untold anxiety in the minds of this marginalized population of women. If medical institutions were open to understanding the conditioning or cultural psychology of this group of women, a decrease in infant and maternal mortality could be the productive end results of incorporating the key components mentioned in this study and model. The previous model advocates a greater emphasis on patient satisfaction. In order to increase the level of care, medical staff and institutions must become aware of the culturally linked and problematic stories intergenerationally transmitted about healthcare. This is the area for reformation. Rural reproductive healthcare can be transformed through proper education for both the provider and receiver community.

Cultural Environmental Conditioning Theory, and QUILT CARE Model, invites a different perspective to negotiate reproductive healthcare. CEC was instrumental in creating an implementable model, which would help to ensure, more people are partners in their healthcare. Both communities must re-think past policies of reproductive health relations. Women are capable of assisting in their reproductive health care experiences. The medical community would benefit from a different, more humanistic approach to care across the board. CEC highlights the needs of rural African American women in Leake County, Mississippi. A culturally specific model of care is appropriate and could benefit other marginalized communities.
The most important characteristic of this study resides with the invitation of a maligned community to partner with their reproductive healthcare. The voices of these rural African American women encourage a diverse approach to reproductive healthcare. As mentioned previously, no one enjoys feeling insignificant in any situation. To have inaccessible reproductive healthcare is unacceptable to everyone, especially rural African American women.
BIBLIOGRAPHY

BOOKS


**JOURNALS**


Beverly, Claudia J, Robin Mcatee, Jane Costello, Ronni Chernoff, and Jane Costeil, “Needs Assessment of Rural Communities: A Focus on Older Adults,” *Journal of Community Health* 30, no. 3 (2005): 197-205.


**WEBSITES**


U.S. Census Bureau

http://factfinder.census.gov/serlet/OTTable?_bm=y&-geo_id=01000US&-
gr_name=DEC...

National Rural Health Organization

http://www.nrharural.org/about/sub/different.html...

NEWSPAPER

(accessed April 28, 2008)

MAGAZINES
