Community Support Persons and Mitigating Obstetric Racism During Childbirth

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ABSTRACT

PURPOSE We undertook a study to assess whether presence of community support persons (CSPs), with no hospital affiliation or alignment, mitigates acts of obstetric racism during hospitalization for labor, birth, and immediate postpartum care.

METHODS We conducted a cross-sectional cohort study, measuring 3 domains of obstetric racism as defined for, by, and with Black birthing people: humanity (violation of safety and accountability, autonomy, communication and information exchange, and empathy); kinship (denial or disruption of community and familial bonds that support Black birthing people); and racism in the form of anti-Black racism and misogynoir (weaponization of societal stereotypes and scripts in service provision that reproduce gendered anti-Black racism in the hospital). We used a novel, validated instrument, the Patient-Reported Experience Measure of Obstetric Racism (the PREM-OB Scale suite), and linear regression analysis to determine the association between CSP presence during hospital births and obstetric racism.

RESULTS Analyses were based on 806 Black birthing people, 720 (89.3%) of whom had at least 1 CSP present throughout their labor, birth, and immediate postpartum care. The presence of CSPs was associated with fewer acts of obstetric racism across all 3 domains, with statistically significant reductions in scores in the CSP group of one-third to two-third SD units relative to the no-CSP group.

CONCLUSIONS Our findings suggest that CSPs may be an effective way to reduce obstetric racism as part of quality improvement initiatives, emphasizing the need for democratizing the birthing experience and birth space, and incorporating community members as a way to promote the safety of Black birthing people in hospital settings.

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INTRODUCTION

The provision of hospital-based obstetrics care in the United States facilitates disparate maternal and perinatal health care experiences and outcomes that disproportionately and unfairly impact Black mothers and birthing people.[1-5] Scholars of racism and gender oppression are clear that these health inequities are emblematic of the afterlife of slavery.[6-8] Legal scholar Dorothy Roberts describes in great detail how reproductive control and coercion were a bedrock of chattel slavery, and continued to manifest through the war on drugs and into present day devaluation of Black women and their children.[1] Recent studies have shown that anti-Black police violence may have an impact on pregnancy loss for Black women.[9,10] Additionally, reproductive justice advocates have found links between mass incarceration and reproductive oppression.[11] Taken together, these associations indicate that the pathologization, criminalization, and devaluation of Black birth, parenthood, and kinship have their roots in chattel slavery and have continued to adapt to and reflect the ongoing logics of carcerality, racial capitalism, gender violence, and anti-Blackness.[1,12-14]

Obstetric racism operationalizes the recognition of historical and ongoing oppression as the root cause of the ubiquitous health inequities in Black birth outcomes, in order to interpret the quality, value, and safety of obstetric care.[15] Obstetric racism is grounded in an understanding that Black birthing people are subject to obstetric violence and medical racism, and that these processes take on

Conflicts of interest: K. A. S. is the Chief Black Feminist Physician Scientist, founding CEO, and owner of Birthing Cultural Rigor, LLC, which owns the PREM-OB Scale suite. E. L. is the Black Feminist Statistician for Birthing Cultural Rigor, LLC, and Associate Editor of Annals of Family Medicine. The other authors report no conflicts of interest.

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new and specific harms.[2] Obstetric violence is a term that characterizes the control and dehumanizing treatment of obstetric patients due to the actions of medical professionals and staff.[16] This sort of abuse is borne out of power relations and attitudes around gender and race such as misogynoir,[17] anti-Black racist misogyny or gender-based violence uniquely enacted against Black women. Medical racism refers to influence of a medical professional's decisions by the race of the patient, and it ranges from the historical use of Black people's bodies for experimentation to modern day disregard for Black people's pain.[16,18] Obstetric racism is a multivalent phenomenon that can vary in intensity and duration during an episode of care and across settings and spaces during care provision. Obstetric racism can be also be initiated and perpetuated by different actors in different contexts independent of race, class, gender, or positionality. This framework demands serious engagement with the experiential knowledge of Black birthing people, which can provide crucial data that might be obfuscated by other modes of inquiry.[16]

Data show that health inequities in pregnancy and the postpartum period hold across social protections such as being married, having high income, and being better educated.[19-21] Although this might be confusing in some contexts, obstetric racism accounts for the ways in which these institutions have historically been complicit in the oppression of Black people.[15] Furthermore, data raise concerns about transmisogynoir, which is the intersection of transphobia, misogyny, and anti-Black racism,[17] in the obstetric setting through the erasure or exclusion of Black birthing people who do not identify as women, highlighting the particular challenges that this community faces. Obstetric racism as a framework encompasses the historical and ongoing logics that create these inequities and implicates the medical field in these harmful processes.[22]

Historically, Black communities, Indigenous communities, and other communities of color have used community-based networks and knowledge to protect against the structural drivers of poor birth outcomes.[23,24] Recently, hospital systems and municipalities have considered the role that midwives and doulas might play in reducing negative health outcomes for Black birthing people. Both Los Angeles and New York City have created programs that connect Black birthing people in areas with the worst health outcomes to doula support.[25,26] At the same time, some hospitals have weaponized fear of the COVID-19 pandemic to ban partners and support people from attending to birthing people. This response to the pandemic runs the risk of exacerbating poor health outcomes and fails to account for the myriad factors that create health inequities related to pregnancy and the postpartum period.[27]

At this pivotal moment, we conducted a study to explore whether having community support persons (CSPs), including midwives, doulas, partners, parents, and siblings, present during hospital birth care might mitigate negative experiences and support better birth outcomes among Black birthing people. We assessed differences in experiences of obstetric racism in multiple domains according to whether this potential form of protection was present or absent.

METHODS

We conducted a cross-sectional cohort study, using data from the psychometric validation study of a novel instrument to measure obstetric racism among Black mothers and birthing people, the Patient-Reported Experience Measure of Obstetric Racism (the PREM-OB Scale suite).[28] This study was approved by the University of California, San Francisco Institutional Review Board on July 13, 2020.

Primary Outcome

The PREM-OB Scale suite translates the Davis[2] analytic framework and the phenomenon of obstetric racism into a valid measure of patient safety based on patient-reported examples of harmful and hurtful clinical practices and policies, using cultural rigor methodology[29,30] in measurement development and validation[28] as defined and refined for, by, and with Black women as patient, community, and content experts. The study instrument was developed using an adaptation of the Patient-Reported Outcome Measurement Information System (PROMIS) scientific standard for instrument development and validation, through implementation of the theories and practices of Black feminism, reproductive justice, and research justice across the 4 modalities of cultural rigor: social movement, analytic framework, praxis, and vision.[28] The validation study is described in full elsewhere[28] and summarized in the Supplemental Appendix.

The PREM-OB Scale suite facilitates empirical analyses of the associations between process, outcome, and structural measures and patient experiences of obstetric racism enacted exclusively against Black mothers and birthing people during labor, birth, and the immediate postpartum period in hospital settings. The suite also allows for greater insight into protective factors against obstetric racism, such as receiving support from people not employed by or affiliated with the hospital.

The final, validated PREM-OB Scale suite has 3 independent scales that capture different elements of obstetric racism: humanity, kinship, and racism (Table 1). The humanity scale captures experiences across 4 subdomains, specifically, the violation of safety and accountability, of autonomy, of communication and information exchange, and of empathy. The kinship scale captures how hospital policies and practices disrupt or deny the social and biologic networks that support Black birthing people composed of community members, partners, and given and chosen kin. The racism scale captures anti-Black racism and misogynoir,[17,31] which in the obstetric context is characterized by degradation and humiliation enacted by hospitals against Black mothers and birthing people on the institutional, departmental, and interpersonal levels. Notably, this scale captures anti-Black medical and gendered racism as a subdomain of the totality of obstetric racism.

All scale scores are constructed so that higher scores indicate more patient-reported acts of dehumanization, disrupted kinship, and racism enacted against Black birthing people by any member of the hospital team, regardless of the team member's race, gender, or specialty. These 3 scales were the primary outcomes of our study. Table 1 provides sample themes for items included in each scale. The full suite of scales is available only under exclusive license from Birthing Cultural Rigor.

Table 1. Sample of the PREM-OB Scale Suite

Scale	Number of Items	Subdomain	Sample Themes
Humanity	31	Safety	Health care delay, denial, neglect, or dismissiveness
		Autonomy	Health care exclusion or erasure in medical decision making
		Empathy	Health care inquiry and elicitation of attitudes, feelings, and daily life
		Communication	Health care information, comprehension, transparency, and relevance in eliciting informed consent
Kinship	9	Nonapplicable	Health care team or system affirmation, disruption, or denial of biological or social relationship between Black birthing person and their newborn, partner, parent, or doula
Racism	12	Nonapplicable	Health care practice of biologic determinism and racial stereotyping in medical counseling and decision making

PREM-OB = Patient-Reported Experience Measure of Obstetric Racism.

Note: The PREM-OB Scale suite is proprietary and owned exclusively by Birthing Cultural Rigor, LLC. Please contact the authors for more information.

Study Participants

Details of participant recruitment are given in the validation study.[28] Briefly, study participants were Black people aged 18 years or older who gave birth to a live newborn in a hospital setting between January 1, 2020 and December 31, 2020. Participants were recruited via social media, self-referral, community word of mouth, and dissemination strategies localized to Black communities. Recruitment was conducted in collaboration with 15 Black women-led community-based organizations as well as hospitals, community health care centers, health plans, and providers, and all participants who completed the study survey received a $100 electronic Visa gift card.[28] In the validation study's qualitative phase, 37 Black cisgender women who had had a birth hospitalization completed in-person focus groups; in the quantitative phase, 806 participants across 34 states and Washington, DC, completed an online survey about their birth and hospitalization experience.

CSP Exposure

Our exposure was the presence of CSPs during hospitalization for labor, birth, and the immediate postpartum period during a continuous episode of care. We defined CSPs as any individuals or group of individuals, without formal or informal hospital affiliation or alignment, identified and/or selected by Black birthing people to be present with them during their childbirth hospitalization. Community support persons are partners, parents, family members, friends, or other loved ones who, through their presence or active participation throughout the provision of care during childbirth hospitalization, act in a manner to shield Black birthing persons from obstetric racism through real-time prevention or mitigation strategies. We identified presence of a CSP using an item that asked "During your birth, did you have a partner or support person with you?" and used this binary variable in our analyses.

Statistical Analysis

We computed standard descriptive statistics to summarize sociodemographic characteristics for participants overall and for those with and without CSPs. To assess the relationship between CSP exposure and the humanity, kinship, and racism scale scores, we used univariate and multivariate linear regression models. The multivariate models were adjusted for age, relationship status, household size, annual household income, education, and Census region.

The 3 independent and valid measures within the PREM-OB Scale suite were developed with item response theory (IRT), which has the benefit of making them comparable across studies. We therefore present the associations of CSP presence during the childbirth hospitalization and obstetric racism as both unadjusted and adjusted coefficients based on regression onto the IRT scale scores. IRT scale scores are calculated based on summation of the numerically coded 5-point Likert scale survey items, and conversion using standard practice in IRT as described in the psychometric validation article of the PREM-OB Scale suite.[28] For ease of interpretability, we also standardized the IRT scores to a mean of zero and used unit variance so that the magnitude of the association is estimated relative to the scale SD.

We provide 95% CIs for all measures of association; those that do not span zero are statistically significant at the type I error rate of .05. All statistical analyses were carried out in R version 4.2.1 (R Foundation for Statistical Computing).

RESULTS

Participant Characteristics

Among the 806 Black birthing people in the study, 720 (89.3%) had at least 1 CSP present during their hospital labor, birth, and immediate postpartum care. Nearly all participants (99%) identified as women (Table 2). A total of 2 participants

Table 2. Characteristics of Participants, Overall and According to Whether a CSP Was Present During Birth

Characteristic	All (N = 806)	No CSP (n = 86)	CSP (n = 720)
Age, mean (SD), y	30.2 (5.9)	30.1 (6.7)	30.2 (5.8)
Gender, No. (%)			
Woman	799 (99.1)	84 (97.7)	715 (99.3)
Gender nonconforming/nonbinary	1 (0.1)	0 (0.0)	1 (0.1)
Genderqueer	2 (0.2)	1 (1.2)	1 (0.1)
Transgender male[a]	1 (0.1)	0 (0.0)	1 (0.1)
Unknown	1 (0.1)	0 (0.0)	1 (0.1)
Missing	2 (0.2)	1 (1.2)	1 (0.1)
Race, No. (%)			
Black or African American	806 (100.0)	86 (100.0)	720 (100.0)
White	24 (3.0)	0 (0.0)	24 (3.3)
American Indian or Alaska Native	16 (2.0)	2 (2.3)	14 (1.9)
Asian	10 (1.2)	0 (0.0)	10 (1.4)
Native Hawaiian or Pacific Islander	11 (1.4)	0 (0.0)	11 (1.5)
Ethnicity, No. (%)			
Not Latine	766 (95.0)	81 (94.2)	685 (95.1)
Latine	35 (4.3)	4 (4.7)	31 (4.3)
Missing	5 (0.6)	1 (1.2)	4 (0.6)
Education, No. (%)			
Less than high school	31 (3.8)	5 (5.8)	26 (3.6)
High school graduate/GED	141 (17.5)	19 (22.1)	122 (16.9)
Some college	218 (27.0)	29 (33.7)	189 (26.2)
Associate's/bachelor's degree	251 (31.1)	23 (26.7)	228 (31.7)
Master's/doctoral degree	162 (20.1)	9 (10.5)	153 (21.2)
Missing	3 (0.4)	1 (1.2)	2 (0.3)
Household income, No. (%)			
$0-$24,999	256 (31.8)	39 (45.3)	217 (30.1)
$25,000-$49,999	212 (26.3)	31 (36.0)	181 (25.1)
$50,000-$74,999	108 (13.4)	6 (7.0)	102 (14.2)
$75,000-$99,999	58 (7.2)	3 (3.5)	55 (7.6)
≥$100,000	122 (15.1)	4 (4.7)	118 (16.4)
Missing	50 (6.2)	3 (3.5)	47 (6.5)
Relationship status, No. (%)			
Partnered/married and cohabiting	434 (53.8)	26 (30.2)	408 (56.7)
Single	212 (26.3)	27 (31.4)	185 (25.7)
Partnered/married and living separately	95 (11.8)	19 (22.1)	76 (10.6)
Cohabiting with biologic parent, not partnered	62 (7.7)	14 (16.3)	48 (6.7)
Missing	3 (0.4)	0 (0.0)	3 (0.4)
Household size, mean (SD) number of people	3.4 (1.6)	3.7 (1.5)	3.3 (1.6)
Census region, No. (%)			
Midwest	107 (13.3)	15 (17.4)	92 (12.8)
Northeast	83 (10.3)	7 (8.1)	76 (10.6)
South	207 (25.7)	31 (36.0)	176 (24.4)
West	404 (50.1)	32 (37.2)	372 (51.7)
Missing	5 (0.6)	1 (1.2)	4 (0.6)

CSP = community support person; GED = general equivalency diploma.

[a] Trans man/female-to-male (FTM).

identified as genderqueer, 1 as a transgender male, 1 as gender nonconforming and nonbinary, and 1 with unknown gender identity; 1 participant had missing data for gender.

Consistent with the study inclusion criteria, all participants identified as Black. Three percent additionally identified as White, followed by 2% as American Indian or Alaska Native, 1.4% as Native Hawaiian or Pacific Islander, and 1.2% as Asian. Given how few participants fell into these additional racial subsets, there was a difference between groups whereby there with no Asian or Native Hawaiians or Pacific Islanders in the group not having CSPs. Distribution of Latine ethnicity was consistent across groups at 4.7% in the no-CSP group and 4.3% in the CSP group. The CSP group had more participants with associate's or bachelor's degrees (31.7% vs 26.7%) and master's or doctoral degrees (21.2% vs 10.5%).

Some other demographics were similarly unbalanced between groups, with the no-CSP group having lower household incomes and being less likely to be cohabiting with a partner or spouse. Both groups were regionally diverse with representation from the west Census region dominating.

Obstetric Racism Outcomes

Compared with peers having a CSP present during their childbirth experience, participants not having a CSP present had more positive scores for experiences of obstetric racism across all 3 domains (Table 3). These differences indicate that those not having a CSP reported more acts of dehumanization, kinship disruption, and racism enacted against Black birthing people by hospital clinicians and staff.

The difference in the mean humanity score between people having vs not having a CSP during their childbirth hospitalization was −0.31 (95% CI, −0.52 to −0.10) in unadjusted analysis, and it remained similar in adjusted analysis (−0.33; 95% CI, −0.58 to −0.09) (Table 4). This difference corresponded to a more than one-third SD decrease in score (−0.36; 95% CI, −0.61 to −0.10).

Table 3. Scores for Obstetric Racism According to Whether a CSP Was Present During Birth

Scale[a]	No CSP (n = 86)	CSP (n = 720)
Humanity score, mean (SD)	0.30 (0.97)	−0.01 (0.93)
Kinship score, mean (SD)	0.50 (1.05)	−0.04 (0.88)
Racism score, mean (SD)	0.36 (1.01)	−0.04 (0.90)

CSP = community support person; PREM-OB = Patient-Reported Experience Measure of Obstetric Racism.

[a] PREM-OB scores are item response theory (IRT) scaled scores.

The decrease in kinship disruption with the presence of CSP during childbirth hospitalization was even greater, with an unadjusted difference in scores between groups of −0.53 (95% CI, −0.74 to −0.33) and an adjusted difference of −0.57 (95% CI, −0.81 to −0.33). This difference corresponded to a nearly two-thirds SD reduction in score relative to individuals with no CSP at the birth (−0.62; 95% CI, −0.99 to −0.36).

The presence of a CSP during the childbirth hospitalization was also associated with decreased racism, with an unadjusted difference in scores between groups of −0.40 (95% CI, −0.60 to −0.19) and an adjusted difference of −0.43 (95% CI, −0.67 to −0.18). This difference corresponded to a nearly one-half SD reduction relative to individuals with no CSP at the birth (−0.46; 95% CI, −0.73 to −0.20).

DISCUSSION

Our study demonstrates the potential of CSPs to function as protectors and mitigators of the harm and hurt of obstetric racism enacted against Black mothers and birthing people by hospital clinicians and support staff during labor, birth, and the immediate postpartum period. Across all 3 measured domains of obstetric racism, presence of a CSP was associated with less severe obstetric racism. Although obstetric racism remains a primary driver of the disproportionate burden of Black maternal and infant mortality and morbidity, quality and safety professionals must not conflate the absence of perinatal pathology with the presence of perinatal equity and safety. Advancing quality, equity, and accountability requires acceptance that a patient experience of obstetric racism, regardless of other outcomes, is an adverse event and patient safety violation.[32] On the basis of the domains captured by the PREM-OB Scale suite, Black birthing people who did not have a CSP during their childbirth hospitalization experienced less empathic treatment, less robust and responsive communication, and more violations of their bodily autonomy and emotional, mental, cultural, social, and physical safety in medical decision making (humanity scale); more separation from their newborns and isolation from their communities and loved ones (kinship scale); and more experiences of interpersonal, departmental, and institutional anti-Black and anti–Black woman degradation and humiliation based on their race or their race and gender (racism scale).

Regardless of the physical health of the infant and parent at the birth, the harmful adverse events associated with obstetric racism can impact maternal mental well-being with downstream effects on the long-term health of both parent and child.[22,33] Our findings therefore provide compelling evidence to health plans, accreditation organizations, state perinatal quality care collaboratives, and state and federal investigators of discrimination in health care to consider measuring obstetric racism as a key performance indicator of the quality, value, and safety of childbirth hospitalization among Black mothers and birthing people. Moreover, our findings support public and private investment in community-focused solutions that facilitate the implementation, spread, and scale of CSPs such as community health workers, perinatal support workers, doulas, and more who deserve equitable compensation by health plans as evidence-based strategies to mitigate obstetric racism and advance safety.

The results of our study emphasize the need for democratizing birth spaces in a way that expands our understanding, recognition, and use of expertise and support. Black feminist epistemologies offer one way of doing so. Because a tenet of Black feminism is valuing experiential knowledge,[34] it supports the inclusion of CSPs without health training or

Table 4. Association of CSP Presence vs Absence During Birth With Obstetric Racism

	CSP Present vs Absent		
Scale[a]	Unadjusted Analysis	Adjusted[b] Analysis	Adjusted[b] and Standardized[c] Analysis
Humanity score, coefficient (95% CI)	−0.31 (−0.52 to −0.10)	−0.33 (−0.58 to −0.09)	−0.36 (−0.61 to −0.10)
Kinship score, coefficient (95% CI)	−0.53 (−0.74 to −0.33)	−0.57 (−0.81 to −0.33)	−0.62 (−0.88 to −0.36)
Racism score, coefficient (95% CI)	−0.40 (−0.60 to −0.19)	−0.43 (−0.67 to −0.18)	−0.46 (−0.73 to −0.20)

CSP = community support person; PREM-OB = Patient-Reported Experience Measure of Obstetric Racism.

[a] PREM-OB Scale scores item response theory (IRT) scaled scores.
[b] Adjusted for relationship status, age, household size, annual household income, education, and Census region.
[c] Scale was standardized to a mean of zero and unit variance was applied before model fitting.

hospital affiliation throughout childbirth hospitalization to shield birthing individuals against hospital acts of obstetric racism through real-time prevention or mitigation strategies. After acknowledging that the current status quo for hospital birthing experiences embeds obstetric racism against Black birthing people, the value of CSPs becomes clear. A Black feminist approach would recognize that the role of CSPs can include emotional and mental support and safety for Black birthing people as well as advocates and interventionists against obstetric racism. In the context of the anti-Black racialized maternal health inequities in the United States, there has been a resurgence in collaborating with birthing centers, doulas, and midwives, particularly among Black birthing persons.[35] Our findings make the case, however, for a more radical democratization of the birthing experience that includes all types of community members, partners, parents, given and chosen kin, as Black birthing people historically and contemporarily experience harms directly related to obstetric racism.[22] Radical democratization of birth spaces through the prioritization of given or chosen kin as CSPs, compared with use of doulas and perinatal support workers who require compensation, addresses structural barriers and burdens to achieving emotional and sociocultural safety such as costs, access to community birth professionals, and hospital policies that limit the type and/or number of visitors allowed during childbirth hospitalization. Our study findings justify the need for Black birthing communities, hospitals, health plans, quality improvement and implementation scientists, and community advocates to recognize the added value of using CSPs as community birth professionals or chosen and given kin during hospital birthing experiences as prevention and mitigation strategies against obstetric racism. As physicians and other health professionals whose ethics of care prioritize patient, family, and community health and well-being, we strongly believe family medicine physicians can use their voice and power to activate and amplify the agency and self-efficacy of Black birthing people in choosing the type and number of people they desire and deserve to be present with them during childbirth hospitalization. We also recommend that family medicine physicians share the evidence of the role and impact of CSPs with their physician colleagues and hospital administrators, and advocate for inclusive hospital visitation policies.

An important nuance to our findings is that the association of CSPs with decreased elements of obstetric racism was significant after adjustment for the relationship status of the birthing person. This finding emphasizes that being married or partnered does not sufficiently mitigate obstetric racism and that the physical presence of CSPs, who may include individuals other than partners or spouses, is more important as a protective factor. Presence of the CSP is particularly important to emphasize in the context of the COVID-19 pandemic. During the pandemic, as hospitals have implemented visitation exclusions to control virus transmission, Black birthing people are at risk for being isolated from their community in a noxious environment of hospital obstetric racism. Black communities faced more impact from the COVID-19 pandemic, which has compounded poor health outcomes for Black birthing people.[27,36,37] Our findings echo the calls from academics and community scholars and advocates who demand that a balance must be struck between COVID-19 transmission control and the needs of community participants for the safety and well-being of Black birthing people.[27,38,39]

The primary limitation of our study is that our findings do not establish a causal relationship between presence of CSPs during the birthing experience and less obstetric racism, because the exposure and outcome were ascertained simultaneously in this cross-sectional study. Future, longitudinal studies will need to follow Black birthing people throughout the birthing experience and measure experiences of obstetric racism repeatedly across hospital visits to assess the causal effect of CSPs on obstetric racism. In the psychometric validation study,[28] the scores of humanity, racism, and kinship did not vary by reported clinical characteristics (including maternal body mass index, gestational age, and mode of delivery), demonstrating that the measure is independent of clinical risk. We therefore recommend future studies move away from "mother blame"[3] hypotheses and analyses that assume maternal and neonatal comorbidities contribute to inequitable care experiences of poor quality and harm. We are conducting analyses examining variations in obstetric racism scores based on clinician-, unit/department-, and hospital-level factors as well as social and structural determinants of maternal-perinatal health.

This study also provides the option for more intersectional research around health outcomes for Black women and birthing people. Community birth workers have discussed the potential for CSPs to provide affirmation for birthing people of varying genders and sexualities, mitigating harms related to transphobia and cisheteropatriarchy.[40] Although our study included only a few transgender individuals, the scales we used are applicable and our work can be extended to future intersectional studies that include targeted recruitment and oversampling of transgender Black birthing people. Furthermore, the concept of obstetric racism can be useful in contexts with other communities that face histories of reproductive injustice.[2] Future research thus may look at the effects of CSPs in a variety of contexts: for Black immigrants, for Black lesbian, queer, or bisexual people, or for Black people who are incarcerated. Future advocacy might include "Know Your Rights" training[41] for birthing people and their support persons, building on the training and education that community birth workers are already doing. Our study strengthens the evidence base and provides the foundation for democratizing birth in order to combat ongoing obstetric racism.

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Key words: childbirth; labor, obstetric; maternal health services; obstetric racism; medical racism; health care disparities; misogynoir; Black maternal health; health inequities; community support person; labor coach; vulnerable populations

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Supplemental materials

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