

DISCUSSING THE RACIAL ASSOCIATION WITH BLACK MATERNAL
MORBIDITY AND MORTALITY AND THE ROLE OF PUBLIC
INTELLECTUALISM IN PROVIDING EQUITABLE
HEALTHCARE THROUGH SOCIAL MEDIA.

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ABSTRACT

Social determinants of health have become a bit of a buzzword in today's discussion of healthcare inequities. Social determinants of health are broadly defined as conditions in the places where people live, learn, work and play that affect a wide range of health and quality-of-life risks and outcomes. These factors almost always include education access and quality, health care access and quality, neighborhood and built environment, economic stability and social and community context. All of these factors play a role in how individuals and communities maintain their health. Social determinants of health plays into the black experience within healthcare, which is a factor in the increase in black maternal morbidity and mortality. An important note to highlight in the increase in black maternal morbidity and mortality is the growing public knowledge of the racial history within Obstetrics and Gynecology. We have these disparities and more and more Americans are learning about this health disparity, yet there are not many articles that highlight the ways to save black women from being just another statistic. I propose that if we focus on improving the public intellectualism of our country through social media, we are then all fighting for the survival of black women throughout pregnancy and post-partum.

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CHAPTER 1: MATERNAL HEALTH DISPARITIES

Racial and ethnic disparities have been reflected in healthcare, and specifically maternal morbidity and mortality, dating back centuries specifically. Disparities are defined as “differences in the quality of care received by particular groups who have similar health insurance and the same access to a doctor (Grobman 2015). This conception unfortunately does not take into account a known distrust in the medical community, specifically within the specialty of obstetrics and gynecology. There is a historical distrust in regard to women’s health. The proclaimed father of modern gynecology, Dr. James Marion Sims, performed the majority of his pioneering work on enslaved Black women without anesthesia. He invented the vaginal speculum, which is used for dilation and examination of the cervix. He also developed a surgical technique to repair vesicovaginal fistulas, which is an abnormal connection between the uterus and the bladder leading to pain and urinary leakage. Both of these have contributed greatly to the medicine of gynecology, but on the backs of enslaved women. The ethics of physicians like Dr. Sims have been taken into account recently because of the strong push to dismantle the many statues in his honor. The exploitation and dehumanization of these women further contribute to the disparities experienced today.

Defining disparities in healthcare can be challenging, but approaching disparities mathematically can help. Disparity can be defined in 3 overarching themes: agency for healthcare research and quality, residual direct effect method and institute of medicine (Bryant and Worjolah, 2010). Of these three distinct definitions, residual direct effect method is closest to the colloquial definition of healthcare disparities. One example of

healthcare disparities on the basis of race includes higher incidence of neural tube defects among Hispanic women. Adequate intake of folic acid is still low within the Hispanic community despite the 1998 U.S. Food and Drug Administration mandate to fortify all cereal grains in the U.S.A.

Food insecurity is another example of a disparity present within minority and urban communities, and ultimately their pregnancies and children. Many communities tend to have less healthy food options, and more quick, convenient and unhealthy food options. With that being said, there is a large amount of discussion surrounding Black women with a higher than normal body mass index and fetal size. There's a common assumption that Black women gain more weight in pregnancy and therefore have larger babies. According to Bryant et al., "Black women are more likely to experience fetal growth restriction." In addition, it is noted that black women can have inadequate weight gain during pregnancy due to food insecurity during pregnancy. Both of these factors eventually affect pregnancy experience and maternal and fetal outcomes.

One of the most common disparities present amongst the Black and Puerto Rican communities is preterm birth and low birth weight. Much of this is thought to be determined based on chronic stressors like how, "Black and American Indian/Alaska Native women are most likely to report exposure to chronic stressors during pregnancy." (Bryant et al. 2010). I was personally surprised by this similarity. Potential overlapping stressors include financial hardship and the likely impact of historical medical treatment of minorities. It has been found that there are higher levels of corticotrophin releasing hormone (CRH) in women destined to have preterm birth (Bryant et al. 2010). This

finding has potential inconsistencies, but it has been noted that minorities can have the added stressor of navigating a majority world as a minority.

Substance use in a patient is something that should be evaluated for throughout a patient's lifetime, particularly during pregnancy. One particular legal substance that is commonly asked about is tobacco and alcohol use. White women are more likely to use tobacco and white women, American Indian and Alaska Natives are more likely to use alcohol (Bryant et al. 2010) while pregnant. Alcohol and tobacco use during pregnancy is associated with a myriad of maternal and fetal complications. This is where I believe implicit bias comes into play. Individuals may insinuate the education level based on a person's race. Minority women are less likely to discontinue use during pregnancy than white women (Bryant et al. 2010). In clinical settings, biased assumptions about race and education are a factor. Throughout my clinical years, I have experienced instances where attendings or residents made assumptions on what patients know and did know. If it's assumed that minority women won't discontinue substance use, the resources available to them may not be emphasized or may not be accessible. Accessibility is one of the most important components of providing a resource. The internal drive may be present but if the resource is not made accessible for patients, it's like there is no resource at all.

Disparities are also present with contraception rates. These disparities are dependent on many different factors, mainly age, race, and language. Sixteen percent of women receive a highly effective postpartum contraceptive method like sterilization, intrauterine contraception, or implant (de Bocanegra, et al., 2017). As it pertains to age, the odds of obtaining postpartum contraception decreases with age. This may in part be due to select biases from clinicians, but also a potential misconception of fertility with

advanced maternal age. While the ability to conceive becomes more and more difficult the older you get, does not mean someone can't conceive as that person comes closer to menopause. If the bias is from the clinician's perspective, then there is the possibility that they are not offering postpartum contraception for older mothers. This lays clear the delicate balance of patient autonomy with the expertise and authority of the clinician.

Highly effective postpartum contraception was also less likely to be received by Black and Asian patients. For Black patients, this appears to be more of a chicken and the egg situation. A common stereotype is that Black patients have more children, but is that because postpartum contraception isn't offered as much compared to white counterparts? Black women are also more likely to experience short interpregnancy intervals and poor maternal and infant health outcomes. There are some programs geared toward increasing postpartum contraception use, like an app called "Text4Baby". This provides medical information to the general public regarding pregnancy and childcare. Programs like this need to be advertised and made known to expectant mothers.

Patient perception of healthcare and pressure of physician documentation is also a large factor in disparities. This is most evident in the types of advice given during a prenatal appointment. Smoking cessation was the most common advice reported (69.5%) closely followed by cessation of alcohol consumption (68.4%). Receiving breastfeeding advice was reported by only 51% of all women in the United States (Kogan et al., 1994)" These statistics unfortunately are not surprising given that this article was written in 1994. In a more recent study, African Americans continue to have the lowest rates of breastfeeding initiation (60%) and continuation at 6 months (28%) and 12 months (13%) compared with all other racial/ethnic groups in the United States (Jones et al., 2015).

Alcohol and tobacco use tend to be topics of conversation that physicians feel more comfortable bringing up. The disparity comes in when physicians choose what advice to give to what groups of patients. For example, advice about smoking and drug use were skewed towards poorer women, whereas advice pertaining to alcohol use and breastfeeding was skewed towards wealthier women. Alcohol, tobacco and other drugs in pregnancy are topics that are applicable to all women regardless of socioeconomic status. If healthcare providers are deciding who to give this information to and who not to then this can lead to the potential health disparities that may arise amongst both cohorts of women. It was also shown that the age, location of prenatal care and participation in The Special Supplemental Nutrition Program for Women, Infants, and Children, commonly referred to as WIC, was shown to play a role in whether or not patients received advice pertaining to substance use.

The racial disparities present amongst non-Hispanic Black women pertaining to childbirth also extends to the children. Many articles and literature have been surfacing recently, like Mahase, 2020, discussing the health disparities present in minority children whose healthcare providers are not of their own race or ethnicity. This is most prevalent within the African American community. Non-Hispanic Black women are at a greater risk of preterm birth than white counterparts, after accounting for socioeconomic status (Grobman, et al., 2018). It is thought that this is potentially related to Black women having more perceived stress than white women (Grobman et al., 2015). I believe this is due to the systemic racism and micro-aggressions association with medicine and the Black lived experience.

It is also important to note that this article identified that all groups were more likely to have a small for gestational age (SGA) birth than non-Hispanic white women. I wonder if there is a commonality in the stresses that minority women experience which makes SGA babies more likely. It is thought that perceived social support is an important factor improving this outcome. The perception is that “low support being associated with all preterm birth and SGA birth, although the magnitude of this association was very weak (Grobman, et al., 2018).” This is an interesting theory to further pursue to determine if the type of social support plays a role. Many hospitals have birthing groups, where women of similar gestational ages have their appointments together to share in the experience. I wonder if this is enough, especially because often times our strongest support comes from family, friends and the father of the baby.

The Adverse Childhood Experiences (ACE) study was a long-term follow up study done between 1995 and 1997 that surveyed individuals about their negative childhood experiences and proposed that these experiences would negatively impact future health outcomes (Felitti, et al., 1998). The three categories considered to be ACEs included abuse, neglect and household dysfunction. There is a proven link between ACEs and chronic health problems, mental illness and substance misuse in adulthood (Felitti, et al., 1998). It is thought to be associated with long term stress. When we look at ACEs scores and pregnancy, birth timing is shown to be impacted by increasing ACE scores. Gillespie et al., 2017 suggest that “childhood stress may promote long term activation of the HPA axis, including during pregnancy, which is consistent with the finding of an association between childhood trauma and peripheral CRH”. In this finding, I would be interested to know how much the physical, mental and emotional stresses of pregnancy

account for the increased peripheral CRH. This study found that childhood interpersonal loss, including death of a loved one, parental separation, and social isolation were the particularly common stressors among this cohort.

Racism in medicine is not a foreign topic, especially within the medical community. Racism is defined as “a system of oppression that structures opportunity and assigned value for interpersonal exchange based on someone’s perceived race” (Slaughter-Acey, et al., 2016). There are a multitude of different ways racism is encountered, whether that is systemic or interpersonal. Interpersonal racism and discrimination is defined as “prejudiced assumptions about an individual’s abilities, motives and intentions due to the individual’s race and discrimination, defined as unfair treatment of an individual due to his or her race. (Slaughter-Acey, et al., 2016)” This concept of interpersonal racism is the lived experience seen in daily interactions, including times where individual’s are at their most vulnerable like during childbirth. Adding to the additional bodily stress that every pregnant woman can experience, concepts like prejudice, racism and microaggressions add to the chronic activation of the HPA axis that those with high ACE scores already experience.

CHAPTER 2: INTERVENTIONS FOR BLACK MATERNAL MORBIDITY AND MORTALITY DISPARITIES

Black maternal morbidity and mortality has become an important topic amongst the medical community over the last few years, but has been an important topic amongst the Black community for decades. There are countless scientific studies and articles surrounding race and maternal morbidity and mortality, specifically in the African American population. Many of those articles end with a vague statement advocating for more research to better come to a possible intervention. There is a great deal of work that needs to be done in improving outcomes for minority patients, but there have been few articles that have laid out a foundation in which to do so.

Eichelberger, Doll, Ekpo, & Zerden state that data is used to “demonstrate the significant disparities Black women face across their reproductive lives and conclude that these outcomes are not only statistically significant, but morally significant and fundamentally unjust (Eichelberger et. al., 2016)”. I believe this article gets into the nuance surrounding equity and equality. Something that is equal can also not be equitable and vice versa. A common example is three people of varying heights looking over a fence. Equality would be to give each person a box to stand on. Only two of the three people can see over the fence. Equity would look like each person getting a different number of boxes to stand on so each person can see over the fence. That may mean that one person may not receive a resource because they do not need it, while another person may receive more than the standard due to the display of need. The care that Black women receive in the United States is sometimes equal but not always equitable.

An additional point to consider is the recent shift in how clinicians view the relationship they have with their patients. This shift from physician paternal demand to patient-physician partnership and shared decision making has certain implications on a Black patient's trust in the healthcare system. Often times, Black patients are further behind in access to care and newer healthcare options (Eichelberger et. al., 2016). In a recent study, Black women are significantly less likely to express understanding that genetic testing is optional (Eichelberger et. al., 2016). This just further reinforces that physician paternalism may still be present within the medical community, especially for African American patients.

Another aspect to consider is that African American patients are less likely to participate in research studies, often times due to the historical and current social environment of mistreating Black bodies. In addition, pregnant patients are often times not incorporated into crucial studies, especially clinical trials like the most recent COVID-19 vaccine trials. Failure to include pregnant patients is done for multiple reasons, the most important being the health and safety of the mother and the child.

In 1993, Congress finally directed that women were to be included in all federally funded clinical investigations. Prior to this time, any research results were assumed to apply to women as well. Now the NIH requires that women and members of minority groups be included in all NIH-funded research “unless a clear and compelling rationale and justification establishes to the satisfaction of the relevant institute/center director that inclusion is inappropriate with respect to the health of the participants or the purpose of the research (Committee Opinion No. 646, 2015)”. So as to assist in the recruitment of women, researchers need to address barriers to participation, such as lack of necessary

childcare. There do not seem to be any initiatives that specifically address minority women and the unique distrust that comes with being a minority. Many of the articles I have come across do not consider the historical aspect of healthcare distrust, despite the fact that the history of family planning for Black women is one of the most abhorrent in medicine, with eugenics campaigns and forced sterilization disproportionately targeting Black women (Eichelberger et al., 2016).

As far as pregnant women in research, one of the many reasons pregnant women were excluded from research is the perceived “vulnerability” of this patient population. A vulnerable population is often defined as one that has a compromised ability to protect its interests and provide informed consent. Pregnant women as a cohort do not meet this definition. Pregnancy does not impact their capacity for autonomous decision making and pregnant women are as able to make informed decisions as nonpregnant patients. Instead of vulnerable, I think it is appropriate to refer to pregnant patients as scientifically complex, both ethically and physiologically. Ethically, there needs to be a balance between the health of the pregnant woman and the health of the fetus. More often than not these two concerns align, but in research they may diverge, especially if the research is not concerning pregnancy, labor, or fetal health.

A potential solution for actively incorporating minorities into research is having African American clinicians and researchers be not only a part of recruitment but make up the majority of a research study. This unfortunately feels like an enormous undertaking. As of 2015, Black scientists and engineers make up a smaller proportion, about 5%, than the scientist and engineering community as a whole which is 12% (Occupation, 2017). In order for there to be an increase in Black scientists, researchers,

and physicians, our society needs to create a space that allows for Black children to have the financial freedom and adequate representation to achieve these careers.

CHAPTER 3: DEFINING PUBLIC INTELLECTUALISM AND THE ROLE SOCIAL MEDIA PLAYS IN MEDICAL EDUCATION OF THE GENERAL PUBLIC

Public intellectualism has many definitions. A public intellectual can be defined as a well-known, intelligent, learned person whose written works and other social and cultural contributions are recognized not only by academic audiences and readers, but also members of the general society (What Is Public Intellectualism and Why Should We Care About It?, 2020). This does not encompass the greater population unfortunately. There can be a “who’s who” of world’s most intellectual people within a particular field, but if the rest of the population has a below average understanding of that field, I would say the state of public intellectualism is low. Public intellectualism can be defined as a steady, collective movement towards insight; an irrepressible hope that people together will seek knowledge. A true public intellectual should be based on their ability to share knowledge in a way that the general public can best understand and further pursue said knowledge.

When we take public intellectualism as the above definition, it arms us all, experts and non-experts, with the ability to learn, teach, share, debate and discover the ultimate truths that impact how we make decisions on a day-to-day basis. In that, I believe that’s exactly what social media has the ability to do. Using social media as a tool for public intellectualism only allows our community and patient population the ability to advocate for their healthcare.

It is said that there are eight pillars (or axioms) of public intellectualism (What Is Public Intellectualism and Why Should We Care About It?, 2020). The pillars are

accessible, authentic, collaborative, entertaining, ethical, factual, interdisciplinary, and translatable. Accessibility is not based solely on socioeconomic or education level, but by how many research articles and studies are made accessible. If you are not affiliated with a university or have the finances to subscribe to an educational journal, then that knowledge is inaccessible. Knowledge should be made accessible regardless of socioeconomic, race, social status, disability, education level, or self-identity. Newspapers, televisions, and the internet are examples of sources that provide accessible knowledge.

When a news anchors experiences their emotions in real time to a tragic story, that news outlet is providing not only information but a level of authenticity that cannot be faked. Authenticity is hard to define, but it is easily identifiable. Authenticity is something that companies often times struggle with, especially when it comes to selling and providing for the Black community. Martin Luther King Jr. Day is an example of a day that has been losing its authenticity. This day has often times become a day to pander to the Black community, without providing a long-lasting and community-first service initiative.

The ability to collaborate with other healthcare providers is the cornerstone of positive community engagement. We often times use collaborative to mean “caring for the whole patient”. This makes sense within a hospital, but this is also crucial in academia and research. These two entities need to communicate effectively with each other, the community, government, and any other entity that will improve the knowledge of the collective.

In education, entertainment is one of the best ways for information to solidify. For example, many of us learned how a bill becomes a law and what a conjunction in grammar is through the lyrics and catchy tunes of Schoolhouse Rock. This is also why comedians are some of the best educators of their generations because they use comedy to instill knowledge on a larger scale.

CHAPTER 4: 'MEDICINE FOR THE CULTURE'

Medicine for the culture is an Instagram account that provides evidenced-based and culturally appropriate and sensitive medical information geared toward the Black community. This page was started by me and four other Black female medical students. This idea sparked from many conversations centering around access to self-advocacy resources, which as individuals within the medical community we are able to share some of those resources. Many patients, including ourselves, have experienced going to a doctor's appointment and being asked if we had any more questions and completely drawing a blank. Then, when we leave that's when we think of all the questions we could have asked. Some patients, specifically minority patients with minimal health literacy may not even know the appropriate questions to ask.

We discuss a different health topic each week. Each month includes a topic related to obstetrics & gynecology, pediatrics, psychiatry and general medicine. Our audience is majority Black and less than 40 years old. The topics most liked by our followers are black maternal morbidity and mortality, and racial equity within healthcare, to medical disorders and diseases such as vaccines, COVID-19, and acne. We have discussed most of these topics with our platform with positive feedback.

We also believe that it is important to provide a historical context to the topics we discuss. The posts where we discuss the historical injustice often have the most likes, profile visits, and shares. For example, we did a week specifically about contraception and the many choices to control pregnancy. Before we discussed what each type of contraception does, we took a moment to discuss the history of eugenics, specifically on

Black bodies. Many Americans know of the atrocity that was the Tuskegee Syphilis Experiment (1932-1972), where Black men with syphilis were being monitored to observe the natural progression of syphilis. The African American men that were enrolled in this study were made to believe that they were receiving free healthcare, well after the discovery of penicillin as a treatment for syphilis. Not many know the case of Relf v Weinberger. In 1973, Minnie Lee Relf, age 14, and her mentally disabled 12-year-old sister Mary Alice were both sterilized without their consent or the consent of a parent. This took place in Montgomery, Alabama at a federally funded health clinic. The mother, who was illiterate, was made to believe her daughters were receiving birth control shots. This case was tried and initially was in favor of the two young girls, but the case was eventually dismissed. There are unfortunately many more stories similar to the Relf sisters, which adds to the distrust associated with the many options for contraception. Our followers appreciated this additional knowledge of our history and learning more about the different options for contraception in order of permanence and efficacy.

In addition to providing this medical information, we also quiz our followers. On Instagram, there is a feature called “story”. The story is where people can post additional photos, videos, texts responses, and even poll questions. The contents of the story remain viewable for twenty-four hours. We use the story for advertising our posts on our main page and to ask knowledge and opinion questions and debunk some common myths about whatever the topic is. At the beginning of each week, we ask a few questions related to the coming week’s topic. For example, when we discussed polycystic ovarian syndrome, also known as PCOS, we asked a 2-3 knowledge questions prior to discussing PCOS. We then teach our audience using text and video posts pertaining to PCOS. We

even include some well-known Black celebrities that are open about battling PCOS. At the end of the week, we then ask the same 2-3 questions to see if our audience has learned and retained the knowledge from this week. So far, for most weeks there has been moderate improvement and great engagement with these posts.

There are some limitations with educating through social media. Much of our reach to our audience began via word of mouth. Our first post was in May 2020, and we have gained roughly 100 followers per month, which has been wonderful. Social media platforms have many different algorithms that control what content we see based on who we follow and how much we engage with them. For example, we learned that if a follower saves our posts to view at a later date, then that tells Instagram that that follower values this Instagram page. So, the follower's timeline will begin to incorporate more and more posts from Medicine for the Culture and also more similar medical pages, if that follower follows more.

In the beginning, we believed it was crucial to introduce ourselves and ensure that our audience knew that we were Black female medical students. It is my belief that although the trust in the healthcare system is minimal, Black patients trust and value the opinions of their Black healthcare providers. I believe platforms like similar to ours are important because it does not come across as pandering to the Black community. Black people can be sensitive to pandering and when it feels as though there is a lack of genuineness, it is less likely to be successful. For example, McDonald's commercials in urban environments, particularly in the 1990s to early 2000s, had majority Black actors, urban vernacular, and was clearly marketed towards the Black community. It is also well known that there are few, if any, Black urban members of the community that have a seat

at the table with McDonald's marketing executives. This pandering to the Black community is also damaging in how others view this community. The stereotypes that have perpetuated for centuries are ones that can be seen in modern commercials, television shows and movies.

CHAPTER 5: THE INSTAGRAM ALGORITHM AND THE BEST WAY TO USE THE ALGORITHM TO INCREASE PUBLIC INTELLECTUALISM

The question I am most curious about is if something like Medicine for the Culture can improve health care outcomes in Black maternal morbidity and mortality. In what ways can Black maternal morbidity and mortality be reduced? In addition, what factors among social media medical influencers increase trust with the African American patient population? There are other secondary questions that can be answered in regard to patient advocacy and comfortability with medical information.

I would consider setting up a study with local health centers where patients can answer surveys in relation to what media outlets are used to learn more about their health. It is known that more and more Americans are using the internet for medical information. Being able to narrow down which sources are searched more often can be helpful in how we tailor our content. I would also ask questions centering around how comfortable patients feel to confront their provider with questions surrounding information found on social media. I would also like to know to what extent patients trust the medical information listed on reputable health websites in comparison to their physician and if that is influenced by the contrast of race between their physician and that patient.

To shift gears, we could look at the sources used by patients. As we know, there are many illegitimate websites and social media accounts spreading false information surrounding health care, vaccines, women's health and more. It would be interesting to know how patients and the general population determines what sources are reliable and which are not. As a health professional student, we learn how to determine the legitimacy

of the many different sources of information we receive on a daily basis. Similar to access to clinical peer-reviewed papers, the general population does not often have access to these papers or the health literacy to dissect these papers in relation to their own health. Without access, without a focus on health literacy and valid distrust within an inherently racist medical system, it is no surprise minority patients are not finding accurate medical information that they trust.

There are a few difficulties in reaching our target community members and much of that comes from advertising Instagram pages to our target audience. During the start of our page, we have gained about 100 followers per month, and we are very close to one thousand followers. A good portion of our subscribers are “medicine-adjacent”, meaning they tend to have friends or family that are medical professionals, or they are medical professionals themselves. We have polled our community to ensure that our posts are easily understandable and not too wordy. We have also noticed that the overwhelming majority of our followers identify as female. I am unsure if this is because of the perception that women care more about their health and the health of their family than men do or if this is due to the fact that we, as the creators, are women.

Another difficulty in reaching our target audience is advertising within the Instagram platform. Advertising on social media “stories” which are photos and videos that can be shared for 24 hours, does cost money. They also charge money to advertise within the social media timeline. Each platform has different fees, and since we are all medical students, we have yet to have a budget for advertising with our Instagram page. Both Instagram and Facebook also have an algorithm to tailor which of your followers sees the posts made. The Instagram algorithm works by prioritizing six factors: interest,

relationship, timeliness, frequency, following and usage. The Instagram feed will show accounts and types of posts based on what you have liked in the past, in addition to who you follow, this is the interest factor. Consistency is the key to increasing Instagram interest. We consistently post something at least 3 days a week but using apps that will post for you at different times throughout the day is helpful in increasing consistency. The types of engagement are also important to the Instagram feed. The most important are comments, likes, reshares, and views. Although saving posts are now an option as well which has been growing in importance.

Relationship and following are also important within the Instagram algorithm. Relationship prioritizes who and what accounts are important to you. The content you like, who you direct message, who you search for and who you know in real life will influence how much of their content you see. We have consistent accounts that tend to like and comment on our content which often times are people we know and who has messaged us in the past. The amount of people you follow can also impact who sees your account. This is especially important in “ghost” or inactive accounts. Searching through your Instagram followers and removing inactive accounts can help increase the account’s algorithm ranking.

Timeliness, frequency and usage also play into how much engagement and eyes will see and interact with your post. To improve timeliness it is important to take into account when your followers are online and most active, because Instagram and most other social media sites want to give the user the most up to date posts. There are many applications and blogs that discuss the best times to post, but that will vary depending on your followers. Frequency falls on the follower, not so much the person trying to gain

more followers. Frequency is determined based on how much a user opens the Instagram app. If the user is a frequent scroller, opening Instagram multiple times a day, then Instagram tries to show the best post since the last visit. If the user is an infrequent user, then the feed will be curated into what Instagram thinks the user will like, regardless of chronologies. Usage is similar to frequency in that the amount of time you spend on Instagram will determine how much of Instagram you do see. If you are an infrequent user, the Instagram feed will only show highlights of the day. Although if you are a frequent user, the Instagram feed will just keep finding new and similar content to what that user already gravitates toward. Ultimately, some of the limitations fall on the user while others fall on the consistency of the influencer.

Another difficulty in reaching our community members is how they hear about our Instagram page. Much of our promotion has been through word of mouth. One thing that does help and increase following is “trending”. A trending topic is a subject that experiences a surge in popularity on one or more social media platforms for a limited duration of time. Often times celebrities will trend on social media, i.e. when Beyonce had her twin babies, or when Colin Kaepernick took a knee during the National Anthem. Much of what helps a piece of content “go viral” is recognizability, relatability, and emotional investment. For example, Beyonce is already recognizable as a celebrity. The process of giving birth is relatable to many women across the world. It is also not unusual for fans to have some sort of emotional investment into whatever celebrity they admire. This admiration often times can translate into trust. As medical students we don’t have that recognizability yet, but we are relatable which helps people interact with our content, especially if our faces are included in that content.

Much of the changes that need to happen involve getting people who are not Black and brown women to care about the health and medical well-being of Black and brown women. Organizations like Black Mamas Matter Alliance have been influential in raising awareness of this serious issue. Much of their work has been through social media and conferences. One important campaign that was started is their annual national Black Maternal Health Week campaign that was founded four years ago and led by this organization. This week is geared toward increasing awareness, activism, and community building that keeps the conversation and efforts for Black maternal health alive. Black Maternal Health Week is every year from April 11th to April 17th. With national activism like this, this can keep the conversation, and hopefully the relief efforts going.

Ultimately black maternal morbidity and mortality is an epidemic in this country. We know that black women are dying at an alarming rate during a time that should be absolutely joyous, which is now full of sadness and loss. There are many articles in many reputable journals that highlight this epidemic. What I struggled to find was more evidence on ways to combat this epidemic. There are some articles particularly geared at intervention, but the vast majority are only associated with identifying black maternal morbidity and mortality as a problem. Social media has become an increasingly prevalent form of news and education for more and more Americans. The ability for social media to improve the current state of public intellectualism and therefore reducing the number of mortality and morbidity cases associated with black women is something that I believe is possible. Social media pages, like Medicine for the Culture, that uses social media and the algorithm to improve reach and therefore improve the status of public intellectualism allowing everyone to better advocate for themselves, especially black pregnant women.

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