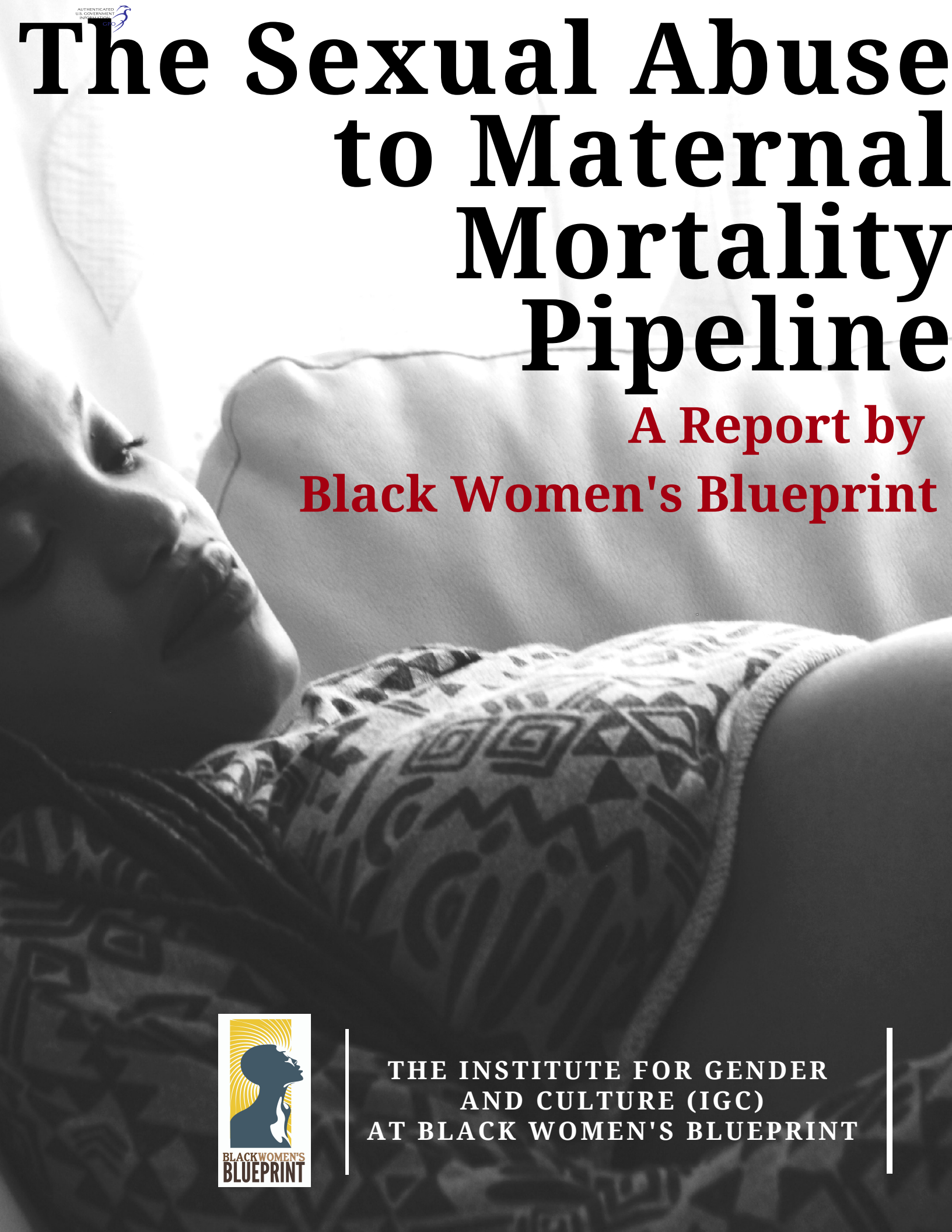
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# The Sexual Abuse to Maternal Mortality Pipeline

## A Report by Black Women's Blueprint



THE INSTITUTE FOR GENDER AND CULTURE (IGC) AT BLACK WOMEN'S BLUEPRINT

# The Sexual Abuse to Maternal Mortality Pipeline: Unifying Sexual Assault and Reproductive Justice Advocates


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# About Black Women's Blueprint

Black Women's Blueprint is an organization that uses civil and human rights approaches to organize and develop a culture where women of African descent are fully empowered and where gender, race and other disparities are erased. For nearly a decade, the work of Black Women's Blueprint has focused on sexual violence prevention, training, advocacy, and healing justice in partnership with sexual assault survivors across a variety of identities. Since its launch, Black Women's Blueprint has focused on critical interventions across African diasporic communities of the U.S. and abroad. Black Women's Blueprint is the convener of the first Black Women's Truth and Reconciliation Commission on Sexual Violence to occur in the United States. The human rights policy advocacy by Black Women's Blueprint has focused on the United Nations and the Committee on the Elimination of Racial Discrimination (CERD), The Committee on the Convention Against Torture (CAT), and localized efforts to implement the UN Convention on the Elimination of Discrimination Against Women (CEDAW). As part of a national task force on gender-violence and a think tank to end racism and racial capitalism, the organization engages legislators, other advocacy networks, feminist and human rights entities in order to center the needs of Black women and girls. Our flagship initiative, the Institute for Gender and Culture (IGC), is a critical intervention in the anti-violence movement.

The IGC delivers prevention education and intervention curricula based on an understanding of the complex interplay between the individual, relational, social, cultural, environmental, historical and persistent systemic factors that influence the spectrum of discrimination, oppression, and violence that impact people's lives. Using proven effective pedagogy and methodologies, the IGC works to equip organizations and institutions with a framework for the development of strategies that directly address civil and human rights measures, offers anti-oppression analysis and key points for intervention.

BLACKWOMEN'S BLUEPRINT

# The Institute for Gender & Culture at Black Womens' Blueprint

**TRAINING**

Using culturally specific pedagogy, methodology and applying transnational liberatory models, the Institute For Gender and Culture at Black Women's Blueprint bridges together gender justice, culturally competent, in-depth intersectional analysis and expertise to communities. Whether one is new to the social justice, social responsibility, philanthropy fields or is a veteran of advocacy, IGC participants gain opportunities to engage in learning exchanges, seminars, workshops, webinars, podcasts and teach-ins that address difficult issues related to gender, race and equity, violence and hate crimes. Workshops are trauma informed and aligned with current and emergent strategies, debates and innovations.

**INTERVENTION**

We specialize in liberatory intervention models that are transformative and restorative. We teach asset-based institutional and community accountability models. Using current research and proven effective strategies, the Institute works to equip people, groups and organizations with a framework for developing interventions across key points of individual and cultural layers.

**PREVENTION**

Recognizing that few resources exist that are responsive to all genders, that are culturally competent and that focus on preventing violence before it occurs, the IGC delivers prevention education curricula based on an understanding of the complex interplay between the individual, relational, social, cultural, environmental, historical and persistent structural factors that influence the spectrum of discrimination, oppression and violence that impact people's lives.

# Executive Summary

The national sexual assault, reproductive health and maternal mortality crises in the United States are interlinked. This demands that gender-violence prevention and reproductive justice fields work together to prevent victimization or retraumatization in women's healthcare settings, which fall short of an integrated approach. All the while survivors of color, whether subject to ever more visible sexual harassment and abuse, the shutdown of women's health clinics in rural areas and/or the increase in maternal deaths, continue to be left out of local and state strategies for recourse.

There are over 32,000 pregnancies resulting from rape each year in the United States according to the Bureau of Justice Statistics. (1) Furthermore a survey completed by Black Women's Blueprint as part of the Truth and Reconciliation Commission on Sexual Assault, found that close to seventy percent of Black girls surveyed experienced sexual violence before reaching their 18th birthday. (2) A local doula services agency—among a growing number of doula services who find it imperative to inquire into pregnant women's sexual abuse history—reported that almost 20% (50 of 275) of pregnant women served, report having experienced some form of sexual abuse across their lifespan. (3) Women in labor and women in their childbearing years also report a variety of retraumatizing experiences in obstetrics and gynecological settings that exacerbate pre-existing post-traumatic stress from past sexual abuse. (4)

Sexual violence survivors report lasting impact throughout their reproductive life-span and where maternal health is concerned, the long-term effects of trauma experienced by women is directly proportional to the lack of gender-responsive care and intervention. (5) Yet, as Penny Simkin's book "When Survivors Give Birth" documents by drawing on case studies to surface the challenges between clients and caregivers, the lack of attention drawn to sexual trauma and the lack of trauma-informed care for pregnant and laboring women is pervasive. (6)

To date, there are few local efforts to address what has been coined as the “Sexual Abuse to Maternal Mortality Pipeline:" the trajectory of individuals engaged in women's health across the spectrum of one's reproductive lifespan in which sexual abuse impacts maternal health and one's physical health more broadly. Even where some fragmented efforts are emerging, there is a dearth of research on the impact of sexual abuse on women’s long-term reproductive health and morbidity outcomes. Consequently, sexual assault and reproductive justice advocates do not yet have the appropriate framework, models and tools to address sexualized violence in reproductive healthcare. We lack the adequate strategies for gender-responsive interventions to prevent what survivors of color have reported as “negative sexualized experiences” in women-and-maternal healthcare.

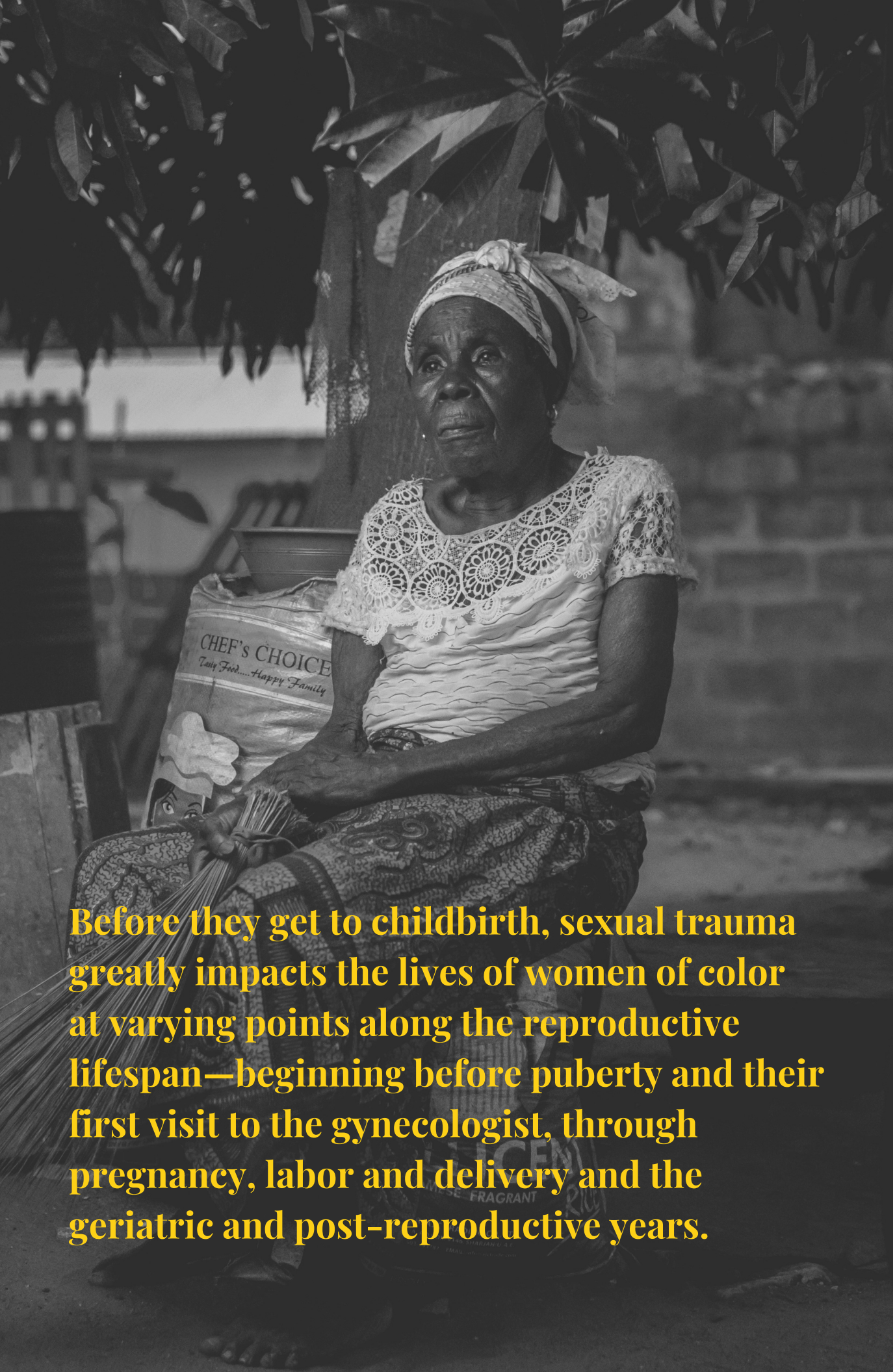
This report offers a comprehensive examination of the “Sexual Abuse to Maternal Mortality Pipeline” and its markers. These include factors such as sexual abuse, to unaddressed trauma, to superimposed social/structural stressors like racism and sexism, retraumatization within OBGYN experiences, distrust and avoidance of health care professionals, obstetrics violence and finally, maternal mortality. It will also:

- Lay out recommendations for research to determine how pervasive this issue may be in maternal health and gynecological service settings across the nation;
- Expose the ways in which we neglect the sexual trauma histories — especially of Black women — who receive OB/GYN services and/or are at risk for pregnancy complications and maternal morbidity; and
- Offers policy recommendations to dismantle the-abuse-to-maternal-mortality-pipeline.

Further, the report also provides a qualitative examination of the sexual abuse to maternal mortality pipeline through the lived experiences of Black mothers. Examples include, pregnant women who do not seek gynecological and prenatal care due to childhood trauma of abuse, rape and incest, pregnant women who report experiences of virginity testing as girls with vaginal penetration practiced with parental consent by OB/GYN professionals, and stories of young women and girls who experience non-consensual vaginal exams, non-consensual pelvic exams, or who report what they experience as “obstetrics violence.”

This report includes incidents reported by women who disclose non-consensual gynecological procedures, violation and stressors during labor, like “disrespect and abuse” and sexualized language used in communicating with young women who won’t open their legs or refuse to push during labor. (7)

By illuminating both the problem and potential solutions, we hope to take the first step toward addressing the pattern of sexual-abuse-to-negative-maternal-outcomes for marginalized women. The link between race and maternal health outcomes has been repeatedly identified in government reports by state and local entities, such as the New York State Task Force on Maternal Mortality and Disparate Racial Outcomes 2019 report. We hope this report deepens the understanding of the healthcare community, sexual assault prevention and reproductive justice advocates, of the gendered nature of the race discrimination many women of color suffer and how to break the larger pervasive and toxic cycle in which specific incidents manifest. (8)




**Before they get to childbirth, sexual trauma greatly impacts the lives of women of color at varying points along the reproductive lifespan—beginning before puberty and their first visit to the gynecologist, through pregnancy, labor and delivery and the geriatric and post-reproductive years.**

# THE SEXUAL ABUSE TO MATERNAL MORTALITY PIPELINE



AN INSTITUTE TO UNIFY SEXUAL ASSAULT AND REPRODUCTIVE JUSTICE ADVOCATES

NYC July 25-26, 2019
Long Island University

ATL August 1 - 2, 2019
Loudermilk Conference Center

D.C. August 7, 2019 (CLOSED: Invitation Only)
Black Women's Health Imperative

AL August 9, 2019
The Alabama Coalition Against Sexual Assault

To register head to www.BlackWomensBlueprint.org



# THE CURRENT STATE OF AFFAIRS

# THE CURRENT STATE OF AFFAIRS

## BLACK AND NATIVE WOMEN ARE DYING IN CHILDBIRTH

**According to the World Health Organization (WHO) "Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth", and "between 6 and 9 million more experience serious complications." (9)**

The CDC reports that in the U.S., the risk of pregnancy-related deaths for Black women is 3 to 4 times higher than those of white women, and Native American women are 4.5 times more likely to die from pregnancy and childbirth related causes than non-Hispanic white mothers. (10)

Several reports point to racial disparities as one of the causes for maternal mortality for Black and Native women. In New York City where over the past decade there has been a 60 percent increase in maternal mortality, (11) a 2018 City Council Women's Committee Report addressed the issue of maternal mortality.

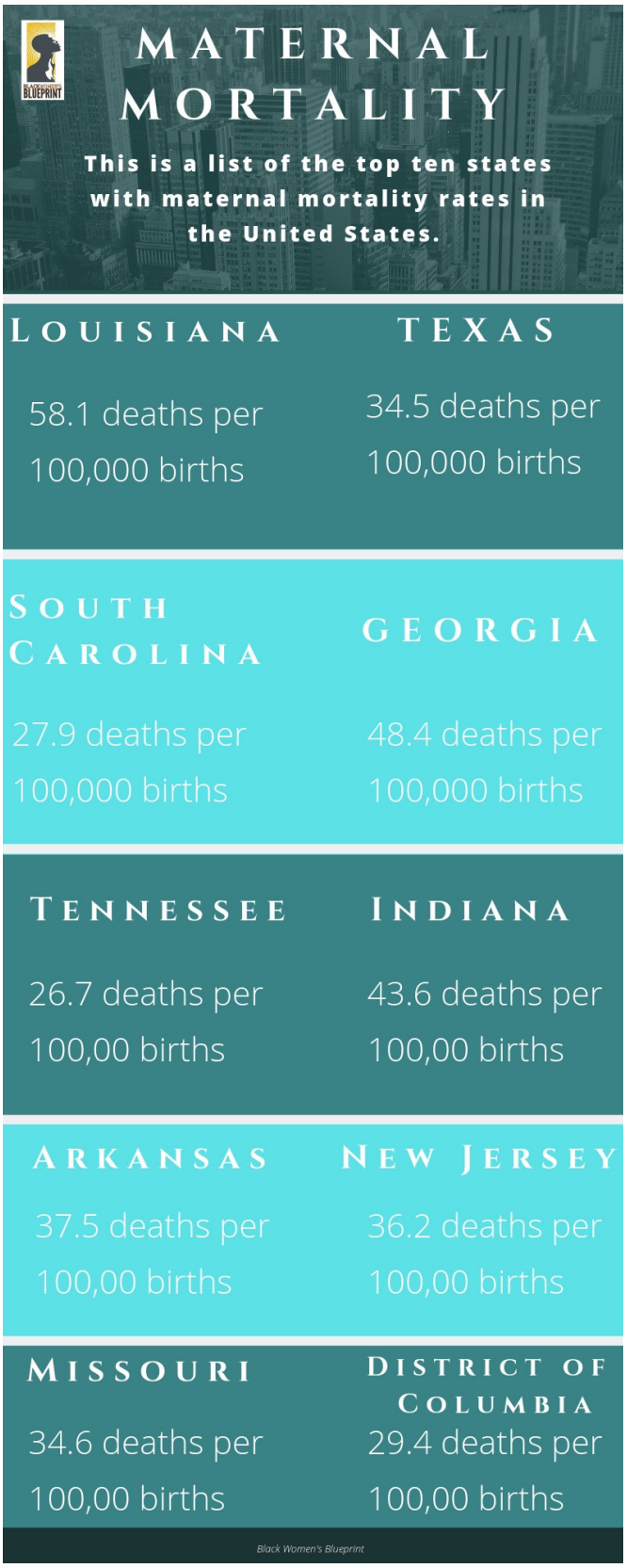
In their Report to Council Member Helen Rosenthal, the Committee recommended special attention be paid to racial oppression as a structural barrier to women accessing women's health and OB/GYN services. (12)



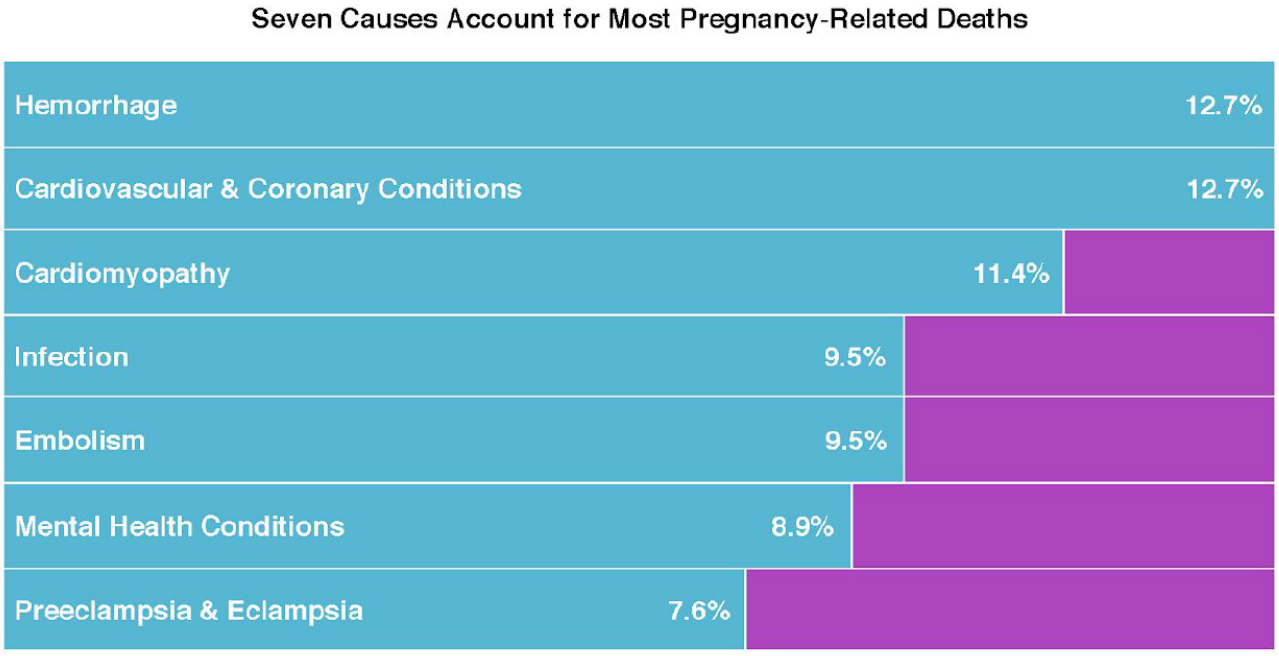
More recently, in March 2019, the New York State Task Force on Maternal Mortality and Disparate Racial Outcomes highlighted the impact of race and poverty on maternal outcomes in a Report submitted to Governor Cuomo's office. (13) Again, the report reveals racial disparities as a primary barrier to access to healthcare, and demonstrates correlation to maternal mortality.

The NYS report also highlights the issue of “reproductive coercion”, and the staggering statistics on the ways women of color are disproportionately impacted by maternal death, and addresses critical factors to reduce maternal mortality. (14)

At the national level, Southern states represent almost half of the top ten states that rank highest in maternal mortality. A 2019 USA Today Investigative Report entitled, "Hospitals Know How to Protect Mothers, They Just Aren’t Doing It," (15) breaks down a state-by-state ranking of maternal harms and deaths. In Louisiana, the state with the highest maternal death rate, there were 58.1 deaths per 100,000 births. The next highest, Georgia had 48.4 maternal deaths and Indiana, 43.6 maternal deaths per 100,000 births. The report identifies the 10 states with the highest maternal death rate as: 1. Louisiana, 2. Georgia, 3. Indiana, 4. Arkansas, 5. New Jersey, 6. Missouri, 7. Texas, 8. District of Columbia, 9. South Carolina, and 10. Tennessee.



# WHY WOMEN ARE DYING IN CHILDBIRTH: "WEATHERING" IN ADDITION TO PHYSIOLOGICAL CAUSES IS PROVING DEADLY FOR WOMEN OF COLOR




*Source: "Report from Maternal Mortality Review Committee: A View Into Their Critical Role," February 2017*

Maternal Mortality Review Committees, which can now be found in 36 states, have determined several physiological factors as causes for the high rates of pregnancy complications and maternal deaths among women of color and ranked the seven main causes as: hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infections, embolism, mental health conditions, preeclampsia and eclampsia. Women in behavior sciences in particular, have linked the seven causes identified by the Maternal Mortality Review Committee directly to Arline Geronimus' theory of "weathering," which is defined as the "toxic stress resulting from racism, bias and discrimination." (16)

There are four main hormones released which regulate the body's response to stress: Catecholamines, Cortisol, Opiates, and Oxytocin. Catecholamines particularly govern our fight and flight response, and cortisol is responsible for the regulation of energy available for fight or flight reactions. When exposed to constant, long-term or chronic stress, like racism, police brutality, community violence, or when witnessing racial harassment and discrimination, these hormones are released in excessive amounts, creating psychological and physiological wear and tear over years.

In connecting “weathering” to mortality, experts point to unabated stress. The body is resilient in the face of more ordinary and intermittent daily stress that can take the form work deadlines, traffic, waiting in line for coffee, with minimal harm from physiological reactions to those experiences. However, exposure to racism and race discrimination represent persistent threats to which the body is consistently exposed and culminates into “unabated stress.” In reaction, the body develops complex, adaptive responses.

“Weathering” illuminates the impact of racism as a more pervasive form of stress requiring a more complicated understanding of the ways in which systems of oppression impact women’s health. Weathering stems from a complex web of social and cultural relations and anxieties that influence stress levels, a consequence of the lived experience of black women” in America.

Geronimus’ seminal research found that “the stresses associated with living in a race-conscious society may lead to early health deterioration in Black women through a complex mechanism that includes telomere shortening” and that the bodies of people of color, especially Black women, age prematurely because of this lived experience. (17)

The psychological and physiological exposure and accumulation of the impact of racism, create a "perfect storm” of toxic stress that leads to health problems.

Rich-Edwards and colleagues’ work laid the foundation for understanding the physiological impact of racism and systems of oppression on the body.

Long term exposure to constant threat reduces the body’s ability to maintain homeostasis. Rich-Edwards and colleagues hypothesized that a woman’s long-term exposure to racism creates an accumulation of both psychological and physiological stress on the allostatic system, stating:
“The price of this accommodation to stress can be allostatic load, which is the wear-and-tear from chronic overactivity or underactivity of the allostatic system.

We theorize that frequent stress, whether it be concurrent, feared, or remembered, increases allostatic load. Thus, we propose that a woman’s chronic exposure to racism or violence creates an allostatic load that imprints itself upon her HPA axis prior to conception, altering the endocrine milieu in which the placenta is established, and potentially changing the hormonal interaction between fetus, placenta and mother." (18) The environmental stress within the U.S due to racism and violence, contributes to negative maternal health outcomes for women of color, particularly Black and Indigenous women.

**Weathering as it relates to Women in Criminal Justice Systems: Survivors, Gynecological Access, and Obstetrics**

The issue of weathering as it pertains to Black women is multi-generational and the current implications of the historical context cannot be denied. For Black women in the United States specifically, fully accounting for the ways in which their experiences of sexual assault, constitute an act of torture requires understanding the historical context and institutional legacy of slavery and the contemporary burden placed on victims of the criminal justice system.

Black women were subjected to sex-specific violations such as rape, forced pregnancies, and other gender-based violations. As women, they were subjected to chattel slavery and were therefore reduced to being viewed, treated, and consumed as property, and not as human beings. (19) As bodies to produce other enslaved bodies, as flesh to satisfy their slave master's desires, as slaves to be worked as needed, and as property to be sold at will, Black women were deemed not able to be raped. Slave owners and other white colonialists justified this torture and inhuman treatment of Black women through stereotypes and pseudo-scientific justifications of their degraded moral capacity, lascivious behavior, and animal-like capacity for sex. (20)

While legal slavery has ended, the rape and sexual torture of Black women and the justification for this torture still continue. Within the current carceral system, women still are subject to sexual abuse, coercion and exploitation. In 2013, Amnesty International USA reported on what they describe as "shocking levels" of sexual abuse in prisons – highlighting the sexual assault and coercion by corrections officers for sex in lieu of punishments for minor infractions and protection against inmate assault. (21)

Further, in 2014, the National Commission on Correctional Health Care reported women are not provided gynecological exams upon entry into the prison, and yearly exams are not guaranteed for every female inmate -even with a history of illness or miscarriage. Most prisons do not have adequate health care providers to offer consistent support to women within their walls. (22)

“I was insulted when I was in the delivery room in 1973, there was leather straps in the delivery room. The leather straps were to hold a woman down while giving birth"

- (excerpt from survivor story)



Incarcerated women continue to experience severe trauma during labor and delivery as the state shackling laws across the country are habitually, and widely ignored by municipal police departments and correctional facilities. As recent as 2018, a Bronx woman filed an anonymous lawsuit against the New York City Police Department claiming civil rights violations as a result of being shackled to her delivery room bed while giving birth to her child in Montefiore Medical Center, New York City in February of the same year. Despite the fierce insistence of the doctors to release the woman, and the existence of a no shackling law in New York State, the woman reports being shackled for hours while laboring only to be partially released – her right arm still restrained making her incapable of fully holding her newborn. (23)

More broadly, incarcerated women, pregnant women in detention, and justice-involved populations at the intersection of the healthcare system are in dire need of dignity protections and integrated holistic support services.



# EXPANDING THE FRAME

# EXPANDING THE FRAME

## WEATHERING MEANS ALSO EXAMINING THE TOXIC STRESS RESULTING FROM SEXISM, GENDER BIAS AND DISCRIMINATION

The research on weathering must be expanded to include toxic stress resulting from lifelong experiences—from cradle to grave—with patriarchal systems, sexism, gender-bias, gender-violence and discrimination based on LGBTQ and additional expressed gender-identities as well as sexualities, especially as they intersect with race creating new forms of unabated stress. Very early in life, people categorized at birth as women and girls around the world, learn through their families, hospitals schools and other institutions, cultural practices, traditions, through paid and unpaid work and through media that the world considers them “inferior”, that they are not only “unequal” but also as “vulnerable.” As children, because of their perceived sex and gender, girls are culturally and socially categorized as the "weaker sex," and their bodies, physical activities and behaviors restricted and controlled. For girls, especially girls of color, an awareness and persistent vigilance about the disproportionate potential for danger or death at the hands of strangers, acquaintances and loved-ones is required. Global inequality, gender-violence, including sex-trafficking, sexual abuse, sexual harassment, street harassment, disproportionately affects girls, including gender fluid and trans identified children and youth. Moreover, the domination and constant threat of violation under which women and girls, across sexualities, live, is likely to also cause what has been defined as “weathering.”

# BETTY'S STORY

Women's health, maternal health fields and institutions are not immune to the patriarchy, sexism and misogyny which pervades our society.

Survivors, girls and young women, gender non-conforming and trans identified persons, in addition to racism, also contend daily with the culture of shaming, silence, violence, hypersexualization, erasure and minimization which continues to sustain patriarchal culture. Gender oppression, gender-role control and gender identity suppression are often experienced with frequent regularity, both in private and public spheres, these are not limited to but include healthcare settings.

Such experiences at relatively young ages with healthcare providers, who are often considered purveyors of truth and knowledge inform many survivors' relationships with their physicians and OBGYNs, distance them from their own bodies and renders routine bodily functions abnormal in their view.

I remember going to the doctor as a girl of 11 or 12. I recently started menstruating so the doctor began talking to me about the changes my body would begin to experience now that I was a "woman". She talked to me about my breasts, telling me now I needed to wear a camisole, and I had to get a "good bra" to keep my "nipples from sticking out" through my clothes. She pointed out that I would need to start watching my weight now and that I should avoid eating chocolate. She also talked to me about getting my period and that I needed to be "watchful" so that I would "not get caught out in public unaware" when my period came because my "period would be embarrassing." She said to me "imagine walking all the way home leaving a trail blood and how terrible it would be; or worse, bleeding all over the seat of the train. Don't ever let that happen to you." She also talked to me about how I would have vaginal discharge and that I needed to keep my "vagina clean to avoid smelling." I left the doctor's office that day clutching several sanitary pads and the knowledge that my vagina was something that would bleed and cause me shame and that it would smell, and it needed to be cleaned constantly.

# LINKING GENDER BIAS TO WOMEN'S SURVIVAL IN LABOR AND DELIVERY

## PATRICIA'S STORY

"When I was laying there, I had requested a full tubal ligation which is a cut, tie, and burn. I had requested the full ligation and when I went to sign for the ligation the doctor who was a woman stopped and said to me: "I was 45 before I wanted more kids..." At the time I myself was only 28 and I said: 'I don't want more kids. I already had one and now I was going to have three' (I was having twins). Then the doctor said 'don't make a decision you will regret later." She had that look of disagreement like she disagreed. After delivery, several doctors said "wow you carried these twins to full term you have the perfect body to have more" as if to say I should have more children because I didn't have the usual complications women have when carrying twins."



In Patricia's experience, a doctor coercing Patricia to not go forward with a medical procedure to prevent pregnancy communicates disapproval and disappointment from an authority through statements and gestures. Referencing Patricia's ability to bear children as her physical purpose also reduces and challenges Patricia's sense of control over her body and medical decisions, as well as her inherent value.

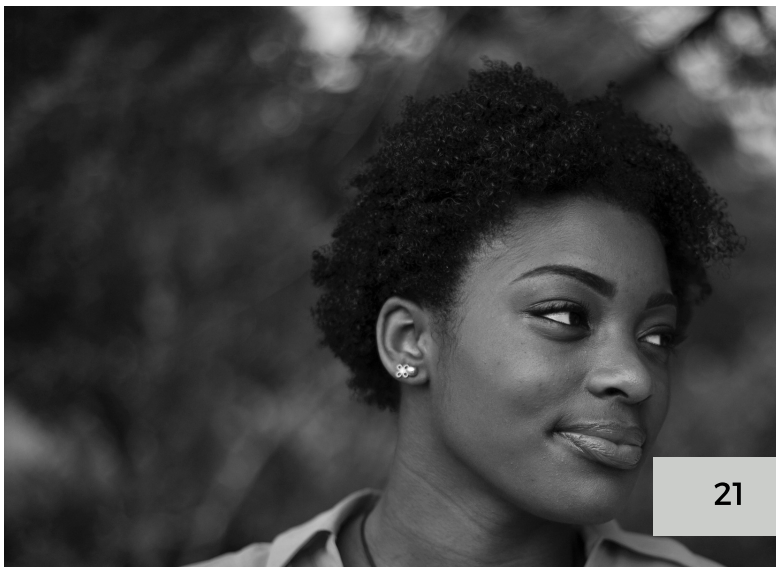
We need a robust and comprehensive understanding of women of color's unique reproductive and full-spectrum health outcomes: examining racism, socio-economic status or educational status without including gender discrimination is an obvious blind spot. The brutalization and control of Black and Brown women's bodies in the U.S. has its roots in racism and white supremacy. (24) However, ample evidence demonstrates that gender discrimination and sexualized violence, practices within patriarchal medical institutions and sexist systems which historically have trivialized and denigrated female bodies, and its reproductive functions, have for centuries contributed to fatality. For example, a large body of medical research suggests that women are less likely than men to survive traumatic health episodes like acute myocardial infractions. (25) The gender disparity in survival rate is triple for women who saw a male doctor compared with those who saw a female doctor. (26) We have no reason to believe that other medical arenas, such as maternal health, are exempt from the gender dynamics leading to disparities overall.

Women continue to share their experiences with medical professionals, frequently male doctors, who are dismissive, minimizing of their physical pain. These medical professionals often don't take them seriously and are misdiagnosing them as a result of gender bias. (27) Women doctors are far from exempt from engaging in patriarchal practices and strategies.

# MARIE'S STORY

***I won't do it: you have a man who might become your husband, and he might want his own children with you someday."***

Marie, 25-years old, survivor of human trafficking over the course of ten-years, and of domestic violence, with seven children in the New York City foster-care system, illustrates how doctors can perpetuate reproductive coercion. In her planning for the labor and delivery of her last child a few years ago, Marie told her doctor "tie my tubes" post-delivery. To this, he responded, "I won't do it; you have a man who might become your husband, and he might want his own children with you someday."



The Journal for High Acuity, Progressive and Critical Care Nursing, in an article published in 2012 asked several critical questions in its report on Gender Bias in Critical Care: “What if some aspects of health care services are tilted to favor one segment of the population while disfavoring another? What if that tilt left virtually half of the adult population—adult women—in the disfavored category?” (28) The same article asserts that inequality can lead to comparatively worse outcomes for women, marked by higher complication rates, higher morbidity, and higher mortality.



**The impact of gender-bias in medical care drives home the need for responses that address patriarchal practices, including gender-disparities, gender-discrimination and the neglect of women's lived-experiences. Women's gendered experience and their reports of insult and bias support the need to advocate for more attentive and comprehensive interventions, especially in assessing sexual assault. The presence of experts who work with sexual trauma and prevention is rare found in women's healthcare settings like gynecology, obstetrics and maternal care centers. These reports also point to the need for involvement by the reproductive justice field in collaborations with sexual assault advocates, in order to make survivor-centered and gender-responsive evaluations and services the standard.**

# THE ROLE OF SEXUAL VIOLENCE AND ABUSE

Women of color are disproportionately victims of sexual violence and the lasting physical and emotional trauma produced by such violence. Sexual assault is any unwanted physical contact of a sexual nature that occurs without consent from individuals or under threat or coercion. Whether by an acquaintance or by a stranger, sexual assault can occur either forcibly and/or against a person's will, or when a person is incapable of giving consent. In some states, by law sexual assault includes rape (sexual intercourse without the consent of both parties), forcible sodomy, forcible oral copulation, sexual assault with an object, sexual battery, forcible fondling (e.g., unwanted touching or kissing for purposes of sexual gratification), or threat of sexual assault, etc. In some states, a person is legally incapable of giving consent if the person is under 18 years of age and sexual assault against such a person is child sexual abuse or statutory rape. A person is unable to give consent if they are intoxicated by drugs and/or alcohol, developmentally disabled, or mentally or physically unable to give consent in any way. The spectrum of sexual violence involves considerably more experiences than what is reflected in the figure below.

**Sexual Violence Disproportionately Impacts Black and Native Women –The Same Population Experiencing Higher Maternal Mortality**

A U.S. Department of Justice, National Institute of Justice report published in May 2016 shows that of over 2,000 women surveyed, 84 percent of Native American and Alaskan Native women have experienced violence and 56 percent have experienced sexual violence.(29) Women of all races are targeted for sexual violence, but some are more targeted than others: 33.5% of multiracial women have been raped, as have 22% of Black women.(30) Young people are especially at risk: nationally, nearly half of all female survivors were raped before they were 18.(31) Moreover, as noted above, there are over 32,000 pregnancies that result from rape each year in the United States, according to the Bureau of Justice Statistics; and seventy-one percent (71%) of trafficking victims report at least one pregnancy while being trafficked, according to one study. Of that seventy-one percent, twenty one (21%) reported five or more pregnancies. (32)

# NEGLECTED DIMENSIONS: THE PHYSICAL AND MENTAL HEALTH IMPACT OF SEXUAL VIOLENCE

**"I had a very traumatic experience. It can be a very difficult. As a survivor I would not want to be re-traumatized and that takes precedence over getting a pap smear." (Excerpt from survivor story)**

The CDC-Kaiser Permanente conducted a landmark ACE (Adverse Childhood Experiences) study from 1995 to 1997 which supports what sexual assault advocates and psychiatrists have been identifying for decades—that "adverse childhood experiences related to sexual trauma are the most basic cause of health risk behaviors, morbidity, disability, mortality, and healthcare costs." (33)

More recent studies by the CDC led by researcher Melissa T. Merrick analyzing data from 214,157 adults in 23 states between 2011 and 2014 further affirm the original study while providing deeper insight into the disproportionate number of women, specifically women of color, impacted by the long term health effects of trauma. (34) In the survey, participants who identified as Black, "Hispanic", or multiracial and those identifying as gay/lesbian or bisexual reported significantly higher exposure to adverse childhood experiences than comparison groups.

The negative health impacts of "Adverse Childhood Experience" are broad. For example, according to a study led by researchers at the Harvard T.H. Chan School of Public Health and Columbia University Medical Center, women and girls who experience sexual violence and subsequent symptoms of post-traumatic stress disorder (PTSD) are at greater risk for developing potentially fatal blood clot disorders than women who have not experienced trauma. (35) In this study, researchers confirmed that trauma exposure and PTSD symptoms are associated with Venous Thromboembolism in women. (36)

Research on the long-term effects of sexual violence in the lives of women of color, across the spectrum—child sexual abuse, incest, sexual assault, sex trafficking and sexual coercion, rape—show an increase in occurrences of physical issues like obesity, cancer, high-blood pressure, fibromyalgia, fibroids which are often the cause of hemorrhaging, preterm labor, miscarriages, fetal growth issues, placental abruption, and frequent C-sections. (37) The correlations warrant further evaluation and examination in the field of reproductive healthcare.

# JANINE'S STORY



Janine, a middle class professional Black woman who grew up around mostly African Americans, is now the mother of four children, the last one who she delivered by C-section, lived only two days after birth. She is a survivor of multiple counts and prolonged sexual abuse which started when she was eight years old. At 12 years old, she was raped and sodomized by an older man in the neighborhood. After spending years dodging unwanted sexual advances and sexual harassment from young men in all public spaces, at the age of 26 she settled with a young man who lived across the street. Her marriage to this man--now the father of her children was abusive and included frequent physical and sexual assaults and other violence while she was pregnant. Throughout her life, Janine struggled with various physical ailments, some of which could not be diagnosed in any emergency room. She suffered from obesity, high blood pressure with heart palpitations, high cholesterol, diabetes, constant migraines, fibroids, anxiety, depression, and gastrointestinal problems. She describes the birth of her last child in this way: "I lost so much blood during the birth of my last child, that it was either he died or I died, and I thought I died until I woke up and he was dead; but with every child, with every labor, I have just been made to feel like an animal--at the mercy of whoever is in the room."

*"...but with every child, with every labor, I have just been made to feel like an animal--at the mercy of whoever is in the room."*

Janine's story illuminates and illustrates the psychological and physiological connections and reactions of a body with unaddressed and superimposed trauma as described in Geronimus' theory of weathering. (38) "Near death experiences" as described by survivors of difficult labor and delivery often happen in the labor stage of "transition"--the stage of labor, which survivors report as the most difficult stage, frequently characterized by "crying", "panicked", "trembling" and experiencing what is described as the "ultimate loss of control" and "feeling of being ripped apart from the inside". Survivor stories also detail instances of "blacking out", "passing out" or "loss of consciousness". According to the doula interviews, many holistic practitioners note that this "transition phase of labor" can often feel like "an out of body experience," re-triggering of the out of body experience described by survivors during sexual assault. (39)



# TELLING: KEY FINDINGS FROM THE BLACK WOMEN'S TRUTH AND RECONCILIATION COMMISSION REPORT

Data Chart 1: Is this the first time they (the survivor) is telling someone about their abuse?

| Was this the first time telling someone about their abuse? | Valid % |
|---|---|
| Yes | 30.4% |
| No | 43.2% |
| No Response | 26.4% |

The Black Women's Truth and Reconciliation Commission (BWTRC) was the first of its kind in the nation to focus on rape and sexual assault against Black women in the United States. The BWTRC received over 3,600 disclosures of sexual assault and sexual abuse. The Cornell University School of Industrial and Labor Relations in conjunction with The Yasamin Miller Group worked with Black Women's Blueprint to analyze the qualitative narratives of 128 individuals, representing a sample of the thousands who disclosed they were survivors through the BWTRC. These 128 survivors provided full narratives about the sexual abuse and trauma they experienced. The methods by which the narratives were collected by Black Women's Blueprint allow for anonymity and no information shared with the analysis team allowed the identification of any individual providing data. Through the data which can be found at www.blackwomensblueprint.org, we found the following:

- The survivors ranged in age from 13 to 65 years old with an average age of 40.
- The age at time of first assault ranged from infancy (one year old) to 64 years old, with an average age of 10 years.
- The majority of the survivors are women, with two identifying as transgender.
- The majority of the survivors are African American/Black (87%), 11% are mixed race, and only 2% are white.
- The majority of the survivors were children at the time of their first sexual assault.

Data Chart 2: Who did they tell (about the abuse) OR who knew about it?

| Who did they contact or who knew about the abuse? | Valid % |
|---|---|
| They told no one | **52.8%** |
| Mother | **22%** |
| Other family member | **8.7%** |
| Police | **7.9%** |
| Friend | **7.1%** |
| Other adult person they perceive as a "helper", ex. Teacher, counselor, friends' parents | **5.5%** |
| Father | **4.7%** |
| Hospital/medical workers | **4.7%** |
| Sister/brother | **3.9%** |
| Coworker/supervisor/boss | **3.1%** |
| Lawyer/legal aid | **2.4%** |
| Religious figure/priest, minister, imam, rabbi | **0.8%** |
| Other (please describe) | **0%** |

More than half (52.8%) of respondents we spoke with reported telling no one their abuse. Among those who did disclose their abuse, the majority (22%) reported either telling their mother or that their mother knew about the abuse. It's worth noting that less that one in 10 (7.9%) indicated reporting this information to police and less than 1% reported their abuse to a religious figure.

Data Chart 3: Has the abuse impacted the survivor in a negative way (either now or at some point since the abuse)?

| Impact of abuse | Valid % |
|---|---|
| Impacted their sense of happiness | 58.3% |
| Impacted their self-esteem | 55.7% |
| A fractured sense of self (around race, class, gender, sexuality) | 53.5% |
| Impacted their mental health | 50.4% |
| Become less trustful/don't trust now or since the abuse | 48.0% |
| Become fearful, anxious, kept to self/isolated self | 46.5% |
| Kept it a secret | 37.0% |
| Feel guilt, shame | 26.0% |
| Experience(d) self-doubt, self-blaming, self-loathing | 22.8% |
| Other (please briefly describe) | 13.4% |
| Didn't impact negatively | 3.1% |
| Became depressed/thought of suicide | 2.4% |
| Impacted their physical health | 2.4% |

Respondents we spoke with, reported a myriad of negative impacts associated with their abuse. The majority report that their happiness (58.3%), self-esteem (55.7%), identity or sense of self (53.5%) and mental health (50.4%) had suffered as a result of their abuse. Further, nearly half report becoming less able to trust (48%) and fearful or anxious (46.5%) since their abuse occurred. Nearly one in three (26%) of respondent's report experiencing feelings of guilt or shame; and one in five (22.8%) reported having experiencing self-doubt and self-loathing.

In response, respondents reported engaging in a range of unhealthy coping mechanisms to try and alleviate the pain and avoid the trauma. These behaviors included isolating themselves and leaving work or school, as well as self-medicating with drugs and alcohol, eating and sleeping disorders and risky sexual behavior.

Data Chart 4: Do they feel whole now? Even if it did impact their life in some way – have they regained their sense of self-esteem, sense of happiness, mental health, resumption of normal life routines, taken action to do something for themselves?

| | Do they feel whole now? | Valid % |
|---|---|---|
| | Yes, completely feel whole | 10.10% |
| | Yes, somewhat feel whole | 31.90% |
| | No, still struggling | 57.90% |

Very few survivors we spoke with report feeling recovered from the trauma of their abuse, 9 out of 10 (89.8%) not feeling whole or still struggling. For instance, one survivor stated: “I spent years struggling with what healthy relationships were, it took twenty years before I could say no. My body was so numb I was unaware of what felt good or what was painful.”



# THE BRAIN BODY CONNECTION: THE CYCLICAL RELATIONSHIP BETWEEN THE PHYSICAL AND PSYCHOLOGICAL FOR SURVIVORS

**“The truth about childhood is stored up in our bodies and lives in the depths of our souls. Our intellect can be deceived, our feelings can be numbed and manipulated, our perceptions shamed and confused, our bodies tricked with medication, but our soul never forgets. And because we are one, one whole soul in one body, someday our body will present its bill.”- Alice Miller (40)**

The neurophysiology and biology of trauma triggers lasting effects on the brain and the body. These lasting effects are trauma’s neurophysiological signature. Bessel Van Der Kolk, M.D., in "The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma,” notes that as it relates to the survivors of trauma, “the body keeps the score.” Further, “if memory of trauma is encoded in the viscera, in heartbreaking and gut-wrenching emotions, in autoimmune disorders and skeletal/muscular problems, and if mind/brain/visceral communication is the royal road to emotional regulation, this demands a radical shift in our therapeutic assumptions.” (41)

Immobilization is a factor in most traumas. When that occurs the Dorsal Vagal Complex (DVC) is likely to take over: "[Survivors'] hearts slow down, [their] breathing becomes shallow, and zombielike, [they] lose touch with [themselves and their] surroundings. [Survivors] dissociate, faint and collapse."(42)

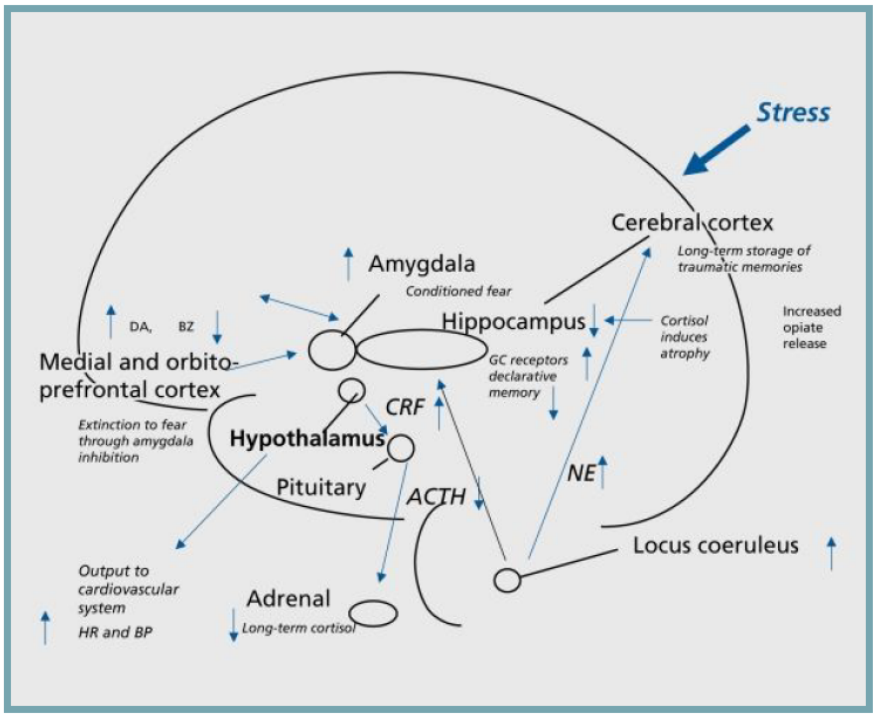
The lasting effects of trauma on the brain shows long-term dysregulation of norepinephrine and cortisol systems, vulnerable areas of hippocampus, amygdala, and medial prefrontal cortex that are affected by trauma. There are four main hormones released which regulate trauma in the body. The primary hormones are: Catecholamines, Cortisol, Opiates, and Oxytocin.

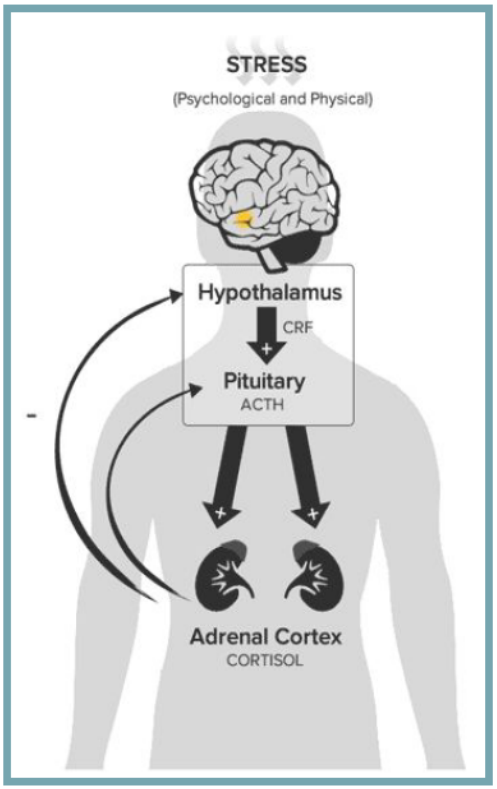
- Catecholamines → fight, flight, or freeze response,
- Cortisol → energy availability and affects the amount of energy the body has available to fight or flee the situation;
- Opiates → Reduces physical pain also known as “Body’s natural morphine;”
- Oxytocin → Reduces emotional pain or the “Feel good hormone” which promotes positive feelings in the body. (43)

For the purpose of this report, we have chosen to focus on the hormone Catecholamines which particularly illuminates the brain-body connection for survivors of sexual trauma. Many people have heard of the fight or flight response, but during a traumatic event there is also a freeze response (another response is appease). The freeze response is a mammalian instinct and it is basically like playing dead which is often the safest response. This freeze response results in tonic immobility (rape induced paralysis) where the survivor cannot move and is rendered immobile by the traumatic event. (44) Survivors of sexual violence experience this rape induced paralysis any time an event replicating the trauma arises or a similar event occurs, triggering the survivor back into the moment of the original violence.

This is what can happen when survivors are in labor and delivery.

**Figures 4 & 5: The Neurobiology of Trauma Illustrated**



# RACHEL'S STORY

In a conversation with her adult daughter about her past experiences of trauma, including the first time she was raped before her thirteenth birthday, Rachel's daughter tried to comfort her mother, encouraging her to seek support and trauma healing counseling. During their talk, the conversation takes a turn as Rachel's memory of the rape begins to surface, then out of nowhere she recalls her daughter's birth story and says: "I've never felt pain like that before", recalling her first experience of childbirth. "The only other time I have felt that level of pain, was when I was being raped."



# SURVIVORS OF SEXUAL VIOLENCE ENTER PREGNANCY WITH TRAUMA SPECIFIC CHRONIC CONDITIONS

Survivors of sexual violence face increased adverse obstetric outcomes especially within marginalized populations. The trauma experienced from sexual assault and abuse has long-lasting effects on women's ability to fully engage with their body's need for medical care. (45)

Women of color are disproportionately victims of sexual violence, including sexual abuse, which are pervasive problems in the United States. According to the American College of Obstetricians and Gynecologists, "sexual violence creates a major effect on public health." (46)

Sexual violence can produce "medical consequences including sexually transmitted infections; mental health conditions, including post-traumatic stress disorder; and risk for unintended pregnancy in survivors of sexual assault who are of reproductive age."(47) Research on the lasting effects of sexual violence found approximately 150 consequences and symptoms in the aftermath of sexual violence. (48) As shown in the COLEVA illustration below, the gynecological effects of trauma are overwhelming.

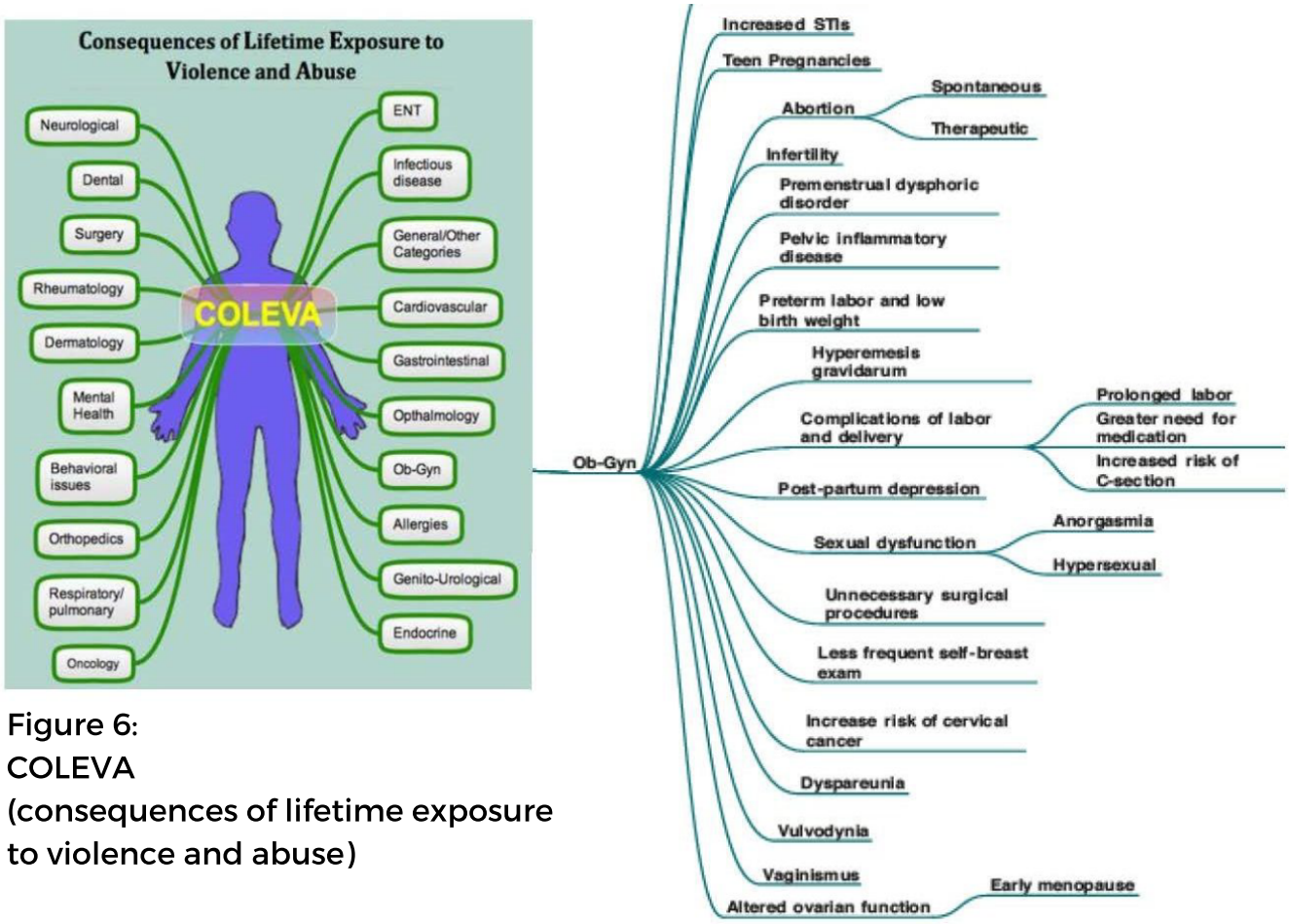



Figure 6:
COLEVA
(consequences of lifetime exposure to violence and abuse)

# THE NEGLECT OF WOMEN'S PAST SEXUAL ABUSE REINFORCES THE MATERNAL MORTALITY PIPELINE

Given the current state of affairs and the intersecting factors which continue to exacerbate conditions for the most vulnerable women and girls in women's healthcare systems, Black Women's Blueprint responded by asking its affiliated sexual assault trauma therapists and counselors as well as doulas and midwives to identify what may be a course for intervention in service of the communities with which we mobilize and the women for whom we care.

In dialogue about and analysis of the challenges faced by survivors, the abuse to maternal mortality pipeline emerged, beginning with:

1. Sexual abuse, and unaddressed trauma both compounded with weathering or the chronic threats superimposed by a continuous accumulation of stress from racism/sexism and other oppression.
2. The combined unaddressed trauma and societal oppression can lead to the avoidance, non-access or delay of gynecological, maternal, and often all health care, all reinforced by dismissive and even callous treatment and abuse within OBGYN and prenatal care settings, re-triggering trauma symptoms; and
3. New incidents of abuse that further traumatizes the survivor like "obstetrics violence" all leading to adverse health outcomes, the most severe of which is maternal mortality.

As noted, Penny Simkin's book "When Survivors Give Birth" surfaces the pervasive lack of knowledge among diverse professionals who should be proficient in survivor-centered and trauma-informed care when engaging survivors, not only in sexual violence but in reproductive justice, reproductive health and maternal health settings. In particular, the lack of adequate data with regards to the adverse maternal outcomes concentrated disproportionately among victims and survivors of sexual violence, continues to perpetuate cycles of trauma for many women of color. (49)

# OLIVIA'S STORY

I had a scheduled labor and delivery due to my being high risk. It was supposed to be a creative, participatory process, and I even had a birth-plan until I went in for a pre-test. Then the Dr. says: “we don’t like that the baby is not moving a lot.” We’re going to have to keep you and induce labor. So I say: “No, I’m not ready. I don’t have my bag, my care plan, nothing, I’m just not prepared.” The doctor then says: “If you leave, you’ll be leaving against medical advice”, and that scared me. They kept me and took me to labor and delivery, and induced labor. The induction failed. They kept me overnight and I was in pain with contractions. In pain, medical students were coming in and out of the room, coming in to see me while I was exposed. Two people were there watching while a man put his hand in my vagina to check my cervix without my consent. When I was 18 years old and a freshman in college I was sexually assaulted. It was a date rape and it was by an older man. When you’re in labor you don’t feel like a human being, you are just a vessel carrying life, especially when in a room with doctors who don’t look like you.

This immediately triggered an anxiety attack. I have a history of anxiety disorder. This was well established. I was supposed to be given valium or ativan as part of my birth plan. My anxiety just kept going up. I said, “I need help”. I have a care plan that specified this. Then the nurse said, “It’s too late. We have to take you in for a C-section.” I became fearful and went from being rational to completely irrational, and I felt like I was going to be murdered. The medical people strapped me down. My legs and my arms were restrained. I blacked out and when I came to, the doctor had completed my C-section, and they were about to stitch me up. When I woke up I remembered the feeling of horror. It is still hard to go back to a maternal ward. No one asked me for consent before touching me. Body Sovereignty is important. They have to do their job and know what issues you are bringing to the table. Your role as a vessel is all you are when you’re in labor. There was already the underlying trauma, and somebody touching me with no consent with others in the room. No one was there. The residents just show up and they are not part of the OB-team. Checking my cervix.



Olivia's story illustrates again, as with Janine's story illustrates the psychological and physiological connections and reactions of a body with unaddressed and superimposed trauma. "Near death experiences" as described by survivors of difficult labor and delivery often happen in the labor stage of "transition" (50)--the stage of labor, which survivors report as the most difficult stage, frequently characterized by the ultimate loss of control. Survivor stories also detail instances of blacking out, passing out or loss of consciousness. According to doula interviews, many holistic practitioners note that this transition phase of labor can often feel like an out of body by experience, re-triggering of the out of body experience described by survivors during sexual assault.

Moreover, what Black Women's Blueprint discovered through doula and survivor testimonies is that the process of "spontaneous bearing down," (51) is a physiological trigger point in which the cervix responds and sends a signal to the brain. (52) For survivors of sexual trauma, this impact can cause a lack of oxygen, hyperventilation, and immense blood loss, leading to fainting, passing out or twilighting. (53) This spontaneous event can be negatively impacted by past cervix injuries or scarring from sexual trauma, and felt at the point where the fetus is fully engaged in the pelvis before the moment of "crowning." (54) Cervical scar tissue can also affect the cervix' ability to dilate, (55) requiring medical provider to go into the vagina to push-back the rim of the cervix. This intervention can cause high levels of anxiety and retraumatization.

# OBSTETRIC VIOLENCE

## KATRINA'S STORY



When Katrina was 10 centimeters dilated at the hospital, her doula was aware that she was a survivor of sexual violence and that she had been administered an epidural. While the nurses and doctors declared her to be performing “insufficient pushing,” her doula had broad knowledge in understanding survivor response to labor. Some of Katrina’s responses included: becoming disengaged from the birth experience; disconnection and disassociation; demonstrating anxiety and increased hysteria and wailing through her birth process. The nurses became frustrated and impatient with her and on either side of her mouthed something and coordinated with one another and proceeded to grab her by her feet (one nurse on either side of her) and hyperflex her legs back while she was pushing. As the nurses held back her thighs and pushed back on her feet, Katrina trembled from the waist down with difficulty controlling her legs due to the epidural.

*"...doctors declared her to be performing “insufficient pushing,” her doula had broad knowledge in understanding survivor response to labor."*

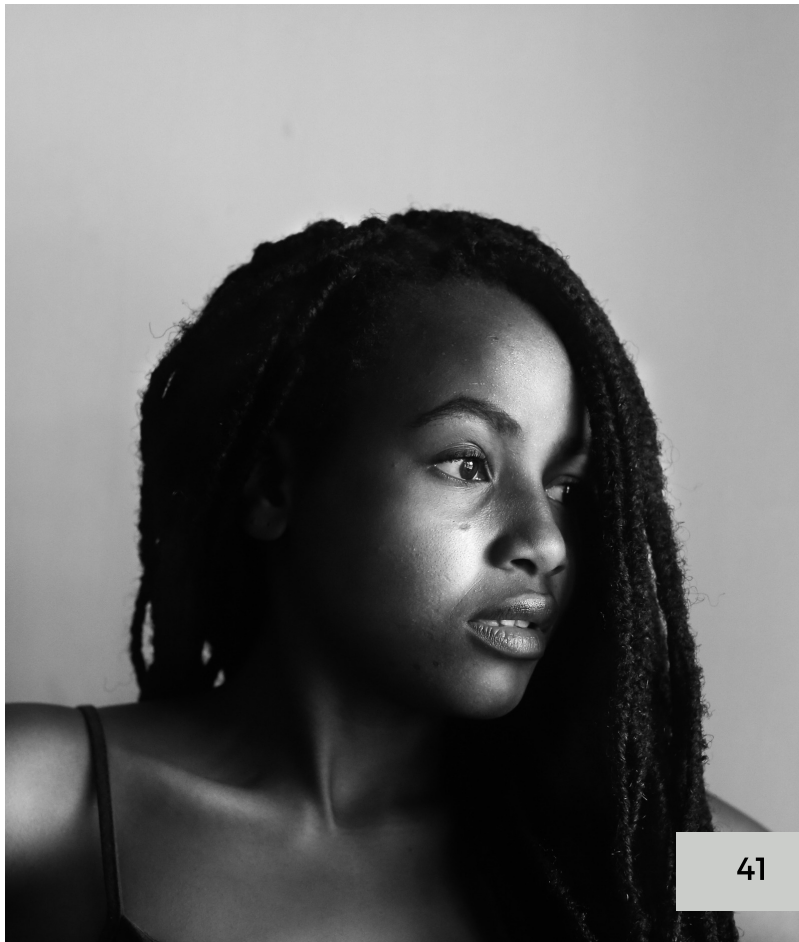
Katrina's story reveals what The Birth Trauma Association describes as loss of control, loss of dignity, the hostile or difficult attitudes of people around the survivor in labor; feelings of not being heard or the absence of informed consent in medical procedures; a lengthy labor or very short and painful labor; poor pain relief or induction and high levels of medical intervention; lack of privacy and dignity.

Katrina's doula actively advocated against the hyperflexing and use of force on Katrina and brought the issue to the attention of the delivering doctor who once aware of this use of force, urged the nurses to stop.  Katrina's doula went to the hallway to get a standing mirror that Katrina could use to see herself pushing, promoting safer, gentler and more effective pushing. Once Katrina had the opportunity to see herself pushing she regained control over her faculties and became an active agent and participant in her birth.



# KRYSTAL'S STORY

As a trauma survivor, Krystal experienced 36 hours of labor. Every two to three hours the doctor would give Krystal a vaginal exam. Because Krystal was not dilating quickly enough for the medical center's standards, the doctors would shame her for her lack of progression in labor. This was incredibly triggering for Krystal. In her book, "With Harp and Sword," Kenya Fairley asserts: "For pregnant survivors, the impact of sexual violence on pregnancy and labor can include: disbelief about the pregnancy, increasing anxiety related to her ever-changing body, unfamiliar sensations in the pelvic and vaginal areas may reactivate trauma triggers, emotional disconnection to her growing baby, trepidation and fear about the birth and experience, flashbacks, nightmares, disturbed sleep patterns, harmful coping practices, delayed access to prenatal and maternal health care." Krystal began to panic when she heard the nurses and doctors speaking about declaring her labor "arrested" or stalled. Medical staff became impatient as they rotated twelve-hour shifts with Krystal, and the nurses and doctors communicated around her head during vaginal exams, in whispers and hush tones. Krystal reached 9 cm, and though she had not yet reached 10 cm, the nurses began coaching her to push. The Charge Nurse was called and she came into the room with a short stool, stood on the stool next to Krystal's bed and began pushing down on Krystals' fundus (the top of her uterus) externally with both hands crossed on one top of the other, as if performing CPR on her pregnant belly. The nurse wanted to push the baby out through external use of force, while two other nurses on either side were yelling "PUSH PUSH PUSH PUSH PUSH," loudly in Krystal's face. The doctor proceeded to perform an episiotomy (cutting Krystal's vagina). The infant's head could be seen bobbing back and forth as the Charge Nurse pushed down on the baby in utero forcefully. When Krystal's baby came out, the infant's face was covered in bruises from force and premature forced pushing. As a result, Krystal's postnatal period required months of processing birth trauma in order to avoid postpartum depression and other detrimental post-natal health outcomes.



The mirroring of abusive behaviors in tone, action or gesture; the reproduction of negative power relations and dynamics, the imposition of rigid instructions or schedules, using shaming, judgmental or sexually suggestive language with survivors during pregnancy and labor, can increase risks for maternal morbidity and mortality. The research reveals that survivors experience birthing and postpartum complications. Failure to link those issues to past or recent sexual trauma, failure to implement a culturally attuned, gender-responsive and survivor-centered approach places women at a painful and dangerous disadvantage.

# WOMEN AND GIRLS OF COLOR: FROM THEIR FIRST VISIT TO THE GYN TO LABOR AND DELIVERY



**The encounters of women of color with health and maternal care systems can be sites of sexual trauma and reproductive injustice...**

Before they get to childbirth, sexual trauma greatly impacts the lives of survivors of color at varying points along the reproductive lifespan--beginning before puberty and their first visit to the gynecologist, through pregnancy, labor and delivery and on to the geriatric and post-reproductive years. Black Women's Blueprint conducted interviews with survivors in its healing programs as well as member-advocates. Their responses reveal that the encounters of women of color with health and maternal care systems can be sites of sexual trauma and reproductive injustice, yet the impact of sexual violence on women's reproductive lives has been widely under-addressed in the field of gynecology and obstetrics, leading to continued re-traumatization and broader reproductive health issues.

# ANETTE'S STORY

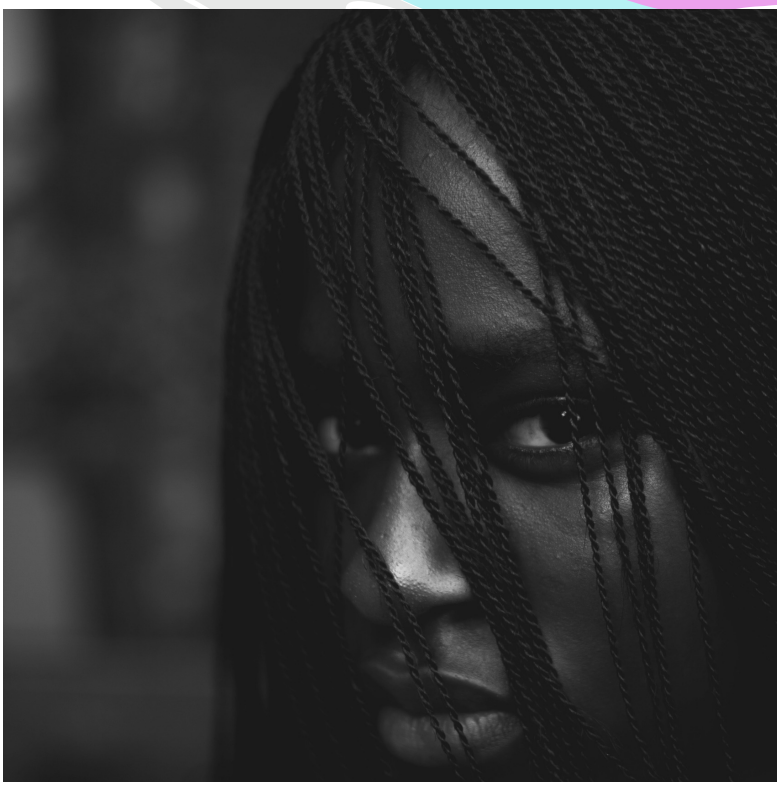
I'm a survivor of rape. It happened when I was nineteen and I have since then, on-and-off, had a really difficult time with my healing process, though I have made progress. I have had extreme pain during my periods for a long time and when I went to a new gynecologist, she was great. She asked if I was a survivor of sexual assault and asked for my consent each step of the way during the exam. But when she referred me for a transvaginal ultrasound, it was a different story. I remember laying there on my back, and the technician kept telling me to open my legs, even though I felt uncomfortable. She then just jammed the instrument inside my body without a word. When I jumped and screamed, she said: "Oh, it's better when it is done it that way because when people expect what's coming, they make it more difficult on themselves." I left there in pain and feeling completely violated.

*"She then just jammed the instrument inside my body without a word."*



# THE IMPACT: TRANS IDENTIFIED AND LGBTQIA PERSONS

## ILA'S STORY



I went to a routine check-up with my partner at the time, who is a trans man. The visit was overall fairly normal besides a comment that was made by the physician, while asking us whether we were sexually active, when we last had sex and the last time we were both tested. The doctor then proceeds to say, in a tone that was supposed to be received jokingly, " Well aren't you glad you can't get her (referring to me) pregnant. I knew exactly what this comment would do, as I looked up to my partner, his eyes were dead. He spoke very little for the rest of the visit. We had recently been having conversations about bringing children into the world and his feelings of not being able to get me pregnant. Though the doctor assumed there would be relief due to the nature of family planning in a cis-heterosexual relationship, it did damage and further established feelings of othering and insensitivity. All genders need access to OB/GYN care. All genders deserve to feel respected and honored when receiving care.

*"Though the doctor assumed there would be relief due to the nature of family planning in a cis-heterosexual relationship, it did damage and further established feelings of othering and insensitivity."*

Ila's story highlights the lack of understanding of gender spectrum and gender expression as well as the difference between gender and sex. Culture shift recommendations needs to focus on the ways in which persons are being treated within a system that should be caring for them and treating their bodies with dignity and respect. This story also highlights the need to include persons who may not identify as women, but still use women's health services.

Almost half of all respondents to a 2015 US Transgender Survey reported facing sexual assault at some point in their lives. Non-binary people who were assigned female at birth are especially vulnerable, with 58% reporting having experienced some form of sexual violence. People of color, and particularly Indigenous people report disproportionate rates of abuse against them. Factors such as being a sex worker or having done sex work at some point, having experienced homelessness, and being a person with disabilities make a trans person even more likely to have been sexually assaulted.

*"...spent the rest of the exam feeling the technician was more concerned with what had come in or out of my cervix"*

# SARAH'S STORY



Another story comes from Sarah, a survivor of child sexual abuse, now in her mid-forties, who has identified as a Lesbian all her adult life. She reports having been referred for a transvaginal ultrasound to determine if there were cysts on her ovaries, during which time the technician comments on the process saying: "wow, your cervix is really narrow; that's surprising." Sarah reports that she felt sexualized during the exam and spent the rest of the exam feeling the technician was more concerned with what had come in or out of her cervix.

# THE CONTINUUM OF REPRODUCTIVE AND SEXUAL VIOLATIONS

The table below provides a summary of how survivors, especially Black women and girls, report doctors traumatizing them.(56) Based on narratives and testimonies by those impacted by these experiences of sexual and/or obstetric violence, there is a broad spectrum of reproductive violations that sit on a continuum from derisive comments to violent rape and are experienced across the reproductive life-span.

There is also a profound and deeply relevant racialized history and the historical dimensions cannot be ignored. Before the experiments by J. Marion Sims, Black women in the Americas faced a peculiarly sadistic form of rape-based torture and reproductive exploitation that has its origins in colonization, slavery and state apparatuses. Practices of forced reproduction and sterilization of Black women's bodies initially evolved to protect the interest of the economic elite, the racially privileged, and public officials. (57) An analysis of the systematic rape of Black women's bodies under slavery for the purpose of breeding and its ensuing trauma should neither be bifurcated by U.S. northern and southern borders, nor shaped by a false conception that time has relegated these experiences to the egregious conditions of the colonial past. The legacy of the slave trade as it pertains to Black women's reproductive freedom, reproductive health and reproductive coercion is insidious as it was historically codified in state policy and created social stereotypes about Black women's sexuality which today, continue to threaten Black women's safety in all spheres. Long-held stereotypes under slavery which figured Black women and girls' bodies as sexually deviant; always and forever violable (unrapeable by virtue of their assumed exploitability); and requiring containment for the purposes of control and moderation; still hold sway in health practices. (58)

Further, and worst still, J. Marion Sims, celebrated as the "father of modern gynecology," was recorded practicing surgical techniques on enslaved women without anaesthesia. As illustrated by historian G.J. Barker-Benfield in his book "The Horrors of the Half-Known," Sims' self-professed contempt for the female body was not a view only held by Sims but by several of his contemporaries.

While these procedures made J. Marion Sims famous, and broadened the profession, Sims' views of women as mere "subjects" and his legacy continues to undergird the field and the practices which survivors describe as traumatizing. While these procedures made him famous, and broadened the profession, Sims' views of women as mere "subjects" and his legacy continues to undergird the field and the practices which survivors describe as traumatizing.

For the purpose of this report, the continuum looks at women and girls' experiences in the following stages: pre-pubescent, adolescence, child bearing age (with or without children), pregnancy, and labor and delivery. This report encourages the field to further examine the experiences of women beyond the labor and delivery stage, post reproductive, menopause and post-menopausal stages.

Violence against women and reproductive justice more than intersect in the lives of women, they are inextricably linked. That current efforts to address maternal mortality have paid little to no attention to intersecting experiences of gender-based violence as well as gender discrimination within reproductive healthcare is a major deficiency.

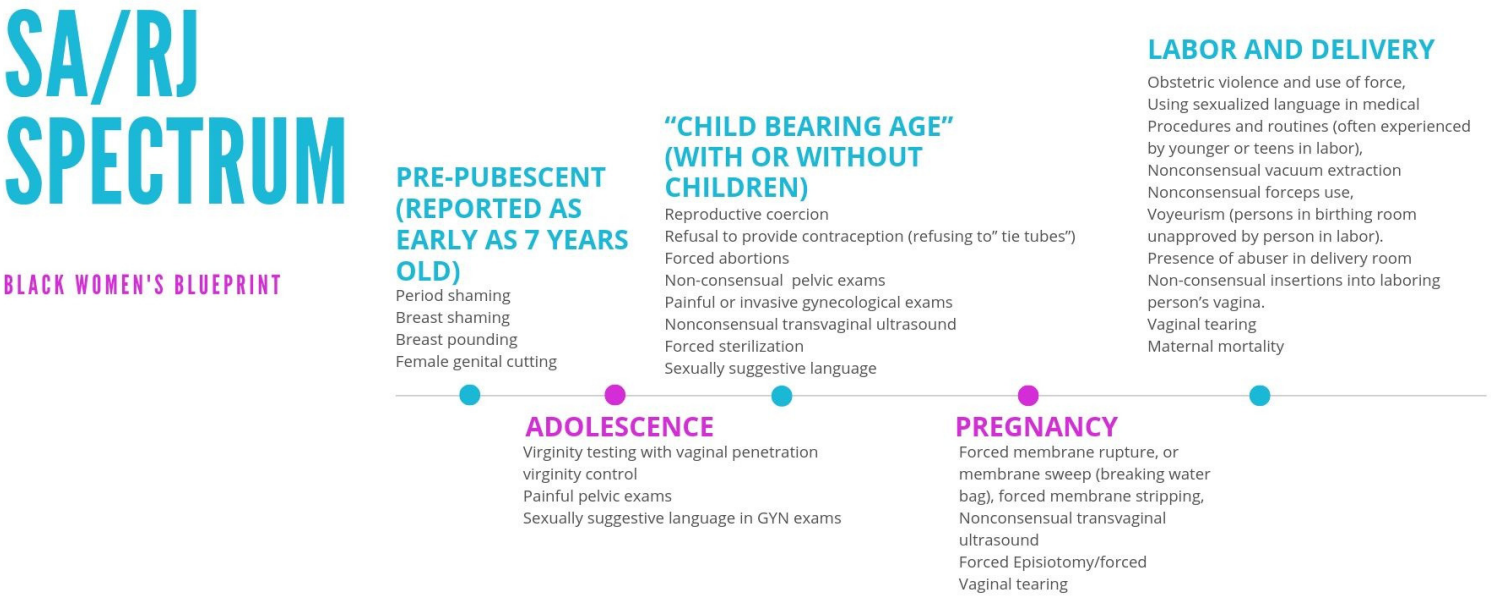



Figure 7. SA/RJ Reproductive Violations Continuum Across the Reproductive Life Span

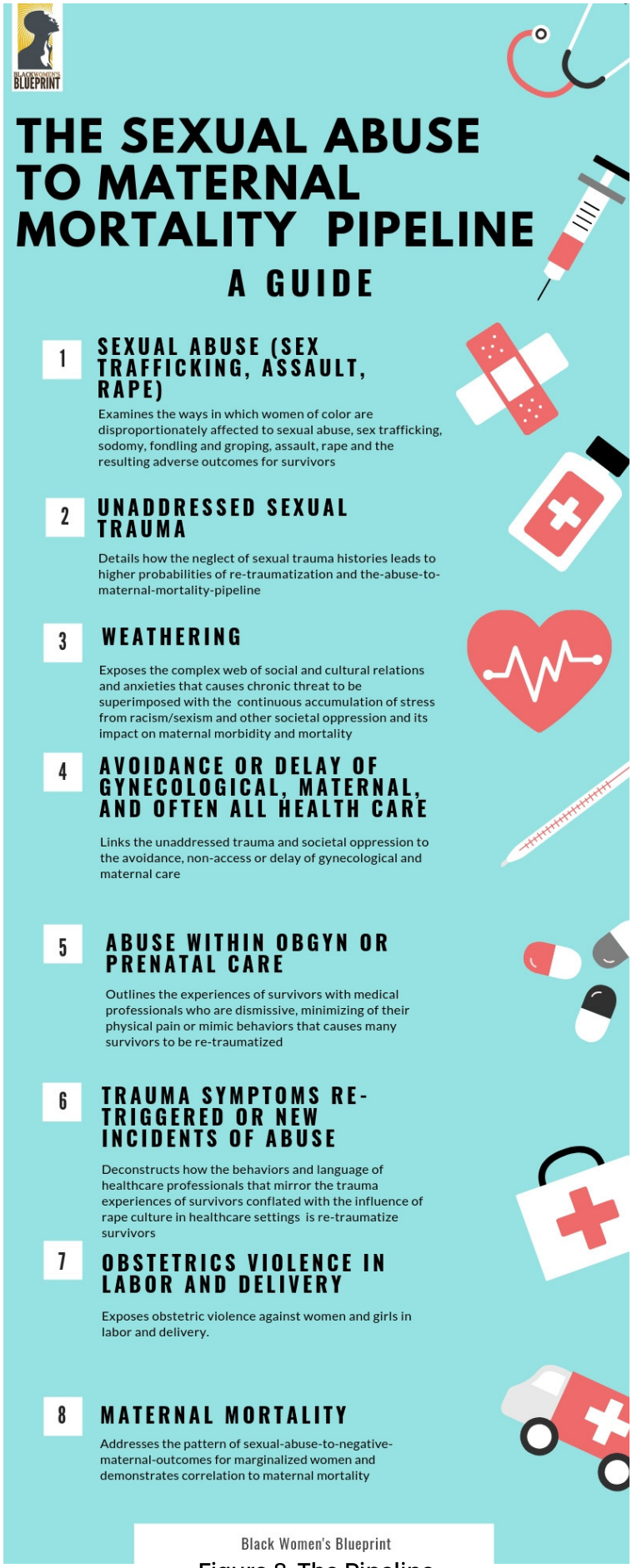


Figure 8: The Pipeline

As reflected above, the most common traumas experienced by women of color are too often replicated in their contact with reproductive health and maternal health professionals. As such, obstetrician–gynecologists and other women's health care providers play a critical role in evaluation and intervention requiring routine screening for a history of sexual assault.

# LYN'S STORY

When I got to the hospital for emergency treatment my body is red, black, blue, swollen, I am in obvious pain. I am not treated. My eyes burn, my abdomen burns. My breast burn. My vagina and rectum burn. I am weak from suffering. The worst thing that ever happened to me: I woke up from surgery and my throat was still burning and burning worse than ever. My underwear were removed. I asked the nurse standing in the doorway, " Why were my underwear removed?" The nurse stated, "Your underwear was removed because SOMETHING was done to your body that would have burned your underwear against your skin." I asked "What the fuck are you talking about with my husband present?!" She smirked and did not answer. I felt wet and needed to urinate. I screamed as I saw my urine was all blood. He (the doctor) harmed me further...I trusted people who are trying to kill me. I am afraid to go to the hospital or see doctors because they have burned me and I needed medical attention ASAP.

# BODY SOVEREIGNTY

In 2019, seven states passed bills that limit women's access to abortions with no regard to medical need, economic insecurity, exposure to violence or trauma, socially oppressive elements or their right to bodily sovereignty. Concurrently, in most states, access to birth control and sexual health resources have been regulated and funding cut.



The legislation being presented by law makers not only restricts women's access to the full spectrum of reproductive health services, they attack the core of women's ability to make informed decisions about their own needs and their own bodies. The gains in racial and economic justice, women's rights and LGBTQ rights achieved over the past 50 years, are methodically being dismantled.

Those in the fields of reproductive rights, sexual assault advocacy, gender equity, queer and trans rights, anti-poverty, and anti-racism work are preparing to continue the work in the face of this shift away from justice and equity; to combat the attacks on body sovereignty and resist further subjugation and oppression.

# DISMANTLING THE PIPELINE

## AS REFLECTED ABOVE, THE MOST COMMON TRAUMAS EXPERIENCED BY WOMEN OF COLOR ARE TOO OFTEN REPLICATED IN THEIR CONTACT WITH REPRODUCTIVE HEALTH AND MATERNAL HEALTH PROFESSIONALS. AS SUCH, OBSTETRICIAN–GYNECOLOGISTS AND OTHER WOMEN'S HEALTH CARE PROVIDERS PLAY A CRITICAL ROLE IN EVALUATION AND INTERVENTION REQUIRING ROUTINE SCREENING FOR A HISTORY OF SEXUAL ASSAULT.(59)

All the experiences on the continuum of sexual and reproductive violence increase adverse maternal health outcomes. These include:

- Exposure to sexual violence and high adverse childhood experiences (ACE) scores,
- The lack of mental health treatment or healing services after sexual violence.
- Re-traumatization through contact with the healthcare industry, as reported by women and girls who disclose incidents with non-communicative gynecologists and obstetricians and disrespect.
- Obstetrics violence like probing insertions in gynecological offices which trigger PTSD about seeking further healthcare;
- Non-consensual transvaginal ultrasounds causing the re-emergence of trauma in pregnant women.

All these experiences are also superimposed on existing layers of fear and distrust of the healthcare system stemming from a history of doctors like J. Marion Sims, who exploited the bodies of Black women. (60) Acknowledging the institutional impact of Sims' disdain for women in general and Black women in particular, is a good place to start when we think of dismantling the pipeline.

This exploitation continues to be affirmed by the medical system via continued invasive treatment of pregnant women, racial and gender discrimination, lack of knowledge, lack of concern, lack of understanding of women's bodies, specifically women of color, and trans identified bodies in particular.

# DISMANTLING THE PIPELINE

Within the context of patriarchy and racism, and the ways in which the bodies of women are specifically placed in healthcare and the system's past trespasses against Black women, these oppresssions conflate to keep the lived experiences of women of color in the perpetual blind-spot of maternal healthcare.

Evidence gathered by the Black Women's Blueprint Truth and Reconciliation Commission as well as narratives from local advocates require that the crisis reproductive healthcare and maternal mortality in our cities and states receive more comprehensive attention beyond the current reports, listening sessions and task-force recommendations.

# SOLUTIONS AND RECOMMENDATIONS



# DISMANTLING THE PIPELINE

The three-pronged national crisis of sexual assault, reproductive health and maternal mortality crisis is not a new one.

If the field were to listen to survivors, the primary ask has long been that reproductive healthcare systems act to implement a culture which honors women across a variety of identities. When physicians and hospital staff are not aware of the realities of sexual violence in the lives of the women they serve, when they perform non-consensual and sexually violating procedures, they perpetuate the sexual abuse-to-maternal-mortality-pipeline.

As outlined in this report, there is a need for immediate interventions that work to eliminate the often unintended, but still pervasive rape- culture which has found its way into institutions of women's health care and more alarmingly in maternal wards, and labor and delivery. (61) Rape culture as defined by advocates is a culture perpetuated through the use of misogynistic language, the objectification of women's bodies, thereby creating a society that disregards women's rights and safety. (62) Women of color, non-female presenting women, and other gender-non conforming persons continue to be "sexual minorities" and are more susceptible to exposure to rape culture in all aspects of life - including within the medical profession.

The summary of recommendations outlined in the next few pages are assigned to three areas that address each point along the Abuse-to-Maternal-Mortality-Pipeline:

- Policy
- Medical Practice
- Culture Shifts





*We must reinvigorate the practices and ideas of the "Black granny", midwives, doulas and practitioners of holistic medicine and traditions, who worked to maintain the dignity and sacredness of all individuals giving birth, and especially women's bodies across the reproductive life span."*

*– Sevonna Brown*

# DISMANTLING THE PIPELINE: SEXUAL ABUSE

A study by the Boston Medical Center and Brigham and Women's Hospital from 2015 to 2017, interviewed 20 women with a history of sexual trauma and 10 without. Women with a history of sexual trauma desired clear communication about their history with prenatal care providers and the labor and delivery team and desire control over who is present in during cervical examinations of any kind. (63) In the intrapartum period, they desired control over who was present in the labor room at the time of cervical examinations and required that health care providers avoid language that mirrored sexual trauma. (64)

## POLICY:

- **Strengthen VAWA to include protections for survivors of sexual violence in gynecology and obstetrics services:** Black Women's Blueprint recommends an expansion of Sexual Assault language and funding in the Violence Against Women Act (VAWA), (65) to include a reproductive health-care provision which can address the needs of women and girls of childbearing age and expectant mothers. This expansion of VAWA should be responsive to the spectrum of reproductive violations outlined in this report, cover services especially related to obstetrics and gynecology, including resources and the prevention of sexual victimization and re-traumatization within medical-care systems for survivors of sexual trauma.

# MEDICAL PRACTICE:

- **Expand protocols by the Joint Commission on Accreditation of Healthcare Organizations** (JCAHO), (66) requiring appropriate screening for sexual abuse and assault, for OBGYN patients and pregnant individuals prior to labor and delivery. The Joint Commission accredits more than 4,000 hospitals—the vast majority of our nation's hospitals. Mandated screening not only in hospitals, but in a variety of health care settings, and not just when physical signs of abuse are present is vital to dismantling the pipeline where it begins. The first step towards creating or expanding protocol is adequate research to demonstrate how the protocol will improve outcomes, out of which should emerge a national consensus from clinicians and health care organizations regarding the new standard of care. In addition, we recommend mandated training for medical personnel performing sexual violence screenings. Without proper training, the screening process will be ineffective.

# CULTURE CHANGE:

- **Meet the challenge head on**, and address rape culture that pervades all institutions, including all gynecology and obstetrics, labor and and delivery wards. Address gender-bias and discrimination by training physicians and nurses not only within hospital and other clinical settings, but also in medical and nursing schools, and related programs in their academic learning settings.
- **Incorporate culturally specific and gender-responsive sensitivity assessments as required parts of medical training.** To address rape culture, we must address a person's rights to agency and volition in their reproductive healthcare. Towards this end, we must improve doctor-patient relations and teach medical professionals to address the intersectional needs of survivors, and understand the ways in which constructed identities create oppression.

# DISMANTLING THE PIPELINE: UNADDRESSED TRAUMA

## POLICY:

- **Improve the Use of Medicaid to Cover the Cost of Trauma-Related Care.** A 2013 guidance letter, (67) issued by the US Department of Health and Human Services (HHS), offers assistance to states to use Medicaid more effectively to cover the cost of trauma-related care, as well as design Medicaid treatment strategies for individuals who have experienced trauma. Recommended strategies include using Medicaid funds to cover evidence-based screening and assessment practices, as well as home and community-based services for women and girls exposed to trauma. (68)

## MEDICAL PRACTICE:

- **Strengthen Research** to address three general areas: (1) expansion of the theoretical frameworks and analytic models used to understand the impact of trauma, and in particular sexual assault due to its intimate nature and the ways in which it relates to reproductive trauma, for survivors' in OB/GYN and maternal healthcare, (2) Increase research on the reproductive health care needs of women who have experienced sexual violence, and (3) research and documented intervention strategies that could be implemented most effectively in reproductive health care settings.
- **Screen for Maternal Depression:** A standardized and validated tool is recommended for screening for maternal depression. Depression in women is often caused by past trauma. An example of such a standardized and validated screening tool is The Edinburgh Postnatal Depression Scale. (69) A validated, quick 10-question screening tool for maternal depression to be used by primary care providers and includes scoring instructions.

# DISMANTLING THE PIPELINE: UNADDRESSED TRAUMA

- **Screen for Postpartum and Perinatal Anxiety that is often ignored in the lives of Women of Color. (70)** Using this screening tool to distinguish mild from more severe anxiety symptoms will help to facilitate treatment in this population and will help to ensure that the women in greatest need of intervention will be referred to the appropriate services. (71)

## CULTURE CHANGE:

- **Trauma informed and survivor centered services: (72)** A community-based, culturally specific or feminist organization should participate, advise or provide trauma informed services where needed. This model should be used throughout institutions in service of survivors of violence, and in particular within OB/GYN and maternal health, labor and delivery settings. Doula agencies can serve this purpose, or agencies with expertise in violence and sexual trauma. Employing trauma counselors have also been shown to be successful. (73) Additionally, there may be tremendous benefit to stationing a sexual assault and violence intervention counselor in hospitals and OBGYN clinics. (74) This has been found to be successful in clinics that serve individuals with chronic illnesses that often require wrap-around services.

# DISMANTLING THE PIPELINE: WEATHERING

## POLICY:

- **Strengthen the Maternal Care Access and Reducing Emergencies Act (Maternal CARE Act). (75)** The purpose and language of the Act should be expanded to include accountability mechanisms ensuring state application of gender-responsive services, data collection and assessment of persons experiencing all forms of gender-bias as well as gender-violence.
- **State Advisory Group Members Ratio of Gender-Based Violence Experts**: States should ensure and require an adequate ratio of State Advisory Group members that have expertise in the effects and consequences of sexual assault, domestic violence, sex trafficking, as well as knowledge of effective interventions to interrupt such issues.
- **Develop and produce a comprehensive public health strategy to identify and reduce toxic stress.** (76) Beginning in childhood, toxic stress can affect a child's health and education, and eventually the health of the adult they become as "toxic stress" is accumulated. Address "weathering" and "toxic stress" through public education and create public health campaigns that concretely interrupt the effects of weathering. This should focus on those most impacted by maternal mortality--Native Americans and Black women who are also most vulnerable to toxic stress, discrimination, violence and adverse maternal outcomes.

# DISMANTLING THE PIPELINE: WEATHERING

## MEDICAL PRACTICE:

- **Culturally Specific Healers:** Allow the integration of culturally specific **traditional healers, midwives and doulas in short-term and long-term response to survivors who report sexual abuse and/or assault. (77)**
- **Integrate Healthcare with Education Systems:** Resources should be directed towards integrating health care and education in a seamless system of care. According to pediatric and family health experts “health-care providers and educators rarely work together to address the stress and trauma beginning in childhood stress and trauma. (78)

## CULTURE CHANGE:

- **Change the social justice movement landscape to create containers for reciprocal learning and concrete collaboration between sexual assault and reproductive health advocates.** Together, they should develop approaches for integration and service components focused on primary, secondary and tertiary prevention of gender-bias, escalation to gender-violence and ultimately adverse OBGYN, labor and delivery, and maternal outcomes.

# DISMANTLING THE PIPELINE: AVOIDANCE OR DELAY OF GYNECOLOGICAL, MATERNAL, AND OFTEN ALL HEALTH CARE

## POLICY:

- **Strengthen public health policies that promote transparency and contain explicit language regarding accountability for addressing the "occurrence of abuse in health care." (79)**
- **Coverage of midwife and doula services:** As a matter of policy, ensure access to healthcare for all; and require all insurers to extend coverage for midwifery, including direct entry midwives serving low-income communities and communities of color.
- **Partnerships with CBO's:** Policies on "access" should promote partnerships with community based organizations which can decrease distrust of the medical system.

## MEDICAL PRACTICE:

- **Hospital procedures should integrate holistic prenatal care as part of the standard care**
- **Offer Privacy:** Use ob-gyn examination room visits for an initial intake meeting and sensitive issues requiring privacy where mental, emotional and social dimensions of women and girls' lives can be assessed.
- **Wrap-Around Referrals:** Develop a referral system for addressing discrimination, employment and legal concerns, housing, intimate partner violence, and childhood trauma as part of a holistic approach to women's healthcare and prenatal care.

# DISMANTLING THE PIPELINE: AVOIDANCE OR DELAY OF GYNECOLOGICAL, MATERNAL, AND OFTEN ALL HEALTH CARE

- **Operationalize a wellness and strength-based model that builds on individual's health and self-care knowledge and strategies** by supporting a woman's vision for their care in OBGYN and maternity wards, and by respecting their right to evidence-based information and access to trauma support, a range of birthing options including vaginal birth, non-medicated birth, midwife-assisted birth and home birth.
- **Improve information and education** distributed to pregnant individuals regarding medical interventions including induction, epidural, and cesarean birth. (80)
- **Provide hard copy and online resources** regarding women's rights in OBGYN settings, and in prenatal care, to enable women to explore their options before, during and after labor.

## CULTURE CHANGE:

- **Require community and street outreach** in urban, and in remote and rural communities that explain and educate women about informed consent at every step of engagement in OBGYN and labor and delivery. This should go beyond the signing of forms at hospital admission. Targeted outreach should educate communities on their claim to their own agency in the healthcare system and disrupt the narrative of disempowerment.
- **Implement Culture and Language Accessibility for Survivors of Female Genital Mutilation** for patients who seek private, culturally specific clinician/provider and protection from the spectacle of medical resident or teaching hospital cultures where these specific cases are often put on display.

# DISMANTLING THE PIPELINE: ABUSE WITHIN OB/GYN OR PRENATAL CARE

The existing research on obstetric violence is limited, which complicates the task of defining the problem and identifying solutions to address the extent to which women experience abuse, coercion, and disrespect while giving birth. Existing law fails to prevent obstetric violence or provide meaningful recourse to women who experience mistreatment at the hands of their health care providers. Although important constitutional values regarding autonomy and reproductive liberty are central to women's freedom from coercive treatment during childbirth, the constitution provides little direct protection to women harmed by obstetric violence. As the report concludes, Black Women's Blueprint recommends "forms of advocacy within the legal and health care systems that offer promising approaches to shifting maternity care culture and, ultimately, securing necessary changes in policy for women harmed by provider mistreatment during childbirth."

## POLICY:

- **Address sexual abuse, OBGYN and prenatal care in the Violence Against Women Act.** (81) In 2005, a general practitioner was suspended for 4 months after a Fitness to Practice panel found him guilty of serious professional misconduct. A female patient came into his office complaining of bowel problems. He proceeded to examine her back and in bending her right knee, placed his hand directly into her vulval area. (82) Additionally, in August 2005, an OBGYN was found guilty of serious professional misconduct when a patient consulted him thinking she might be pregnant. He proceeded to perform an abdominal examination during which he put his hand beneath her panties, pressed on her pubic bone and pressed at the point where her outer labia starts. The examination was found to be unnecessary, inappropriate, and indecent. (83)

# DISMANTLING THE PIPELINE: ABUSE WITHIN OB/GYN OR PRENATAL CARE

## MEDICAL PRACTICE:

- **Employ the consistent use of chaperones for physicians and other medical providers and ensure survivors are aware of the right to a chaperone** during a physical examination, (84) a right which should be accommodated regardless of the physician's sex and gender. The use of chaperones during gynecological and other medical exams and procedures should be consistent and universal for all patients. While a chaperone policy is still being employed in medical institutions, third party providers should be readily available for every patient regardless of whether a patient has made an explicit request.
- **Develop and implement clear guidelines on preventing sexual assault and produce survivor-centered curricula for OB/GYN professionals to inform routine procedures through the American College of Obstetrics and Gynecology (ACOG)**. **(85)** The American Medical Association in collaboration with the American Psychological Association and American Psychiatric Association must convene a joint task force to develop guidelines in partnership with communities and survivors themselves.

## CULTURE CHANGE:

- **Dismantle the social hierarchies** that insulate medical professionals and render them virtually immune to being held accountable.
- **Utilize sexual assault and abuse prevention organizations** to provide technical assistance to medical professionals and facilities to identify and eliminate rape-culture's manifestations within OBGYN and maternal health settings.

# DISMANTLING THE PIPELINE: TRAUMA SYMPTOMS RE-TRIGGERED

## POLICY:

- See recommendations on VAWA resource allocation for survivor-centered and trauma-informed care.

## MEDICAL PRACTICE:

- **Implement critical revision of pelvic exams to be trauma-informed and survivor-centered: (86)** For patients with a history of sexual trauma, pelvic exams may trigger PTSD symptoms. Studies show that trauma survivors want providers to ask about sexual trauma before the exam (that is, while the patient is clothed and seated). During the exam, patients prefer that the clinician listens, anticipates each step of the procedure, and affirms the patient's control over the exam. (87)
- **Allow women the option of self-inserting the speculum in private: (88)** This practice has been shown to lower patients' anxiety and pain. Adopt this option for the ultrasound wand for transvaginal ultrasound procedures. (89)
- **Determine who needs and who does not require a pelvic exam.** A report (found no evidence that pelvic exams were better at detecting ovarian cancer than ultrasounds or blood tests, and there was slim evidence of success detecting other conditions like bacterial vaginosis. (90) The report also states that "some patients experience embarrassment or anxiety and sometimes do not return for another visit if the pelvic exam causes pain." American College of Physicians (ACP) recommended in 2014 that pelvic exams not be done on nonpregnant women who show no symptoms of gynecological problems. (91)
- **Redesign gynecological tools and instruments:** Hospitals should take a leading role in the creation of gynecological devices by partnering with companies looking to innovate the antiquated devices that cause many women to avoid consistent GYN exams.

# DISMANTLING THE PIPELINE: TRAUMA SYMPTOMS RE-TRIGGERED

## CULTURE CHANGE:

- **Create a culture that acknowledges and implements concrete actions and investments to reduce the painful and often traumatizing effects of the gynecological devices and procedures. (92)** Shed the idea that women must accept and resign themselves to pain as a “natural” part of the process of vaginal examination - especially survivors.
- **Increase empathetic communication with women during their procedures: (93)** explaining every step of the process, obtaining consent before touching a patient’s vaginal area - understanding patient presence is not consent or assumed consent to access a patient's body. (94)



# DISMANTLING THE PIPELINE: OBSTETRIC VIOLENCE IN LABOR AND DELIVERY

The existing research on obstetric violence is limited, which complicates the task of defining the problem and identifying solutions to address the extent to which women experience abuse, coercion, and "disrespect" while giving birth. (95) As the report concludes, Black Women's Blueprint recommends "forms of advocacy within the legal and health care systems that offer promising approaches to shifting maternity care culture and, ultimately, to securing necessary changes in policy for women harmed by provider mistreatment during childbirth. (96)

According to the World Health Organization, in every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women [gender-variant] and families and represent a time of intense vulnerability. (97) The concept of "safe motherhood" is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for women [gender-variant people] and their family; ...issues of gender equity and gender violence are also at the core of maternity care. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care. This Declaration provide the basis and expanded framework upon which all local and state policies to address maternal health, maternal mortality and morbidity can develop.

# DISMANTLING THE PIPELINE: OBSTETRIC VIOLENCE IN LABOR AND DELIVERY

## POLICY:

- **Policy on The Universal Rights of Childbearing Women should be consistently revisited with OBGYNs and doctors in labor and delivery: (98)** To date, no universal charter or guideline either specifically delineates how human rights are applied in the childbearing process or affirms their application to childbearing women as basic, inalienable human rights. A Declaration of Universal Rights of Childbearing Women is key to codify values of personal safety, body sovereignty and bodily integrity as a primary component of protecting the dignity of pregnancy and laboring people. (99)

## MEDICAL PRACTICE:

- **Require consistent use and adherence to birth plans in hospitals and birthing centers for safe and healthy perinatal outcomes that respect survivors:** A Birth Plan is a personal guide created with the leadership of the person in care, regarding their own labor and delivery. It contains information needed at the time of giving birth, and includes opportunities for survivors to make choices about their labor and delivery. It is imperative to the deconstruction of the pipeline to require the use of birth plans and respecting survivor preferences for labor and delivery.
- **Establish mechanisms to improve accountability, patient satisfaction and best practices in relation to labor and delivery** which would require hospitals to establish Community Accountability Boards comprised of individuals who have given birth at the facility, birth workers, community members and staff to provide feedback, communication and transparency about current practices and progress to improve maternal health-care.

# DISMANTLING THE PIPELINE: OBSTETRIC VIOLENCE IN LABOR AND DELIVERY

## CULTURE CHANGE:

**Establish a culture of consent in labor and delivery.** Address patriarchy and related sexism and misogyny in the medical systems and train practitioners to change how they understand sexuality and prevent sexual violence. Make consent is the norm for sexual expression. Provide cultural humility training about race, class, age, gender and sexuality for all nurses, midwives, ob-gyns and other frontline staff which reduces the power dynamics perpetuated between doctor and persons in labor and delivery.

# DISMANTLING THE PIPELINE: MATERNAL MORTALITY

## POLICY:

- **Revise U.S. Department of Human Health and Services (DHHS) policies and rules to foster greater transparency** and accountability in the area of pregnancy and birthing services Transparency in maternity care must be increased. Transparency would include publication of hospital cesarean surgery rates and rates for interventions such as epidurals, inductions, and breastfeeding at discharge, as well as VBAC (vaginal birth after cesarean) rates. This information is collected on birth certificates and aggregated by State Departments of Health but not generally made public. Transparency will increase survivor's ability to make informed decisions about their health care services, options, and access.
- **Expand The Preventing Maternal Deaths Act, (100) which would establish and support Maternal Mortality Review Committees: (101)** At the state level to help states improve how they track and investigate deaths of expectant and new mothers. These groups would be required to review every pregnancy-related death and develop recommendations to prevent future deaths that incorporates a broader sexual violence analysis.

# DISMANTLING THE PIPELINE: MATERNAL MORTALITY

## POLICY:

- **As a matter of policy, develop procedures for confidential case reporting that provides for confidential case reporting of** pregnancy-related deaths to the appropriate State or tribal health agency.
- **Establish a comprehensive data warehouse that considers the impact of trauma and gender-based violence in maternal outcomes: (102)** Establish a comprehensive data warehouse on perinatal outcomes in every state to improve quality. This can be modeled after New York State and California efforts to establish a robust data infrastructure to provide key data to perinatal hospitals and support access to timely quality measures.

## MEDICAL PRACTICE:

- **Implement trauma-informed trainings in teaching hospitals.**
- **Integrate trauma informed training in grand rounds and residency programs. (103)**
- **Design and implement curricula specifically for ob-gyns, nurses, midwives and doulas** that are trauma-informed and survivor centered that integrate coursework in gender, race and cultural humility in all training; this should also be the case in all continuing education modules.
- **Prioritize interdisciplinary education among midwives and ob-gyns** teaching maternal-health professionals and integrating doulas and birth assistants into the birth process. Training should also take steps to reduce restrictions to the presence of doulas and birth assistants in the labor and delivery room.

# DISMANTLING THE PIPELINE: MATERNAL MORTALITY

## CULTURE CHANGE:

- **Address survivor complaints of "disrespect" reported by the CDC and the needs of women and girls at all points of their reproductive life cycle** - particularly laboring women. Rather than viewing uneventful deliveries as routine and devoid of risk, recognize the very likely chance of small complications or medical "hiccups" that quickly turn into crisis when left untreated.
- **Address gender-bias and gender-discrimination which perpetuates the devaluation of women in the healthcare system**. **(104)** Healthcare, has a large proportion of highly trained and qualified women giving healthcare, including OBGYN and maternity wards a unique opportunity to be a leaders in gender equity.
- **Introduce gender-equity and undoing gender-discrimination strategies that combine evidence-based medicine with advocacy. (105)** As a culture change, doctors and other medical professionals must acknowledge their own bias and beliefs about women's inability to make sound, rational decisions for themselves. This also requires a a paradigm shift away from hospital guidelines, rules and regulations that undermine women's agency and decision making.

# #DearSurvivor: an Open Letter to every Black Woman and Femme who wants, needs, desires and deserves a full spectrum doula.

In response to: Assembly Bill A364B and Senate Bill S3344B

ACTION ALERT: Call key stakeholders to prevent blocking doulas from providing trauma-informed support to survivors!

## OUR STANCE:

Full-spectrum doulas have a historic and rich practice steeped in cultural and ancestral maternal care that extends outside the delivery room and integrates mind, body, and spirit into the expectant parents' experience. Studies have shown that having a doula as a member of the birth team decreases the overall cesarean rate, the length of labor, and increases overall quality of care and birth satisfaction before, during, and after delivery. Full spectrum doulas also work with miscarriage, stillbirth, termination, abortion, and end of life.

With full-spectrum doula service providers made up of primarily persons of color and minorities, these new guidelines will negatively affect Doulas and communities of color disproportionately. On Juneteenth and we held national discussions on the legacy of racial oppression in America, reparations, and ways to advance the health and liberation of Black people, Black Women's Blueprint calls on all community members to consider the long term impact of such legislation on racial maternal health and the development of people of color in maternal healthcare fields. Further it is important we recognize that these decisions will not only impact all New Yorkers but will have National repercussions.

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ACTION ALERT: Call key stakeholders to prevent blocking doulas from providing trauma-informed support to survivors!

## OUR STANCE:

1. Trying to reduce the number of people who have say in the room, and are witnesses in the room.
2. Becoming evident that by requiring a license that has heretofore has never been necessary, there is a pruning of what type of person can be involved in birth and delivery.
3. Of the 150 consequences that survivors are threatened with, Mortality is one of them- which waits for us at ever entryway to each maternity ward, labor and delivery room, and even ob/gyn clinics.
4. The only distance between a survivor and doulas should be her desire for one. Part of what makes survivorship so challenging is the lack of body sovereignty. When there are constant and perpetual blockades to us making basic decisions for ourselves, survivors are infantilized and far less likely to receive the overall care they desire. This is a gender issue in the way of creating a mechanism that makes it difficult for survivors to have support, care, and advocacy.
5. Doulas are often the only thing that stand between survivors and death or end of life.

Given the current state of affairs and the intersecting factors which continue to exacerbate conditions for the most vulnerable women and girls in women's healthcare systems, Black Women's Blueprint responded by asking its affiliated sexual assault trauma therapists and counselors as well as doulas and midwives to identify what may be a course for intervention in service of the communities with which we mobilize and the women for whom we care.

**TAKE ACTION**

If your Assemblymember or Senator is on the list below, please contact them today and use our sample script!

# SAMPLE SCRIPT:

My name is [your name] and I am from [city and organization, if applicable]. I am calling to oppose Assembly Bill A364B and Senate Bill S3344B, which blocks doulas from providing trauma informed support to survivors! I urge you to reject this bill with access for survivors of sexual violence in mind. Thank you for investing in advocacy and support of  sexual violence survivors.

After making your calls, please be sure you've signed and shared our campaign's ColorOfChange.org petition. Thank you for helping create social change nationwide!



# BLACK WOMEN'S BLUEPRINT

# Endnotes


1. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. Holmes MM1, Resnick HS, Kilpatrick DG, Best CL.Am J Obstet Gynecol. 1996 Aug;175(2):320-4; discussion 324-5.
2. Constellations of Struggle: the importance of "individual" experiences, the silenced stories of violence and the collective construction of memory through a non-capitalist concept of time. Written for Black Women's Blueprint, by Alan Enriquez, Liberatory Psychologist, El Salvador
3. Ancient Song Doula Services is an international doula certifying organization with the goal to offer quality Doula services to women of color and low income families who otherwise would not be able to afford Doula Care and training a workforce of full spectrum doulas to address health inequities within the communities they want to serve.
4. The American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee members Serina Floyd, MD, MPH, and Joy Anderson, MD.
5. Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror. Herman, Judith Lewis, M.D.
6. When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on the Childbearing Woman. Penny Simkin and Phyllis H. Klaus
7. CDC: Meeting the Challenges of Measuring and Preventing Maternal Mortality in the United States
8. Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities March 2019; New York State Task Force on Maternal Mortality and Disparate Racial Outcomes
9. World Health Organization (WHO) Maternal Mortality Fact Sheet, 16th of February, 2018 https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
10. Urban Indian Health Institute, Seattle Indian Health Board. (2016). Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas. Seattle, WA: Urban Indian Health Institute. http://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf

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11. Lost Mothers: Maternal Mortality In The U.S., NPR Special Series
12. A Local Law to amend the administrative code of the city of New York, in relation to reporting on maternal mortality and morbidity, November 2018.
13. New York State Task Force on Maternal Mortality and Disparate Racial Outcomes: Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities March 2019
14. Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities March 2019; New York State Task Force on Maternal Mortality and Disparate Racial Outcomes.Alison Young, USA TODAY. Updated Mar. 6, 2019 https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/#iwasreallyscared
15. Alison Young, USA TODAY. Updated Mar. 6, 2019 https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/#iwasreallyscared
16. Arline Geronimus, Research Professor, Population Studies Center. Coordinator, Public Health Demography, Population Studies Center. Professor, Health Behavior and Health Education. Sc.D., Behavioral Sciences, Harvard School of Public Health Dr. Geronimus' research interests include understanding the social and biological mechanisms that mediate racial disparities in health along the full pathway from the environmental to the cellular level: cultural influences on population variation in family structure and age-at-first birth; the effects of poverty, institutionalized discrimination, and residential areas on health; the strategies used by marginalized communities to mitigate the harmful health effects of poverty and structural racism; and the perturbations public policies sometimes cause in these autonomous protections. Population Studies Center, Institute for Social Research.
17. Geronimus, A. T. (2001). Understanding and eliminating racial inequalities in women's health in the United States: The role of the weathering conceptual framework. Journal of the American Medical Women's Association, 56(4), 133-137.

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18. The term “allostasis” has been coined to clarify ambiguities associated with the word “stress.” Allostasis is the process of achieving stability, or homeostasis, through physiological or behavioral change. This can be carried out by means of alteration in HPA axis hormones, the autonomic nervous system, cytokines, or a number of other systems, and is generally adaptive in the short term (McEwen & Wingfield 2003). Allostasis is essential in order to maintain internal viability amid changing conditions (Sterling & Eyer 1988; McEwen 1998a; McEwen 1998b; Schulkin 2003). Allostasis provides compensation for various problems, such as in compensated heart failure, compensated kidney failure, and compensated liver failure. However, such allostatic states are inherently fragile, and decompensation can occur quickly, as in acute decompensated heart failure.
19. There is a plethora of literature on this dual burden placed on enslaved women. One example is Jennifer F. Morgan’s Laboring Women: Reproduction and Gender in the New World. University of Pennsylvania Press: Philadelphia, 2004.
20. A key text to articulate this inhuman definition of Black people and Black women in particular is Thomas Jefferson’s Notes on the State of Virginia (1787). In this text, Jefferson postulates that Black people are not only inferior to whites in body and mind, but that Black women are the most unattractive of all, and goes on to write, “Even black men prefer white women over their own, just as orangutans prefer black women over their own.”
21. Amnesty International USA, “Shocking Levels” of Sexual Abuse in Prisons Cannot Continue. https://www.amnestyusa.org/press-releases/shocking-levels-of-sexual-abuse-in-prisons-cannot-continue/ Accessed May 10, 2019
22. National Commission on Correctional Health Care, https://www.ncchc.org/filebin/Positions/Womens_Health_Care_in_Correctional_Settings.pdf, pg.1, Accessed May 10, 2019
23. Ashley Southall, Benjamin Weiser, “Police Forced Bronx Women to Give Birth While Handcuffed, Lawsuit Says”. New York Times. December 6, 2018
24. From Midwives to Medicine: The Birth of American Gynecology. Deborah Kuhn McGregor. Published September 1,1998

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26. https://rewire.news/article/2018/10/04/new-paper-examines-how-gender-bias-in-health-care-can-be-deadly/
27. Patient–physician gender concordance and increased mortality among female heart attack patients. Brad N. Greenwood, Seth Carnahan, and Laura Huang PNAS August 21, 2018 115 (34) 8569-8574; published ahead of print August 6, 2018 https://doi.org/10.1073/pnas.1800097115. Edited by Michael Roach, Cornell University, Ithaca, NY, and accepted by Editorial Board Member Mary C. Waters July 3, 2018 (received for review January 3, 2018)
28. Gender Bias in Critical Care. The Journal for High Acuity, Progressive and Critical Care Nursing, JoAnn Grif Alspach, RN, MSN, EdD, Editor
29. National Institute of Justice Research Report. Violence Against American Indian and Alaska Native Women and Men.2010 Findings From the National Intimate Partner and Sexual Violence Survey By André B. Rosay, Ph.D. May 2016 https://www.ncjrs.gov/pdffiles1/nij/249736.pdf
30. White House Council on Women & Girls, Rape and Sexual Assault: A Renewed Call to Action 1 (Jan. 2014), available at https://www.whitehouse.gov/sites/default/files/docs/sexual_assault_report_1-21-14.pdf.
31. White House Council on Women & Girls, Rape and Sexual Assault: A Renewed Call to Action 1 (Jan. 2014), available at https://www.whitehouse.gov/sites/default/files/docs/sexual_assault_report_1-21-14.pdf.
32. Lederer, L. J., & Wetzel, C. A. (2014). The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. Annals of Health Law: The Health Policy and Law Review of Loyola University Chicago School of Law, 23(1), pp. 61-91.
33. The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma. Bessel van der Kolk. September 25, 2014
34. https://jamanetwork.com/journals/jamapediatrics/article-abstract/2702204
35. https://www.ahajournals.org/doi/full/10.1161/jaha.116.003197
36. https://www.ahajournals.org/doi/full/10.1161/jaha.116.003197
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38. Geronimus, A. T. (2001). Understanding and eliminating racial inequalities in women's health in the United States: The role of the weathering conceptual framework. Journal of the American Medical Women's Association, 56(4), 133-137.
39. Kaiser Permanente. Clinical review by Jane Dimer, MD. Reviewed 03/01/2014
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42. Bessel Van Der Kolk, M.D., in The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma
43. From Rebecca Campbell. The Neurobiology of Sexual Assault (December 3, 2012) (Retrieved from nij.gov)
44. End Violence Against Women International (EVAWI) Understanding the Neurobiology of Trauma and Implications for Interviewing Victim. Christopher Wilson, Psy.D. Kimberly A. Lonsway, Ph.D. Sergeant Joanne Archambault (Ret.) November 2016 https://www.evawintl.org/Library/DocumentLibraryHandler.ashx?id=842
45. Bessel Van Der Kolk, M.D., in The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma
46. The American College of Obstetricians and Gynecologists
47. ACOG Committee Opinion: American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee members Serina Floyd, MD, MPH, and Joy Anderson, MD.The American College and Obstetricians and Gynecologists
48. Dr. David McCollum put together COLEVA — Consequences of Lifetime Exposure to Violence and Abuse. It's an interactive map that depicts how childhood trauma affects every system in our body.
49. When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on the Childbearing Woman. Penny Simkin and Phyllis H. Klaus
50. Kaiser Permanente. Clinical review by Jane Dimer, MD. Reviewed 03/01/2014
51. Spontaneous bearing down usually occurs in response to the leading part of the baby's head descending deeply into the birth canal, beyond the ischial spines. - See more at: https://www.bellybelly.com.au/birth/bearing-down-or-pushing/

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52. Cervix: a narrow canal at the base of the uterus, with an opening above the “internal os” into the inside of the uterus, an opening below, “the external os,” into the birth canal. The cervix is composed of connective tissue with muscle fibers interspersed.
53. Twighlighting: a temporary loss of consciousness usually related to insufficient blood flow to the brain. It's also called fainting or "passing out." It most often occurs when blood pressure is too low (hypotension) and the heart doesn't pump enough oxygen to the brain
54. Crowning takes place when the baby's head remains visible without slipping back in as you a laboring mother is pushing during birth.
55. Cervical Scar Tissue https://www.bellybelly.com.au/birth/cervical-scar-tissue/
56. How doctors traumatize pregnant women with unnecessary procedures, Sevonna Brown. For Harriet http://www.forharriet.com/2016/08/how-doctors-traumatize-pregnant-women.html August 2016.
57. There is a plethora of literature on this dual burden placed on enslaved women. One example is Jennifer F. Morgan’s Laboring Women: Reproduction and Gender in the New World. University of Pennsylvania Press: Philadelphia, 2004.
58. A key text to articulate this inhuman definition of Black people and Black women in particular is Thomas Jefferson’s Notes on the State of Virginia (1787). In this text, Jefferson postulates that Black people are not only inferior to whites in body and mind, but that Black women are the most unattractive of all, and goes on to write, “Even black men prefer white women over their own, just as orangutans prefer black women over their own.”
59. The American College of Obstetricians and Gynecologists’ Committee on Health Care for Underserved Women in collaboration with committee members Serina Floyd, MD, MPH, and Joy Anderson, MD.

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60. The Surgeon Who Experimented on Slaves. “J. Marion Sims. Celebrated as the “ father of modern gynecology.” Sims practiced the surgical techniques that made him famous on enslaved women. The first serious challenge to Sims’s lionization came in a 1976 book by the historian G.J. Barker-Benfield titled The Horrors of the Half-Known. Barker-Benfield juxtaposed Sims’s “extremely active, adventurous policy of surgical interference with woman’s sexual organs” with his considerable ambition and self-interest.” From Sarah Zhang, The Atlantic, April 18, 2018
61. “It’s Time to Start Recognising Birth Rape”. Zion Lights. Huffington Post.https://www.huffingtonpost.co.uk/zion-lights/birth-rape_b_2155384.html. Accessed April 19, 2019.
62. Rape Culture is an environment in which rape is prevalent and in which sexual violence against women is normalized and excused in the media and popular culture. Rape culture is perpetuated through the use of misogynistic language, the objectification of women’s bodies, and the glamorization of sexual violence, thereby creating a society that disregards women’s rights and safety. Marshall University.
63. Researchers at Boston Medical Center (BMC) surveyed women with a history of s sexual trauma and found that they have clear preferences regarding how they communicate their history with providers as well as certain aspects of their t treatment plan. Published in Obstetrics and Gynecology, these results can help inform providers on best practices when caring for these women.
64. Pregnancy and Childbirth After Sexual Trauma: Patient Perspectives and Care Preferences. Boston Medical Center and Brigham and Women's Hospital, Boston Massachusetts. Sobel L1, O’Rourke-Suchoff D, Holland E, Remis K, Resnick K, Perkins R, Bell S. U.S. National Library of Medicine, National Institute of Health. 2018 Dec,13.

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65. Passed in 1994, The Violence Against Women Act (VAWA) is a landmark piece of legislation that sought to improve criminal justice and community-based responses to domestic violence, dating violence, sexual assault and stalking in the United States.
66. JCAHO standards for accreditation address a health care organization's level of performance in specific areas—not just what the organization is capable of doing, but what it actually does. The standards set forth maximum achievable performance expectations for activities that affect the quality of care. These standards are developed in consultation with health care experts, providers, measurement experts, purchasers, and consumers, and usually are updated every 2 years. (Drawn from http://www.jointcommission.org/standards_information/standards.aspx).
67. Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study. MMDLN/Rutgers CERTs Publication #1. July 2010. Distributed by Rutgers CERTs at http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html
68. At the federal level, policymakers recently reintroduced the Mothers and Offspring Mortality & Morbidity Awareness (MOMMA) Act (H.R. 1897 and S. 916.), which would expand pregnancy-related Medicaid coverage to cover the full post-partum period (one year). A sizeable percentage of maternal deaths occur in the post-partum period.
69. Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786 .
70. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) states that a major depressive episode or major depression qualifies as peripartum if onset occurs during pregnancy or in the 4 weeks following delivery.

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71. Somerville S, Dedman K, Hagan R, et al. The Perinatal Anxiety Screening Scale: development and preliminary validation. Arch Womens Ment Health. 2014 Apr 4. [Epub ahead of print]
72. Lauren Owens, MD, MPH, defines trauma and trauma-informed care, describes the prevalence of trauma among various populations, describes a trauma-informed approach to the pelvic exam and informs of a trauma-informed approach to labor and delivery.
73. http://www.ncdsv.org/images/CharacteristicsCCR.pdf Characteristics of an Effective Coordinated Community Response.
74. Trauma in the obstetric patient: Evaluation and management . Noah D.Kauff MD, Nergesh Tejani MD,Primary Care Update for OB/GYNS, Volume 5, Issue 1, January–February 1998, Pages 16-20
75. A bill to support States in their work to end preventable morbidity and mortality in maternity care by using evidence-based quality improvement to protect the health of mothers during pregnancy, childbirth, and in the postpartum period and to reduce neonatal and infant mortality, to eliminate racial disparities in maternal health outcomes, and for other purposes.
76. Recent advances in developmental science have implications for pediatric practice and public policy that demand a public health approach to providing optimal care.
77. Haen, Lisa Sophia (2018) Labor doula care for survivors of sexual violence. Master's Thesis, University of Pittsburgh. Birth experiences and maternal satisfaction can be facilitated through labor doula care which may enhance a survivor of sexual assault's personal security, knowledge, connectedness, respect and agency. The public health significance of this research is that it examines labor doula support for survivors of sexual violence and how this form of nonmedical assistance can mitigate and buffer the impact of trauma-related challenges, in an effort to decrease adverse birth outcomes affecting survivors of sexual violence and their children.

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78. Priscilla Chan is CEO of The Primary School and co-founder of the Chan Zuckerberg Initiative. She is a practicing pediatrician and former educator and focuses on integrating health and education through the school's design. Meredith Liu is president and COO of The Primary School. She has spent her career in urban K-12 education, including Match Education and Codman Academy.
79. Silence, shame and abuse in health care: theoretical development on basis of an intervention project among staff
Barbro Wijma, Anke Zbikowski, and A. Jelmer Brüggemann. Published online February 27, 2016
80. The effect of medical and operative birth interventions on child health outcomes in the first 28 days and up to 5 , years of age: A linked data population-based cohort study Lilian L. Peters PhD,Charlene Thornton RM, PhDAnk de Jonge RM, PhD,Ali Khashan PhD,Mark Tracy MBBS, PhD,Soo Downe RM, PhD, Esther I. Feijen-de Jong RM, PhD, Hannah G. Dahlen RM, PhD
81. Passed in 1994, The Violence Against Women Act (VAWA) is a landmark piece of legislation that sought to improve criminal justice and community-based responses to domestic violence, dating violence, sexual assault and stalking in the United States.
82. General Medical Council. Fitness to Practise Panel. GMC vs. Shar, Mohamed. [online]. 2005 Aug 17-18 [cited 2005 Aug].
83. General Medical Council. Fitness to Practise Panel. 2005. GMC vs. Dr Gopakumar, Chempakaserry.http://news.bbc.co.uk/1/hi/england/west_yorkshire/4156866.stm (accessed 3 Dec 2007)
84. A chaperone is a person who acts as a witness for a patient and a practitioner during a medical examination or procedure. A chaperone should stand in a location where he or she is able to assist as needed and observe the examination, therapy or procedure.

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85. Committee on Health Care for Underserved Women, This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee members Serina Floyd, MD, MPH, and Joy Anderson, MD. Sexual violence continues to be a major public health problem affecting millions of adults and children in the United States. Medical consequences of sexual assault include sexually transmitted infections; mental health conditions, including posttraumatic stress disorder; and risk of unintended pregnancy in reproductive-aged survivors of sexual assault. Obstetrician–gynecologists and other women's health care providers play a key role in the evaluation and management of sexual assault survivors and should screen routinely for a history of sexual assault. When sexual violence is identified, individuals should receive appropriate and timely care.
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87. Barr W. Vaginal Speculum Examinations Without Stirrups. BMJ. 2006; 333(7560): 158-159.
88. Wright D, Fenwick J, Stephenson P, Monterosso L. Speculum 'self-insertion': a pilot study. Journal of Clinical Nursing. 2005; 14(9): 1098-2111.
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90. http://annals.org/aim/fullarticle/1884537/screening-pelvic-examination-adult-women-clinical-practice-guideline-from-american
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93. In September 2010, The Society of Obstetricians and Gynaecologists of Canada ( SOGC) and The Association of Professors of Obstetrics and Gynaecology of Canada (APOG) issued an updated policy statement on pelvic examinations and consent
94. Liu KE, Shapiro J, Robertson D, et al. Pelvic examinations by medical students. J Obstet Gynaecol Can2010;32:873–5 Available: www.sogc.org/guidelines/documents/gui246PS1009E_000.pdf (accessed 2011 Apr. 27).
95. Obstetric Violence, Elizabeth Kukura. The Georgetown Law Journal. [Vol. 106:721 . https://georgetownlawjournal.org/articles/261/obstetric-violence/pdf
96. Obstetric Violence, Elizabeth Kukura. The Georgetown Law Journal. [Vol. 106:721 . https://georgetownlawjournal.org/articles/261/obstetric-violence/pdf
97. Bowser, D., and K. Hill. 2010. Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth: Report of a Landscape Analysis. Bethesda, MD: USAID-TRAction Project, University Research Corporation, LLC, and Harvard School of Public Health.
98. All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women.
99.https://www.who.int/woman_child_accountability/ierg/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf

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100. The legislation has been a top priority of the American College of Obstetricians and Gynecologists (ACOG), which praised the House for passing the bill on December 11, 2018. The Senate passed it December 13, 2018.
101. MMRCs have existed in the United States for more than a century. Originally, these committees were composed primarily of obstetricians. They have since expanded their membership to include a vast array of professionals and partners engaging with and serving women during pregnancy and the year postpartum.
102. The program, modeled after the California Maternal Quality Care Collaborative, is central to improving maternal outcomes as well as addressing disparities.
103. The objective of this series is to inform physicians and other health care professionals of advances and their scientific basis across various fields within Internal Medicine.
104. CMS proposes to add a new section 482.13 (i) to the Patient Rights section of the hospital CoPs to prohibit discrimination and require written policies prohibiting discrimination, including on the basis of gender identity.
105. Standard are RI.01.01.01's Element of Performance states "the hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression"