Black Women's Burden:

An Analysis and Collection of Black Women's Health Experiences in the South

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Abstract

Black women's intersectional experience as both Black and woman creates a unique health experience and medical history for the population. Historically, as well as currently, Black women encounter discrimination for their racial and gender identities. The racist and sexist othering and objectification of the Black woman have resulted in mass discrimination and exploitation of Black women's bodies by health professionals and the institution of medicine. This paper reviews African American women's relationship with medicine and health providers from the Antebellum period to today, by analyzing existing literature and semi-formal interviewers with Black women who have received health care in the Southern U.S. Additional research should be conducted to preserve the medical histories of Black women. In addition, Black feminist Health Studies should receive further recognition as a field, for its work could assist researchers understanding and rectifying health disparities among Black women in the U.S.

Introduction

Currently, Black women in the U.S suffer from significant health disparities due to economic, social, access, political, historical, and cultural barriers and discrimination. According to the Centers for Disease Control, Black women are at the highest risk for singleton preterm births at 11.1% compared whites 6.9%, and American Indians or Alaska Native 9%; hypertension (44.0%) compared to Asian or Pacific Islander women who has the lowest rate (25.0%). In addition, from 1999–2013 Black women experienced the highest rates of infant mortality with 11.11 infant deaths per 1,000 live births in 2013 compared to the lowest rate of 3.90 among non-Hispanic Asian or Pacific Islanders (2015). The reasons for these poor health conditions are multifaceted, but cultural memory and systematic oppression are significant contributors.

This paper defines cultural memory as an embodied historical experience that accumulates and produces population recognized actions, beliefs, and thoughts. Cultural memory is significant. "For oppressed peoples, cultural memory engenders the spirit of resistance…" (Rodriguez & Fortier, 2007). Historical trauma is similar to cultural memory they are not the same. The concept of historical trauma is used in public health to understand the multigenerational effects of forced migration/relocation, genocide, slavery, war, and colonialism on a population. Studies have shown that populations who have endured long-term mass trauma, such as the traumas mentioned above, have a higher prevalence of disease, and these effects can be observed several generations after the trauma (Sotero, 2006). Public health recognizing the influence of historical trauma among Black women are vital to understanding the health disparities they face. According to Michelle Sotero, historical trauma "validates and aligns itself with the experiences and explanatory models of affected populations and recognizes issues of accountability and agency" (2009). Most importantly, the historical trauma concept empowers populations because it recognizes past inflictions forced on their bodies, rights, and health and does not blame the individual (Sotero, 2009). This paper attempts to tell an overall health story based on the cultural memory to address how this concept functions, and how the past continues to be woven into our present.

Recent research stresses the need for cultural competency and sensitivity in the healthcare model to improve Black women's health results (Cohen, Gabriel, Terrell, 2002). Promoting culturally competent and sensitive health care are essential in improving the nation's health, but I argue the solution does not lie in post-racial and post-feminist ideologies. Instead, the recognizing historical discrimination, exploitation, systematic oppression, and racist and sexist ideologies continue to impact Black women's health. It is not solely the physician's

responsibility to transcend cultural barriers to health care and health access. The historical and systematic roots of health disparities among Black women must be rectified, and Black women's relationship with healthcare systems and definition of health must be considered.

The rise of the professionalization of medicine has led to a continual decrease in Black women's control of their bodies and Black men and women's medical abuse. Due to a long history of medical abuse in the Black community, Black women and men have developed resentment and mistrust of health care workers (Musa, Harris, & Thomas, 2009). In a study by Musa, Harris, and Thomas (2009), focused on Black and White patients' mistrust, Black patients reported significantly less trust in their physicians "compared to other races and greater trust in informal health information sources than did whites" (Musa, Harris, and Thomas 2009). These poor relationships only widen the health care gap in the U.S. For physicians and researchers to create culturally competent and sensitive environments and interventions there must be both a recognition of medicine's downfall in the Black community and responsibility taken for the past and current exploitation in the Black community.

The purpose of this paper is to create a platform for Black women's health histories to be told and prioritized by breathing life into the stories of Black elders, rethinking what Black women's health means, and continuing the much-needed dialogue around Black women's current position in society. As a Black woman, I know what it means to grow up with the cultural knowledge of medical oppression and exploitation. When I first arrived at college, I enrolled in a Health Disparities course. During the first day of class, my professor reviewed common health barriers for U.S racial groups. Eventually, she flipped to a slide with the question "why Black patients do not adhere to treatment regimens from their physicians?" Without hesitation, I replied to myself, "because we don't trust ya'll (physicians)". I perceived my thought as a simple snarky

comment, but my professor soon answered the question "because many African Americans do not trust their doctors." I later realized what I counted as being sassy was a valid response based on my cultural experience. Throughout college, numerous instance continued to remind me of the significance of my cultural history. During my sophomore year, I shared information I learned concerning the untested Ebola vaccinations distributed in Sierra Leone with my eighty-year-old grandmother. I remember, before I could conclude the story, my grandmother interrupted with a stern warning. She said, "they always test things on Black people first, don't you ever forget that. Don't ever participate in research". My grandmother's comments called to my attention the contradicting realities of my community's cultural memory and my career aspirations as a researcher.

I chose to write this paper to honor my experience as a Black woman and honor the Black women who have come before me through the art of story-telling. I have chosen to write this paper honoring Black Feminist Scholarship and scholars (e.g., Collins, Bowleg, and Crenshaw), by using the literature and drawing upon qualitative interviews to complement this paper. I conducted three semi-structured interviews with three women over the age of 80. I used their narratives to inform my arguments below. A traditional, empirical social science format would not allow for the intentional interweaving of past and present, nor the significance of cultural memories to be explicitly created through the back and forth of interviews and references to medical history. A marching through time approach was chosen for this paper because it honors the power of stories and validates it as a source of knowledge and scholarship.

In this paper, I will discuss Black women's health experiences from the Middle Passage and slavery and compare how these experiences may have affected the perceptions and attitudes

towards physicians, and healthcare of Black women today. I utilize history and storytelling to depict a narrative that has greatly influenced Black women's opinion of healthcare in the U.S.

This research seeks to document Southern Black women's health experiences from the 1930s-1960s through literature and semi-formal interviews to validate and call attention to Black women's experiences and stories through the African tradition of storytelling. Black women have a unique health experience. As such, it should be further studied and recognized as a growing field of study.

To Be Black and Woman

To be Black and woman is to live in a complex system of political, economic, and social infliction while simultaneously balancing the requirements of one's mind, body, and spirit of those around her as well as herself. Society relates Black women's existence to the existence of others whether it of whites or her children. The Black woman is reduced to fit into society's understanding of womanhood and simplified categories that do not adequately depict the wealth of Black womanhood (Crenshaw, 1991). To understand Black women's experiences one must recognize her intersectional experience as both Black and woman, sexualized, and classed.

According to Kimberle Crenshaw, intersectionality is "the recognition of the compounded effects of naming and contending with oppressions linked to one's multiple identities [and] has long been a mainstay in feminist theorizing" (Crenshaw, 199; 1246). Black women occupy a unique position in society, . They experience both gender, class, and racial oppression. Black women's experiences are not the same as white women's nor Black men's and it is essential to recognize these realities health providers seek to treat their bodies and mental health,

Health providers understanding and acknowledging intersectional experiences and identities allows for the rectification of systematic discrimination and the improvement of healthcare, clinical research, and health systems. "Most public health research typically examines each system independently, 'thus impairing efforts to understand the health of people whose lives cut across these diverse realism of experiences'" (Bowleg 2012). We all have intersectional identities, and Black women's intersections go beyond sex and race, including ethnicity, sexuality, socio-economic status, and ability. Recognizing the complexity of the human experience, of not being solely white and male, and valuing these complexities and differences are to the benefit of the medical establishment and ultimately improve the U.S. health care model.

Intersectionality has the ability to "address the multiple and interlocking influences of systems of privilege and oppression such as racism, sexism, and heterosexism" (Bowleg, 2012). Figure 1, depicts the intersectional space Black women occupy. Black women live in a unique space where they must battle with being both a racial and gender minority. Many studies attempt to group women and Blacks as a monolithic group without mention of how one can be both Black and woman. To be Black and woman in the United States is to not be real.

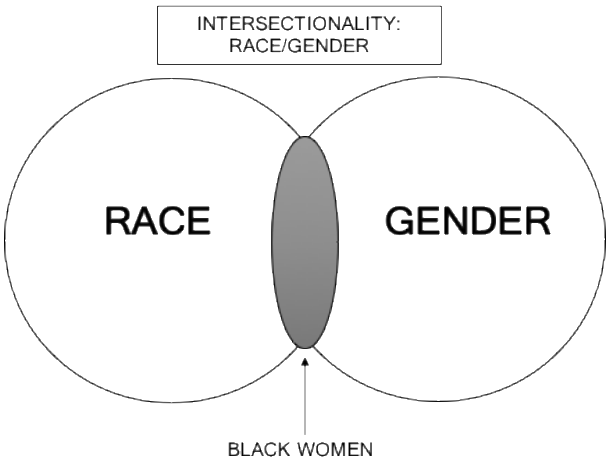

Figure 1

Living between oppressed identities , Black women become displaced in the U.S consciousness. They become unreal. Black women are expected to be strong but not too strong, motherly but not too sensitive, sexual but not hypersexual. These unrealistic expectations and stereotypes are constantly reinforced by media, language, and social behavior. These expectations have been adopted within the schema of the U.S. In this schema Black women only exist within the roles of the Jezebel, Mammy, and Mule (Collins, 2002). These images of the Black woman in U.S ideology are problematic and diminish Black women's womanhood and culture. When Black women are depicted in a positive light, they are often deemed as highly resilient figures, but this image also silences the emotions of Black women and expects them to deal with whatever hardships may occur instead of critiquing and altering systems that create these barriers. The strong Black woman figure is a tool used to perpetuate oppression and to justify blaming those who are not as "strong". To be a strong Black woman is not to be entirely free to feel and express all human emotion. To be a Black woman is to not be human but an image forever evolving in the Western Gaze.

According to Western thought, to be women is to be and to be Black is to be male, but where do these strict lines leave Black women? Black women are certainly not white. Their skin, experiences, and culture are unlike the white woman nor will they ever be. Like white women, Black women are susceptible to sexual violence, low-wages compared to men, economic dependence, and silencing. White women and Black women do share some common gender realities, but they are manifested in different ways. Furthermore, although Black men and women undergo racial oppression, their experiences differ. Black women do not only live amongst white

patriarchy but Black patriarchy. Black women are often spoken of in relation to others but not as a subject in their own right.

Black women are consistently juxtaposed to the experiences of others, thus making them the object rather than the subject. Objectification is the result of binary thinking. Collins defines binary thinking as thinking that categorizes "people, things, and ideas in terms of their differences" (Collins, 2002). Examples of binary thinking include white/black, black/female subject/object/ mind/body. These binary examples are only related because they are oppositional of one another (Collins, 2002). With this Western framework of thinking there is no middle group nor room for interpretation. If Black and white are opposites and so are male/female where do Black women fit? This thinking excludes Black women. As a result, Black women have been ignored in media, in social service initiatives, research, and in health care. In order to dispel the myths of the Black woman, it is essential to have holistic depictions of their lives, feelings, and reflections. Semi-structured interviews were used in this study to encourage these holistic images of Black women's health experiences.

Knowledge and the Spoken Word

In this study, semi-structured interviews were utilized to collect data in a culturally sensitive and competent manner, encourage story-telling from participants, and pay homage to the African tradition of storytelling. in the African American community, storytelling is a recognized knowledge form. This oral tradition can be traced back to Africa where the most respected person in society was the person who kept their sacred stories (Banks-Wallace, 2002). Storytelling is not only a culturally relevant way to conduct research with elderly Black women, but also a culturally sensitive research method. "Invisibility and oppression are routine parts of life for multitudes of African Americans. The sharing of stories provides a means for women to

be seen, touched, and healed from mental, spiritual, or physical hurts and ailments" (Banks-Wallace, 2002).

Storytelling is used as a form of knowledge sharing and healing in the Black community. Story-telling was promoted through open-ended questions such as "Growing up, when you were sick and/or hurt who took care of you? Can you tell me about a time this person/ people took care of you?". Asking participants open-ended questions allowed for participants to share multiple stories and created necessary space for participants to have full control over their responses versus an answer-led question.

The significance of this paper is not solely the women who volunteered to share their lives with me, but the awakening and sharing of cultural memories. Interviews were used as a research method because there is power in the voice, and the women who participated represent Black women throughout history who were never given a platform to share or have power over their health story. The interviewees' participation allowed for us to bring to life silenced voices which is what Grace Hong refers to as bring[ing] out [our] dead (2008).

According to Hong, "to bring out your dead" is to remember what must be forgotten, to find 'evidence of things not seen': that the notion of American equality in the protection of life is a fallacy, that life is not protected if you are raced and gendered, and that you are raced and gendered if your life is not protected" (2008). The mission of this project is to breathe life into the voices of Black women who have been and continue to be silenced and overlooked in the U.S.

Black Women and the Western Gaze: Creating the Premises of Exploitation

The manifestation of mistrust of health professionals by the Black community has its beginnings in the Transatlantic Slave Trade. African women's experience on slave ships were

vastly different than African men's. African women were not only judged for their skin color but their sex as well. During the Middle Passage, African men were shackled at the bottom of slave ships, but African women were not, instead they were permitted to roam on the quarterdeck. Having African women roam on the deck made them "easily accessible to the criminal whims and sexual desires of seamen, and few attempts were made to keep the crew from molesting" them (White 1999, p. 63). Black women were victims of rape while traveling to the colonies and their children were forced to watch this take place before their eyes. The exploitation of their labor and bodies began before they ever reached land.

During the late 1700s to early1800s, scientists and health providers played a major role in the justification of the institutionalization of slavery. During the Enlightenment, scientists were inspired by taxonomy systems and Charles Darwin's *Origins of the Species* which sought to classify the world (Schiebinger, 1990). Scientists and theorists were classifying plants, animals, Christian entities, and men. Racial scientists used this same classification system in order to "understand" the human race. Racial taxonomies justified slavery by deeming Black individuals as incompetent and less than human. Anthropology and racial science viewed Black women as incompetent, feeble-minded, and at the very bottom of the racial hierarchy (Schiebinger, 1990). Racial taxonomies created the blueprint for the justification of genocide and enslavement. Racial theory was, and continues to be, the foundation of racist ideologies and was further employed by slave physicians.

Black Women's Reproduction in the Antebellum South

After the international slave trade ended in 1807, physicians began to play a major role on Southern plantations. The United States' Southern economy was significantly dependent on slave labor, so once the transatlantic slave trade ended slaveholders became hyperfocused on

slave women's reproduction (Schwartz, 2006). As white slaveholders began to own more land, they needed more laborers and the only way they could do so was through natural increase. Slaveholders began pressuring women to have more children closer together, thus using their bodies as means of mass production. Slaveholders denied Black women bodily autonomy and most importantly their health.

Maternal and infant mortality rates were extremely high among slavewomen, and many slaveholders believed Black women were aborting babies on purpose (Schwartz, 2006). This argument further perpetuated the image of the animalistic Black woman and became yet another rationalization for their enslavement. High rates of maternal and infant mortality, were damaging to the business of the South, for if there were no healthy children being born amongst slaves there was no steady supply of new workers. Slave owners were frustrated. Eventually, slaveholders began hiring physicians to care for their slaves' reproductive health and ensure they were healthy enough so they would not lose profit.

Physicians were not visiting plantations in the name of medicine, nor were slaveholders calling upon physicians for the wellbeing of their slaves but to maximize profit. How physicians treated slaves were under the discretion of the slaveholder. When slaveholders called physicians to determine why maternal and infant mortality rates were so high among their slaves, physicians would exclude the clear relation of extensive labor during pregnancy, poor housing, and malnutrition to their poor health outcomes (Schwartz, 2006). Black slave women were living in harsh environments while completing extensive labor. Giving birth was a health risk and having babies back to back did not improve their health status. They wanted control of their lives and bodies. While slaveholders and physicians were attempting to increase fertility among Black women, Black women were pursuing control of their health through birth control methods.

Physicians only treated slaves for profit, and slaveholders only began offering health care to ensure a healthy labor force, and what slave women wanted was of no concern to either party. What Black slave women actually wanted was intervals between pregnancy sufficient for ensuring that mother and infant were both healthy (Schwartz, 2006). Differing goals and approaches created tension between medical men and enslaved women, each of whom thought they knew what best for women's bodies" (Schwartz, 2006). What the patient wanted was not the concern to the physician, for they did not treat the body but served whom provided monetary compensation. Black women's' bodies continued to be used and abused against their will, perhaps most notably by J. Marion Sims.

The field of Gynecology's early beginnings was forged on the slave population during the development of a surgical repair of vesicovaginal fistulas by J. Marion Sims. From 1845 to 1849, Sims conducted experiments on numerous slave women, and even purchased slaves for the solely for experimentation, but the three most notable women were Anarcha, Betsey, and Lucy (Schwartz, 2006). Sims experimented on his participants without anesthesia, thus exposing the slavewomen to excruciating pain. He experimented on Black women's bodies with the ultimate goal of operating on white women for profit. Once Sims discovered how to repair the fistulas, using Black women as his testing subjects, he lied claiming he conducted his experiments on white women instead. Sims' goal was to gain great profit from his work and believed he could not do so if it was common knowledge he learned from "inferior" bodies, although he used anesthesia when operating on white women and not on Black women. Sims was only one of many the benefited from the pain of Black women (Schwartz, 2006).

White males and white medical professionals and researchers continuously used Black women for their personal gain, dismissing Black women as human beings and their right to their

own bodies. Serving as a plantation physician was physician's main source income, such as Sims, during the time. Many physicians were acting upon their personal will not according to the will of the patient. The patients, enslaved women, were ignored and their bodies surrendered in the sake of science and the institution of slavery. This cruelty exerted against Black women has led to Black women not trusting the intentions of medical professionals and researchers.

Ethics in the 20th Century

The U.S. Public Health Service (USPHS) Syphilis Study at Tuskegee, commonly known as the Tuskegee Syphilis Study, is considered the hallmark event that led to the distrust between Blacks and medical professionals. The study took place from 1932 to 1972, and 399 Black men were denied effective treatment for their syphilis and were not made aware of their status (Gamble 1997). The purpose of the study was to evaluate the long-term effects of syphilis on African American males. As a result of the study, over 100 men died from advanced syphilis legions (Gamble, 1997). The medical abuse case captured public attention when Jean Heller of the Associated Press reported the story in an article for the Washington Star on July 25, 1972. Her article quickly reached the African American community and created a critical dialogue concerning medicine's intentions in treating Black bodies (McCallum et al., 2006).

Although the Tuskegee Syphilis Study did not focus on Black women, it is a notable event in medical history, because it is continuously referred to by researchers, the African American community, and public health professionals. Although Black women were not the subjects of the study, there were still affected. Participants in the study were not made aware they could spread the life-threatening disease to their sexual partners, nor how syphilis could affect an infected woman's child. We do not know how many families of participants lost economic security due to their death or the death of their partner whom they may have infected. The effects of the study

are both personal and cultural. The Tuskegee Syphilis Study continues to live on in the memories of African Americans. Eighty-six years later, the Tuskegee Syphilis Study continues to impact communities. The Tuskegee Syphilis study, although a terrible act, is often misinterpreted due to word of mouth and a cultural memory of numerous poor bioethics and cruel experimentation throughout the 19th and 20th centuries.

Birth Control, Black Power, and Eugenics

Throughout history, racists and patriarchal powers have attempted to control African American women's reproduction. The control of Black women's reproduction extends beyond slavery, but within national initiatives, second-wave feminism, medicine, and their communities well into today. In the late 19th century, the eugenics movement, inspired by Darwinism, gained momentum and sought to limit the reproduction of non-whites to ensure the continuation of the white race.

During the Progressive Era, Social Darwinism swept across the nation popularizing the belief that personality traits are genetic. Progressivists believed that the genetically unfit should not be allowed to reproduce for the sake of improving society. As a result, many began to promote the procreation of the "superior" race and began to suppress those of "unfit" races by promoting birth control within their communities. Scientists and medical professionals justified the idea of a fit race. The widespread belief was non-whites were wild, unintelligent, and incapable of caring for themselves. Scientists believed these inferior traits and skills were inheritable for the negro, and it eventually sparked the eugenics movements, which resulted in many women of color being sterilized against their will or without their knowledge (Roberts, 1999). Many argued that sterilization is an aspect of public health, for it was important to have a fit race for the country to continue to strive. The mission to decrease non-white populations was encouraged through the

encouragement of the use of birth control by feminist and federally funded Planned Parenthood (Roberts, 1999).

Birth Control has long been interpreted as the beginning of women's liberation by mainstream feminism, but this liberation was only for white women. The Birth Control Movement began to take height around the time of the eugenics movement in the United States. Simultaneously, there was a push for women's choice to or to not bear children. Eugenic beliefs were held by many Americans that the poor and diseased are not worthy of producing offspring for they will corrupt the stock. The idea did not only include the poor and diseased but Black Americans in general (Roberts, 1999). In the 1970s, birth control was a liberating tool for white women but began a new discourse for Black women in relation to who gets to control and regulate their reproduction. Although, birth control presented freedom for some women, and even some Black women, it was yet another tool used to control Black women's bodies and health.

White medical professionals, researchers, and scientists were not the only groups who sought to control Black women's birth rates and bodies. Upper-class Black male intellectuals called for Black upper-class women to cease utilizing birth control at high rates. These upper-class intellectuals and religious leaders believed upper-class Black women's offspring would possess the skills needed to survive in a racist society and if they did not procreate the African American population would be of lesser quality (Hart 1994). This idea is an extension of the same racial science that believed personality traits and ability were genetic. Black intellectuals believed wealthy Black families possessed satisfactory traits of perseverance and knowledge that needed to be spread throughout the race so that they could initiate a racial uplifting.

This philosophy is a classic adaption of what Audre Lorde refers to as the master's tools. The master's tools are behaviors, ideologies, and actions that make the exploitation and silencing

of a people possible. The master's tools refer to the techniques white men have used to enslave and exploit Black people during slavery and continue to use to oppress marginalized group in and outside the U.S (Lorde, 2012). Black men have used, and continue to use, the same ideologies, or tools, that justified white men's pursuit to colonize, rape, and enslave people of color's, lands and bodies. The belief that Black women should have numerous offspring continued well into the century with the Black Panther Party.

In the 1960s and 1970s, the Black Panther Party and other Black Nationalists sought to improve the living conditions, health, and social capital of Black Americans. They supplied lunches to impoverished children and offered health care to the poor (Nelson, 2003). While the party accomplished much, their ideas of women's reproduction were constraining. According to Jennifer Nelson (2003), Black Panthers and Black nationalists believed black women's role in the movement was to bear multiple children (Nelson, 2003). Black Nationalists believed it was Black women's responsibility to bear children so they can enter the "Black army", for without numbers to resist oppressors they will never succeed. This role silenced Black women's voices and overshadowed their work. These Black nationals also pressured Black women not to accept birth control and to continue to bear children despite their desires.

This reliance on Black women's bodies is similar to the South's dependency on Black women for a sustainable labor force during slavery. The only difference between the two dependencies is one is controlled by white men and the other by Black men, but both employ notions of violent masculinity in order to reach their goal at the expense of Black women's autonomy. In an effort to break their shackles, men of the Black Panther Party and Nationalist movement exploited and silenced Black women.

Although, Black women were submerged in a world of ideas of what they should do with their bodies they persisted and called for their own requirements to be met. Black women fought to be included in discussions surrounding abortion and birth control rights, arguing for white women to consider the social determinants that may lead a Black woman to desire to end a pregnancy, such as lack of social services and unequal pay (Nelson, 2003). Black women were far from silent despite racist and sexist forces. They continued to progress in order to care for their communities, children, and themselves. Since the 1700s Black women have been the target of Western misogyny and exploitive health professional but they sought to revolutionize the system.

Black Women in Medicine

Black women were not always at the mercy of medical exploitation but the trailblazers, caregivers, and voluntaries of medical systems and services. Throughout U.S. history, they have served as healers, caretakers, nurses, physicians, community health workers, and more. Black women's participation in health care began as soon as they arrived on American soil. During early slavery, the institution of medicine was not established, and Western medicine was not well developed. West African traditional medicine was more effective than U.S. medicine. Black medicine women were sought out by her fellow slaves, slaveholders, and the broader community. They possessed much power as healers. In the context of ineffective Western medicine, Black medicine women possessed social capital. This power was a threat to the racial taxonomies and the slave plantation hierarchal system. Slaveholders would control who and when she would heal to limit the social capital she may gain from healing, (Fett 2002).

After emancipation, white health professions refused to treat Black bodies. Their lives were considered not important. Racial animosity reduced the number of white physicians willing to

see black patients. Once gaining freedom, Black people had no place to go for medical care, for hospital and clinic staff risked alienating white clients by opening their doors to Blacks (Schwartz, 2006, p. 295). "Racism led to a shortage of health professionals and medical institutions willing to -serve African Americans" (Smith, 1995, p.17-18).

Black women continued to provide and advocate for health care for their communities after emancipation through nursing and lay health work despite pushback. Before nurse registration laws, Black nurses were active participants of nursing associations along with white women; lay providers were even welcomed in associations such as the National Organization for Public Health Nursing (Hine, 1989). Black nurses supported the effort to establish nursing as a regulated profession, not knowing they would be cast aside based on their skin color (Hine, 1989).

Medicine restricted its opportunities to Blacks by elevating their standards for education and requiring permits in order to practice when many Black women were not educated and could not afford the permit fine. In Southern states where nursing permits were available, Black nurses were barred from taking registration exams or administered a separate examination, despite their demand to receive the same exam white nurses received (Hine 1989).

Black nurses were thought to be incompetent and less qualified compared to white nurses. These racist ideologies diminished Black women's chances of employment and made them appear as inferior members of the profession, thus an inferior hire (Hine 93). Despite many obstacles, Black women did not allow for discrimination to discourage their efforts. Along with Black community, these women formed their own associations and organizations in addition to schools to continue their mission.

With the poor health status of the Black community and the mass discrimination of the medical profession, Black women managed to exert control of their bodies and communities' health. When barred from "white nursing schools" black women, along with Black men, founded nursing schools of their own, such as Spellman College. In addition, Black nurses went on to found the National Association of Colored Graduate Nurses and the Blue Circle for Negro Relief (NACGN) when excluded from "white" nursing organizations (Hine, (1989);(94&108). Like other associations, the NACGN also took measures to professionalize their field by urging nursing schools to raise their standards and suggesting schools to select "superior women" (Hine, 1989). These nurse training programs provided Black women an opportunity to gain financial independence, education, and further professional possibilities for their children. For nursing was viewed as a form of self-help for African Americans and many argued that Black nurses were essential to racial uplift.

The Black community was used to assisting one another in order to endure the harsh conditions of slavery, so establishing women's clubs and community health initiatives was a natural reaction to the dire health conditions being experienced (Schwartz, 2006; Smith, 1995). Black nurses were far form the only group of women who made sustainable contributions to improve the health status of African Americans: so were Black community clubs, lay health providers, and community members. The Mississippi Health project is a notable example of Black women's work to improve their communities despite adversity.

In 1935 the Mississippi Health Project was developed, facilitated, and partly funded by the first Black Greek-lettered sorority, Alpha Kappa Alpha Sorority, Incorporated (AKA). The Mississippi offered alterative health services to African American sharecroppers and children in Holms County, Mississippi (Carlton-LaNey, 1997). During the period, Mississippi was suffering

from significant rates of smallpox and diphtheria. The project's mission was to offer as much preventive care and medical assistance to the area as possible. All doctors, nurses, and other staff were volunteers, and the sorority women would volunteer their time to drive up Mississippi to open the clinic. Clinic would sometimes be hosted out churches and old hospitals and other avenues (Cobbs, 1941).

Eventually, the Mississippi Health Project attained funding from the United States Health Service to target smallpox and diphtheria among children and syphilis among adults. (Cobbs, 1941). From the summer of 1935 to 1942, AKA and the Mississippi Health Project managed to serve over 15,000 patients (Cobbs, 1941). This substantial impact was possible because of volunteerism. The Mississippi Health Project is one example of how Black women have worked to improve the lives of the Black community through grassroots activism.

Community work has been essential in opening doors for Black women to practice professionally and improving the health status of the Black community. Today, there is a growing number of Black women in medicine, but Black women remain underrepresented compared to the percentage of the general population. According to the Association of American Medical Colleges (AAMC), Blacks comprise of 4% of the physician workforce in the United States. Among Black or African Americans physicians, 55% are women and are "the only racial or ethnic group currently comprising a greater percentage of women than men. This difference is even more apparent among medical school applicants where women comprise roughly two-thirds of black or African-American applicants" (2014).

Researchers have found that diversifying the healthcare workforce will help narrow the healthcare gap among racial minorities (Cohen, Gabriel, & Terrell, 2002). As a result, it has revolutionized the healthcare model. Researchers argue that adding more healthcare workers of

color healthcare personal will be able to better identify and offer culturally competently and culturally sensitive care to their patients (Betancourt, Green, Carrillo, & Park, 2005).

There continues to be a shortage of Black physicians and culturally sensitive physicians overall, states and health programming are employing community health workers. The use of community health workers can be seen in hospitals, clinics, and churches. What is problematic about this work is that Black women are once again responsible for the health of others as well as herself, low-pay, and a lack of job and salary growth. Black women are being utilized to bridge health gaps health professionals and systems have created. Black women talents continue to be overlooked and exploited in order to do the work of a capitalistic system, the U.S health care system.

Methods

This project was approved by the University of Florida Institutional Review Board in April 2018. For participants to enroll in the study, they were required to be at least 60 years of age, identify as Black, and had sought or received health care in the Southern United States' during their lifetime. Participants were recruited through snowball sampling from a pool of Black elder women who all knew each other from church and neighborhood networks and were acquaintances of my grandmother. The three participants were all 80 years old or older and grew up in working-class families in the Southern United States.

Interviews were conducted either in person or via phone and lasted an average of 56 minutes, with a range of 39 to 82 minutes. All interviews were recorded, transcribed, and analyzed to identify themes. The information below has been altered to protect the identities and health information of our participants.

The Interviews

Participant #1: Angela Roberson

Angela Roberson is an 89-year-old Words with Friends enthusiast with nine children, 20 grandchildren, 44 great-grandchildren, and ten great-great-grandchildren. Roberson was born in rural Georgia and was delivered and raised mother by her grandmother. Roberson's mother passed when she was twelve years old, so her grandmother was her caretaker when she had minute illnesses. Her grandmother would give her remedies, but she never went to see a primary care doctor at the time. When asked about going to the doctor when she was a child Roberson replied that no one went to the doctor as a child during those times.

Roberson's first health experience was going to the eye doctor. Roberson described the experience as pretty normal. She waited for the eye doctor in the "little cubby hole" that consisted of four seats for Black patients as white patients waited in the large waiting room. When asked how this clear racial divide made her feel she replied, "that is the way it was back then", but this segregation did not stop Roberson. She described herself as "hard-headed and talked too much and would do what [she] want". During Roberson's first eye doctor visit she grew thirsty, but there was no Black water fountain in the waiting room. With her daring spirit but knowing better than to drink directly from the water fountain, Roberson disobeyed her grandmother's wishes not to get up and proceeded to fill her soda can from the whites-only water fountain. While filling her soda can with water, the nurse caught her and was frazzled at the sight of Roberson on her tippy toes filing her soda can with the fountain where a White's Only hung above. The nurse urged Roberson to stop, but she did not care and told the nurse "I'm thirsty" and went back to the Black sitting area. Roberson's grandmother continued to be her primary caretaker with the support of her aunt until she married.

Roberson married at the age of 15. According to Roberson, "back then people did not marry just to marry but the purpose of a wife was to take care of her husband… [her] husband was twenty". Roberson birthed her first child at the age of 17 and birthed a child every year from 1956 to 1965. "It didn't seem like it was bothering me because we had a good relationship… We had fun". She gave birth to most of her children in the hospital, except for her fifth child. Roberson had her fifth child at home with the assistance of a nurse aid. Roberson would have preferred to have her fifth child in the hospital, for women would stay in the hospital for a week and would have health personnel to help mom and baby. Unfortunately, Roberson could not leave her four children, who were all under the age of four, at home. Someone needed to care for them, so Roberson settled with a homebirth and assisted by a nurse midwife.

Roberson birthed children from age 17 to 26, which made her Black male doctor worried. When became pregnant with her eighth child, the doctor told her "I'm going to stop you from having any more children". Of course, Roberson went on to have one more. Roberson had immense pride in her many children and enjoyed raising them, but her doctor believed her body was strained and would not stop having children unless there was an intervention. Roberson Black male physician wanted to have her tubes tied, but in order to do so he had to request permission from the state. When I asked Roberson why the State's permission was necessary, she replied she did not know why and "it's just the way things were."

Roberson's life accomplishments do not only consist of her large family. Having returned to the hospital every year for check-ups and delivery, she got to know the nurses and hospital staff well and was inspired to pursue nursing. Since Roberson married at the age of 15, she did not finish grade school, so at the age of 28, when her children were more independent, she attained her GED and later progressed to an all-Black nursing school in 1964.

Roberson enrolled in an all-Black LPN school in 1964. White nursing students and Black nursing students went to nursing school on opposite sides of town. Roberson began her early work as a nurse in the Black men's ward. A year after Roberson's nursing education, 1965, her nursing program was integrated.

Roberson began her work as a nurse in a segregated health care model; I asked, "do you feel like all patients were treated fairly (at the hospital)? She replied, "yes" and noted her personal work rather than the institutional work. After working at the hospital for a short period, "they had an opening in central supply, and they asked me to be a supervisor. I kept this position from 1975 until 1983". Roberson progressed quickly in the hospital earning several positions until she could not be legally promoted anymore because she did not have a college degree. The hospital was willing to send Roberson to college, but she declined the offer stating that she was not far from retiring.

"After all these years people will come up to me and say I remember you took care of my mama when she was sick". Until this day Roberson is stopped and thanked by her patients and the children of her patients. One day, she even received a letter from a young woman thanking her for caring for her mother when she was deathly ill.

Participant #2: Patricia Edwards

Patricia Edwards is an 81-year-old happily divorced woman who lives in a highly decorated African esthetic home. Edwards was born in rural Florida to a working-class family, where her father was a chauffeur, and her mother was a domestic worker. She was raised by her grandmother who usually would take care of her when she was sick. When asked, "when you were sick what types of things would you grandmother do to make you better?" She responded:

"Oh [there was] so many remedies we had. Usually, she would give me castor oil. Jesus, there's so many remedies she used to give me. It's a wonder I'm not dead (laughs)".

When Edwards' condition required more than her grandmother's remedies, she would go to the local pharmacist. During her childhood, people did not go to the doctor but would go to the local pharmacist and tell him what was wrong, and he would sell the customer a medication to treat the condition. Overall, Edwards had a simple childhood and jumped at the first opportunity to leave the state and live with her Aunt at the age of 18.

In New York, Edwards married and had two daughters with her then-husband. She was pretty progressive in raising her children, especially since she did not talk to her friends about birth control "and stuff" as a young adult. Although she denied utilizing any clinical resources at Planned Parenthood, Edwards collected their educational materials for her two daughters when they were 15 and 16. Edwards did not see anything wrong with women going to Planned Parenthood and believes the institution was a great community resource.

Edwards did not have a very medicalized childhood or young adulthood, but she was critical of the health care system. During Edwards's interview, she briefly commented on what she believed to be an experiment station in her hometown. Edwards believed that the medical center across from the main hospital was referring Black patients there for research purposes. According to Edwards, the hospital assumed all Black patients who came into the Emergency Room were suffering from syphilis, thus they were misdiagnosing them. She believed the mysterious building was a research hub and fueled by the ER patients from the main hospital. This experiment station alludes to those associated with Tuskegee Syphilis Study.

Participant #3 Barbara Allen:

Barbara Allen is an 80-year-old woman who enjoys her neighborhood walks, attending church, and spending time on her porch. Allen was born in urban Florida to a mother and father who spent most of their lives in rural Georgia. Allen described her childhood as not deviating from the normal Black childhood of the time. She grew up in a poor family, but in her opinion, this was not notable because "everyone was poor at the time" and they "may have been poor, but [they] were happy." Allen considered her father a "jack of all trades," because "when you're Black you have to know everything." He grew up farming, worked on the railroad as a young man, and did various jobs throughout his lifetime. Her mother was "just a wife" and took care of the home "as most mothers did."

Like Edwards, Allen did not go to the doctor when ill, but relied on the local pharmacist. When the pharmacist was not available or not sufficient for the illness, there was a community physician who would visit your home named dr. Washington. Like the pharmacist, Dr. Washington, the affordable white doctor, would "give all types of medicine but "he would mostly deliver babies, but he would do almost everything…". If community members did not go the pharmacist, possibly because the condition required additional care, they would contact Dr. Washington. Allen even saw Dr. Washington in her 20s during her first trimester with her oldest child.

Allen does not remember being notably ill that she needed long-term care from a healthy provider, but she does remember the healthcare the county and schoolboard offered to grade school children. Nurses would visit schools to vaccinate children. Allen vividly remembers her Measles vaccination that was inserted in her back. Allen attributes this vaccination to her positive tuberculosis (TB) test results; she cannot take a standard TB test because she always tests positive. Instead, she has to have an X-ray conducted. Allen believes she was given a live

version of Measles during her vaccination as a child, so she now has false positive TB tests. In addition, Allen suspect that her and other students were used for research when receiving vaccinations

Allen's first doctor visit was due to an emergency. "One time I went to the doctor because a fish bone got stuck in my throat. The bread didn't work. My dad carried me on his shoulders all the way from our house… cross the bridge to the doctor. For him (the doctor) to reach down and pull that fishbone out my throat. My daddy was a hero". I remember meeting [the doctor]. I was glad to go. I couldn't swallow. I couldn't do anything." The fish bone incident was Allen's first time receiving care from a physician.

Allen's other health experiences as a young woman were mostly during the birth of her three children. Allen second child was born with extreme scoliosis but denied swift medical interfere because she doctors did not know what they were doing for them to touch her week-old son. When I asked if she would have done it today, she said she would do it today because she thinks doctors now know what they are doing unlike back then.

Allen truly did not think doctors were as efficient and knowledgeable in the 1960s as they are today. Allen suffered a stillbirth with her third child. "It was the most hurtful thing". "I was use to bringing my children home ya know"? She believed her use of birth control as a young woman resulted in her miscarrying at six months with her third child.

Allen's health experiences grew as she became her husband's caretaker, who suffered from heart problems and two types of cancer. As the sole caretaker of her husband, she spent a lot of her time in and out of doctor appointments and emergency rooms, Allen tracked complicated treatment regimens and helped her disabled husband bathe and dress,

Since her husband was physically impaired, she would spend the day before his doctor appointment getting him ready, "and the doctor would only spend 15 minutes with him". According to Allen," they shouldn't be rushing." With numerous doctor appointments for herself and her husband, Allen grew tired of the rush of the doctor office and then pushed against their requests to blindly oblige to their requests without explanation.

Allen is skeptical of the medical profession. "I don't think they give a hoot [about the Black community]," she claims. "We are just a number." When asked if she trusts doctors, she quickly replied: "no, I trust my body." She does not like how doctors forcefully push pills and expect patients to be okay with the side effects. "I don't trust them when it comes to pills. I tell them I won't take it then they'll give you something else, and if you don't say nothing they won't give it to ya… I think they are doing trials on you ya know."

At the conclusion of the interview, I asked Allen tangible ways her health experience may be improved:

Interviewer: Would you prefer your doctor to be a Black woman?

Allen: Yes, at this age. "I've had enough white women (laughs). I want to give another race a chance. I've never had a Black doctor I would like to try one. Everybody has been white. At this age in my life, I would love to have a Black female doctor. She would be up on everything you know".

Interviewer: What do you wish doctors and other health professionals knew about women?

Allen: This is why I have this lady doctor… I don't care for them (men)". "feel like you going to slavery times you know?"

Interviewer: What do you wish your doctor and other health professionals knew about you specifically?

Allen: I wish they knew that I was a friendly person… and that I'm not gonna take the medicine if I don't like the side effects. … I want the same quality of care they would want for their mother, daughter, or wife. Not because I am Black or nothing like that I just the same quality of care".

Results/Analysis

The participants were born in the 1920s and 30s in the South. They had similar experiences with physicians growing up. Going to see the doctor was not a common occurrence, nor was it an option unless it was an emergency. According to Roberson, it wasn't because the doctor was expensive--it was only two or three dollars--but the doctor wasn't needed. Either your mom, grandmother, or pharmacist knew what to do. Their childhood was not medicalized but filled with folk remedies and loving women would nurse them back to health.

The participants all touched upon racial segregation in different ways, alluding to the culture of the time and its normalization. While race was mentioned in all interviews, only one participant's interview highlighted the role of colorism in the 1950-1960s South. Throughout Roberson 's interview, she set herself apart from other Black people. She distanced herself from other Blacks by saying: "My aunt was mean and jealous… my cousins were darker than you [points at me during the interview] and had what they called nappy hair… my hair was long in braids" and "my grandmother was a dark as you [me]" referring to when she was offered a seat in the white section of the train but once the conductor saw her grandmother her proximity to whiteness was reduced. Roberson is a light-skinned Black woman with fine curly hair. She never attributed her privilege to her skin color or curly hair. Roberson compared her skin color to

other nurses but attributed their anger to her promotion to jealousy. There is no doubt, Roberson was a force to be reckoned with, but colorism seemed to be an overarching theme of her interview, unlike other participants. Roberson ignoring her color privilege is an example of the highly complex intersectional space Black women navigate, and how they too may be unaware of their privilege.

All three participants' perceptions of medicine differed depending on their background. Unlike Edwards and Allen, Roberson did not demonstrate any extreme disappointment or skepticism of the health care system. This may be because she was once part of this healthcare system and understand its culture that celebrate efficiency and meeting the bottom-line. Anderson was familiar with the tools healthcare models employ, so she was not questioning of it even in here current medical care.

Edwards was not extremely skeptical of medicine, except for the possible experiment hub. Allen was the most skeptical of health among the participants. Interestingly, all participants were affiliated with the same health system and had differing interviews and opinions on their care. In comparison to other participants, Allen had a very medicalized life. She gave birth three times in the hospital, suffered a miscarriage, refused surgery for her son's scoliosis as an infant, and was a care taker for her husband and brother for numerous years.

Both Roberson and Allen saw medicine step in with the future of their children. Roberson was told she is going be sterilized although her doctor never asked her if this is she wanted, but Roberson says she wanted it and when the doctor had stated she was going to be sterilized she agreed. Roberson's doctor was a Black man who felt he the space to say when Roberson should stop having children. He may have seen the stress her body was having, but it is odd that a doctor

would not ask first. The doctor's wishes seemed to have priority when it came to Allen's and Roberson's stories.

After Allen birthed her first son she stated that doctors wanted to operate as soon as possible to straighten his spine, but she refused. In the same way, Allen refused doctor's taking her stillborn child. "I didn't want them to put him in one of those jars". "I was scared", she said. Allen's stillbirth was a traumatic experience, and she was anxious that her pain would be profited from, so she asked for her stillborn's body and had it buried. This story reflects on the long history of putting Black bodies on display and using Black people for the advancement of medical research. Allen did not want her child to be part of this narrative.

Although Allen is critical of health workers, she says she trusts researchers, for she believes one day they would find a cure to an array of diseases. The contingency to this statement could be that she does not intend to be part of that process, for research only hurts Black people in the process. To some Allen's claims may seem bizarre, but they certainly not incorrect. Allen is reluctant to trust the pills her doctors attempt to give her. Currently, pharmacy companies have a major monopoly in overprescribing numerous drugs to the public and having some physicians push patients drugs they may not need. Allen even mentioned how doctors would not offer her alternatives until she refused the first medication.

One of the most significant findings was that the participants did not prefer for their physician to be a certain race necessarily, but they just wanted them to treat them correctly. All three participants complained about the short time doctors spend with them and the impersonal relationships they have with their current physicians. They feel like a number rather than cared for. Allen did prefer a woman over a physician who is a man. She believed a woman would

understand her more because she had been through the same things. As women, they would share a similar cultural memory.

The critiques given concerning their current medical and health care are common critiques of the fast-paced U.S. health care system. All participants mentioned how impersonal health professionals are, except for Roberson, this perception may be based on the comparisons of their past care givers. Growing up, these women had their mothers and grandmothers caring for them, an easy to access pharmacist to prescribe, and figures such as Dr. Washington who was willing to come to one's home. Medical care was simple. Edwards mentioned how now there is a "heart doctor, a leg doctor, a kidney doctor… there's a doctor for everything".

Participants' detailed stories in this paper provide an example of the increased medicalization of Black women's lives. All participants noted that going to see the doctor was not common nor was it an option at most times. Now in their old age, they find themselves going to numerous specialists who rush and do not take the time to care for them as a person. Some mistrust may be amended if physicians effectively with their patients. Physicians are not sharing what they are doing with their patients' bodies and for Black women, and for many, that can result in anxiety and treatment non-compliance.

This neglect of the human behind the patient could be due to the pressures of the capitalistic U.S healthcare model but also stereotypes the physician may have about the patient. Allen noted how she was not told of the side effects of her medications or alternatives until she asked this may have been due to her doctor's assuming that patients of color do not understand or may not be able to afford non-Medicaid covered medications. Physicians are not sharing what they are doing with their patient's bodies and for Black women, and for many, that can result in anxiety and treatment non-compliance.

Black Lives Matter and Black Mamas Matter Too

Black women have created avenues and spaces to address health in a holistic way that recognizes their experiences. Black Women have authored "Body & Soul: The Black Women's Guide to Physical Health and Emotional Well-Being" and "The Black Women's Health Book" to address their needs. Today, Black women are demanding for their needs to be heard and addressed through movements such as the Black Lives Matter Movement and the Black Mama's Matter Alliance. Modern day social movement challenge what is health and how health is proclaimed and pursued among the Black population and, more specifically, Black women.

Black Lives Matter (BLM) is a social movement created by three Black women to address police violence against Black bodies and Black neighborhoods. #BlackLivesMatter was created in 2013 following the fatal shooting of teenager Trayvon Martin. BLM is a "Black Lives Matter is an ideological and political intervention in a world where Black lives are systematically and intentionally targeted for demise. It is an affirmation of Black folks' humanity, our contributions to this society, and our resilience in the face of deadly oppression" (Black Lives Matter).

BLM is a social movement, but also a public health intervention. "Racism [is] a social condition [and] is a fundamental cause of health and illness". As such, public health work is essentially antiracist work (Garcia & Shariff, 2015). BLM is a real occurrence in people's lives. Mass incarceration and police violence is an epidemic in the Black community. Roberson has a son who has served 20 years in state prison for the murder of a rich white man. He was with the wrong crowd and since he was associated was also persecuted for the man's death. Her family has hired numerous lawyers, each with a higher price tag, in order to get him justice but their efforts have failed.

Like BLM, The Black Mothers Matter Alliance (BMMA) is an alliance spearheaded and for Black women that "center Black mamas to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice" (blackmamasmatter.org). The vision of the alliance is to promote, and help create "a world where Black mamas have the rights, respect, and resources to

The BMMA does not seek to gain public support for Black babies, for many are able to sympathize with an infant but with the mother. I had the pleasure of sitting in on a BMMA seminar at the Annual Public Health Association Conference. After their presentation, an audience member, a white woman, asked "why is it not called the Black Mothers and Babies Matter Alliance? Black babies are also high risk as well". In the U.S, the infant mortality ratio for black women for every 100,000 births there are 43.5 deaths, compared to white women's 14.7 per 100,000 ratio (Reproductive Health, 2017). This focus on mother is crucial. As stated earlier in this paper, Black women are often other named as wife, mother, caretaker. By always relating Black women's identity to another's her experiences are never are never recognized nor prioritized. Naming and dedicating oneself to the health and wellbeing of Black women is a political move that may make some uncomfortable.

Movements and alliances such as BLM and BMMA, are examples of how Black women continue to work to improve the health of their communities and continue to redefine what healthcare looks like and what health means. Black women understand that their survival extend further than the doctor's office. Black women's, and the Black community, progress is dependent on their willingness to revolutionize systems and ideologies and strive for political change.

Conclusion

Black women live in an intersectional space of both Black and woman, and society has done a poor job of realizing these realities. Black women's experiences are different than white women and Black men. Although Black women experience racial injustice and sexism their race and gender significantly alter these realities. Since the Transatlantic Slave Trade, Black women have been oppressed due to her gendered and racial identities. These cultural memories and historical traumas from unethical research, healthcare, and everyday oppression their health is impacted.

Health is more than the biological but is the result of cultural and social realities and individual behavior. The consideration of Black women's cultural memories has the ability to narrow the health care gap. In order for medicine to improve they must begin listening to the stories of women such as Roberson, Edwards, and Allen. In these stories is a wealth of information pertaining to complex identities, complex experiences, and basic tools anyone could incorporate in order to improve patient satisfaction.

It is imperative that health care systems, researchers, and physicians consider these pasts as they pursue innovative ways to reduce health disparities among the Black women and the larger Black community. In addition, it is essential for the intersectional experiences of Black women to be highlighted and celebrated. As all patients, Black women should be prioritized in the health model and given room to exercise their understanding and approach to health without being a cost-effective scape goat.

As initiatives such as Community Health Workers begin to gain momentum, researchers and health programs must be cautious of not exploiting the labor of Black women once again. To prevent modern exploitation of Black women in healthcare, the stories of Black women need to

be recorded and analyzed in order to fully understand how the institution of medicine have developed and to improve health care services and programming for black women.

This research validated and promoted non-hegemonic knowledge present among Black women. The recoding of Black women's stories is a celebration and testament to their humanity, rights to their voices and bodies, and will serve as an empowering force for Black women generations from now.

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