SOLIDARITY, NOT CHARITY: MUTUAL AID AND COMMUNITY RESILIENCE IN RESPONSE TO THE COVID-19 PANDEMIC

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MASTER OF ARTS

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by
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ABSTRACT

The COVID-19 pandemic highlighted the well documented health disparities affecting racial and ethnic minorities, particularly those living in underserved urban settings. Due to historic and contemporary structural racism, these areas are often food deserts, lack adequate access to primary care services, and have higher rates of maternal and infant mortality. The lack of public health infrastructure to respond to emergencies, such as pandemics, can be rapidly met with collective action from communities to take care of their most vulnerable. After providing a basic overview of how structural racism has created the present-day disparities seen in communities such as North Philadelphia, this thesis investigates and makes the case for the capacity of these resilient communities to take care of themselves. To this end, I describe the work of North10 Philadelphia, Fabric Masks for North Philly, and the Maternal Wellness Village—community-based organizations that rapidly pivoted their work to fill the unmet needs of people in North Philadelphia related to food insecurity, personal protective equipment, and childbirth preparation and social support, respectively. I describe the utilization of the services provided by these groups and evaluate the evolution of their work from the onset of the pandemic through present day. Following each case study, I share the stories of the leaders behind each project to give voice to the people fighting for the health and wellbeing of their community. Lastly, I reflect on my positionality as a Black woman and medical student at a large academic institution partnering with these groups and assert the need to maintain partnerships with these and similar organizations to ensure the sustainability of their programming in the long term.

DEDICATION

To the North Philadelphia community

– with hope and courage in the pursuit of equity regardless of where you live.

ACKNOWLEDGMENTS

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CHAPTER 1: INTRODUCTION AND OVERVIEW

Disasters have the ability to expose the structural inequities affecting communities of color and the COVID-19 pandemic was no exception. In the United States, and around the world, the pandemic shed light on the power structures that privilege certain groups of people over others (Dominguez et al., 2020). Underserved and vulnerable populations, particularly Black and Latinx individuals living in urban settings, were disproportionately affected by the pandemic, and lacked equal access to testing, community protections, and treatment (Benjamin, 2020). These effects were seen as the result of historic and contemporary racism that concentrates poverty, underfunded public school systems, violence, food deserts, maternal and infant mortality, and chronic health conditions working in concert with what some refer to as the COVID-19 "syndemic" (Johnson-Agbakwu et al., 2022). In a "syndemic," individuals from marginalized communities are at higher risk of illness because they are often caught in a disease-driven poverty trap in which the effects of poverty on health and conversely, health on poverty, create a positive feedback system that works to their detriment (Dominguez et al., 2020).

Black and Latinx populations were much more likely to contract COVID-19 and had overall worse outcomes than their White counterparts (Ruprecht et al., 2020). For Black Americans, the mortality rate was 2.1 times higher than for White Americans (Johnson-Agbakwu et al., 2022). But the disparities in outcomes extended into the financial, social, and psychological effects of the pandemic as well. Black and Latinx individuals were also disproportionately impacted by the financial impacts of COVID-19 as they were more likely to work in underpaid, essential industries such as food and

product delivery services, making it harder for them to quarantine at home to mitigate viral transmission risk and obtain paid sick leave if they became ill (Ruprecht et al., 2020). Legal segregation of Black and White individuals through redlining, a racialized real estate zoning practice in the United States that ranked non-White neighborhoods as credit unworthy thus blocking fair access to home loans during the 1930s to 1960s, resulted in inequalities in the built environment in which these communities live. This practice concentrated poverty, violence and overall poorer health in areas populated predominantly by racial and ethnic minorities (Bose et al., 2022; Lee et al., 2022). The high housing density, large family/household size and intergenerational living arrangements disproportionately affecting Black and Latinx individuals made it especially difficult to comply with physical distancing recommendations and was compounded by the lack of accessible safe outdoor spaces (Ruprecht et al., 2020). Underlying medical comorbidities including asthma, diabetes and cardiovascular disease are more prevalent in Black and Latinx populations and were associated with increased morbidity and mortality from COVID-19 (Ruprecht et al., 2020). Finally, Black and Latinx populations have disparate rates of psychological stress and trauma which negatively impacted their susceptibility to trauma and mental health consequences related to COVID-19 (Ruprecht et al., 2020).

While the pandemic emphasized these structural disparities, it also inspired an unprecedented emergence of community-led initiatives and mutual aid groups to support those who were most vulnerable. The increased demands for scarce resources and disparate outcomes for marginalized groups were met with activism to provide personal protective equipment, food, mental health services and more (Dominguez et al., 2020).

The pandemic created a sense of urgency to provide extraordinary levels of supplies and support to address the real challenges impacting communities rather than a top-down bureaucratic approach (Loewenson et al., 2021; Ruprecht et al., 2020). In this space, community leaders and members served as their own community experts with a personal understanding of the lived experiences of those affected by structural racism and directed ownership over supplies and resources to allow for greater access for marginalized populations (Johnson-Agbakwu et al., 2022; Ruprecht et al., 2020). Understanding that approximately 80% of what contributes to one's health occurs outside of the clinical setting, these efforts sought to address health inequities by targeting critical gaps in public health infrastructure (Benjamin, 2020). Examples of such efforts can be found around the globe, but more locally, as seen in other cities in the United States, North Philadelphia residents mobilized to support those most impacted by the pandemic.

In this thesis, I describe the work of North10 Philadelphia, Fabric Masks for North Philly, and the Maternal Wellness Village—community-based organizations that rapidly pivoted their work to meet the unmet needs of people in North Philadelphia related to food insecurity, personal protective equipment, and childbirth preparedness and social support, respectively. For some of these groups, their intended programming shifted due to pandemic constraints on in-person gatherings and the need for increased support in the community. Others were born specifically to meet the challenges faced early in the pandemic. What is common to all three, is the commitment to ensuring the health and wellbeing of those who live in North Philadelphia.

I describe the utilization of the services provided by these organizations and evaluate their evolution over the course of the first year of the pandemic to present day. I

also share the stories of the leaders behind each project to give voice to the people fighting for the health and wellbeing of their community. Through an urban bioethics lens, I reflect on my positionality as a Black woman and medical student at a large academic institution partnering with these groups during my time as a Research Associate at the Center for Urban Bioethics and assert the need to maintain partnerships with these and similar organizations to ensure the sustainability of their programming in the long term as initial pandemic restrictions lessen and the world settles into a new sense of normalcy. These case studies demonstrate that a compassionate society actually enhances public health through actions that extend beyond tertiary intervention practice that often fails to address the mental, physical, social, and ecological conditions that affect risk and vulnerability, or that prompt wellbeing (Loewenson et al., 2021).

A brief note on terminology. There are several instances in which I use "mutual aid" to describe a variety of activities and actions that could also be characterized as community led or collective action as the definition of this term remains broad. I use these terms interchangeably in the context of this thesis because of the similarities at the core of these actions – to meet the needs of communities outside of the existing structures that intentionally privilege some communities over others. Central to its mission, mutual aid is rooted in solidarity, not charity.

> Solidarity includes compassion, but it is more. Solidarity is not only a spontaneous movement of the heart that responds immediately, but also a decision to take action to join with, to form community with, those who are suffering. Solidarity takes place when a person or community not only sees a need and acts, but commits to follow up, to endeavor to see that action is taken to improve the other's situation for the long run…
>
> – Marie J. Giblin

CHAPTER 2: NORTH10 PHILADELPHIA

Part One of Chapter Two: Understanding the Landscape of Food Insecurity

The pandemic negatively impacted food security and access across the country, but disproportionately affected communities of color in urban areas (Lofton et al., 2022). Black and Latinx adults in particular had the highest risk of being food-insecure (Lofton et al., 2022). This disparity called attention to the inequity in food access as these communities are more likely to live in food deserts, defined by the United States (U.S.) Department of Agriculture's Economic Research Service as areas with limited access to affordable and healthy food (Dutko et al., 2012). Many theories have been proposed to understand the creation of these food deserts that are found in urban areas. One such theory suggests that demographic changes in larger U.S. cities in the 1970s and 1980s due to the economic segregation caused by emigration of more affluent families to suburban areas led to the decrease of median income in inner-cities and forced closures of nearly half of the supermarkets (Walker et al., 2010). Another proposes that the development of large chain supermarkets in more affluent areas outcompeted smaller, neighborhood markets leading to their closure (Walker et al., 2010).

Regardless of the proposed origin, the impact is the same. Access to affordable, healthier food options is skewed to more affluent individuals and those who can afford transportation costs to these areas. Food hoarding, supply chain disruptions, and soaring food prices left grocery stores empty and further prevented individuals from purchasing the food they needed (Lofton et al., 2022). During the COVID-19 pandemic, food-insecure Black households were more likely to report inability to afford food cost during

the pandemic than their White counterparts (Lofton et al., 2022). Recognizing the increased rates of food insecurity, community organizations banded together to address food system deficiencies. Across the country, organizations collaborated to share food, storage, and transportation resources to meet community food needs. In North Philadelphia, Dr. Kathleen Reeves, Director for LKSOM's Center for Urban Bioethics (CUB) contacted Reverend Mike Majors, Founder and President of Called to Serve, a community development entity with a primary focus on the Nicetown-Tioga neighborhood of North Philadelphia. Together, they worked to create a group of community leaders and university personnel to provide timely updates regarding COVID-19 and strategize a means of safe food delivery. This group, initially called the "North Philadelphia COVID Response Team," met twice a week with representation of individuals, entities, and agencies from the neighborhoods of Nicetown, Tioga, and Hunting Park along with Temple University. During this time, CUB employees acted as social workers contacting families through local elementary schools to schedule weekly food deliveries, assembled food orders in bags using the now closed medical school as a storage hub, and delivered food to homes in the neighborhood. For several weeks, an average of 1,500 bags of food were assembled and delivered to families throughout North Philadelphia each week. When LKSOM reopened to allow students to resume in person didactic and clinical learning, CUB could no longer house their food distribution efforts.

In looking for a new distribution center, North10 Philadelphia (North10), a community-focused foundation with a mission for revitalization of the Hunting Park and East Tioga neighborhoods, had the physical space and means to continue the food delivery efforts and took over the project. The program setup was adapted to meet the

physical space of North10's Lenfest Center and three additional staff members were hired to assist their Manager of Adult Programs to package the various bags of food for weekly delivery. In 2021, they delivered 3,374 boxes of food to homes in North Philadelphia across 32 zip codes. Approximately 80% of those homes were located within the boundaries of the 19140-zip code, accounting for just over 2,660 food boxes delivered. Following, 96 boxes were delivered to the 19124-zip code and 89 boxes were delivered to both 19120 and 19144-zip codes. These accounted for 2.85% and 2.64% of their food distribution efforts, respectively. In 2022, even more households enrolled to receive food boxes. A total of 3,538 boxes were distributed, with about 92% delivered in the 19140-zip code.

Figure 1. Nonperishable Food Items Available At The Choice Market, North10 Philadelphia

North10's food distribution operation has evolved greatly since its inception. The organization renovated their physical space to accommodate the creation of a full-choice food pantry known as the Choice Market to continue food distribution efforts. Created in July 2021, the Choice Market initially served 75 households with 320 individuals— children, adults, and elderly— living in them. By October, this number increased to 200

households and 821 individuals. Less than a year later, in August of 2022, 437 households were enrolled in the program providing for 1,846 individuals. Community members have the opportunity to schedule a ten-minute time slot to “shop” for their groceries in a space that resembles a local grocery store. In addition to the scheduled time slots, which are frequently utilized by senior citizens in the community, the Choice Market is open twice weekly for shoppers to walk-in to browse a selection of perishable and nonperishable food items, depending on availability, that are stocked through partnerships with Philabundance and local farmers.

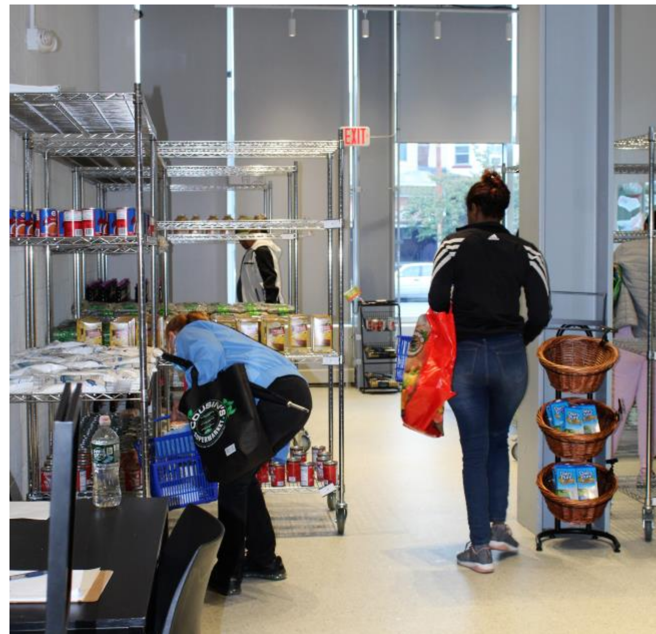

Figure 2. Clients Selecting Groceries At The Choice Market, North10 Philadelphia

Part Two of Chapter Two: Meet Rose, Manager of Adult Programs and Community Services at North10 Philadelphia

Figure 3. Rosemary (Rose) Duarte, North10

Rose was born and raised in Queens, New York until the age of 15 years old when her family moved to Northeast Philadelphia. Her parents moved to the United States from Guatemala when they were in their 20s for a better life and to get away from the violence of their country. They instilled in her the value of hard work and achieving your goals. They wanted their children to take advantage of "The American Dream" so they pushed them in their educational pursuits and expected, without a doubt, that their daughters would attend college. Even when her family didn't have the means for name brand clothing or sneakers, her mother made sure they had food on the table, clean clothes, and their education was never missed. Her mom was very involved in all activities and made sure she was at every parent -teacher conference, field trip, play, chorus, etc., which taught her the value of being involved and staying on the right path.

Her teachers, especially her fifth-grade teacher, also played a pivotal role in her growth as a child. She shared that "she would allow me to stay with her during her breaks

to help organize the classroom, to do extra credit if I needed it, and to talk to me about my hopes and dreams. She [also] taught me to have a passion for teaching." Rose went on to be the first person in her family to attend college. She earned her psychology degree from Penn State University Berks Campus in Reading, PA on a full scholarship as she navigated living in a new city and attending a new school without her friends or a supportive guidance counselor to help process the next steps of her future. Each of her psychology courses served as confirmation that she was on the right path.

After graduating, she ventured into the world of employment in Philadelphia, first as a camp counselor, then moving to foster care, and finally to working in non-profit organizations where she found her true passion. She finds fulfillment in working with organizations with a mission for serving the Hispanic community and helping families in any capacity to grow and achieve their goals. One of her proudest accomplishments is from working as case manager for transitional foster care with Catholic Social Services. She performed intake and discharge for unaccompanied children who were crossing the border and reunited them with family as they were traveling across the United States. In this role, she successfully reunited 20 children with their families. Her mom always taught her to help others and to do things with good intentions without expecting anything in return. When her parents moved to The United States, they had several people help them along the way and Rose wants to be that person for other Hispanic families that may need help.

One of the most valuable lessons she learned so far is the ability to work for the things you want. She remembers working so hard to earn straight A's to receive scholarships because she knew her parents could not afford college and did not want to

add that additional stressor on them. She credits watching her parents obtain their citizenship as being critical in shaping who she is today. As a high school student, she watched them study, take classes and pass their exam as testament of their drive to be in this country and to provide the best for their daughters. It also taught her important lessons about perseverance and determination which she still carries with her today. In her work servicing the community, she has learned that she cannot help everyone, but if she can make one difference along the way then the impact is still significant.

Her greatest hope for the future is for the communities in which she lives and works to feel more united and willing to help each other. Growing up, all of her neighbors would work together to clean the neighborhood, host a barbeque or block party to unite the block, and share goods with one another. She thinks our communities would benefit from continuing to work together in this way and decreasing violence amongst neighbors.

Rose hopes to return to school for her master's in social work to be able to continue spreading love and knowledge to the community. "So many [people] in our community are scared to ask for help because they have had doors closed, and I want to teach them to have a voice and to speak up for what they deserve because someone out there will hear them and help." In her current role supervising the Choice Market at North10, she feels that the more people know about the services they provide and the work they do, the more people will fund pantries in other neighborhoods. People travel from all over the city to find a food pantry they can go to for food, and she hopes to see more markets like theirs become available for other communities to utilize.

CHAPTER 3: FABRIC MASKS FOR NORTH PHILLY

Part One of Chapter Three: Personal Protective Equipment for Risk Mitigation

One of the main challenges during the pandemic was figuring out how to mitigate the risk of viral transmission, especially for medically vulnerable individuals who could not always comply with stay at home and social distancing recommendations. One disease countermeasure required the use of disposable or reusable personal protective equipment (PPE). Early in the pandemic, facial coverings were regarded as an appropriate means for decreasing aerosol transmission of viral particles but were not widely available. Many healthcare providers remember the hospital supply chain shortages that required reuse of single use PPE. Outside of these settings, community members utilized many household fabrics to create protective masks. The efficacy of these face coverings is influenced by appropriate coverage of the nose and mouth, the material and number of layers used to make it, and duration of wear (Rowan & Laffey, 2021).

Respiratory droplets can be generated by breathing, speaking, singing, coughing, or sneezing, and face masks can be used as a method of source control or protection for the wearer (Candevir et al., 2021). According to the World Health Organization, approximately 89 million medical masks would have been required monthly to meet the demand for community and healthcare workforce use (Rowan & Laffey, 2021). With delays in the supply chain providing disposable masks, the pandemic challenged individuals to find other means to cover their faces. Around the globe, government officials, corporations, healthcare systems, and communities sought creative ways to

meet this need. One of these methods was the creation of PPE using 3D printing models. Through collaborative efforts from the Department of Health and Human Services, Food and Drug Administration, and presidential executive orders, the regulations and liability risks around 3D printing of PPE and facial coverings were relaxed due to gaps in the supply chain for medical supplies (Bharti & Singh, 2020). Makers were able to use freely available designs from the National Institutes of Health 3D print exchange, an online design repository of 3D designs, to create medical supplies and PPE (Bharti & Singh, 2020). To achieve adequate protection, the face masks needed to be comfortable enough for extended wear, inexpensive to produce in large quantities from common…materials, and safe to disinfect for reuse without impacting PPE supplies (Darby et al., 2021). Fabric masks are able to do just that.

Fabric Masks for North Philly (FMNP) was an initiative that started at Temple's Lewis Katz School of Medicine (LKSOM) in April 2020 amidst the start of the COVID-19 pandemic. The project's purpose was to create volunteer-made, face masks to be distributed amongst individuals most at risk of adverse outcomes from viral infection. The design for the masks was created by a Temple professor in the College of Engineering, Dr. David Brookstein, and required two layers of cotton fabric separated by a sheet of filter paper. These masks could be produced using a grommet machine to punch holes in the fabric corners and running rubber bands through it to make earloops, making it easy for volunteers with varying skill levels to participate (Boni et al., 2020). Brookstein's design caught the attention of Dr. Kathleen Reeves and Professor Nicolle Strand of LKSOM's Center for Urban Bioethics (CUB) who recognized the need in the community for face masks.

With CUB's support, two fourth-year Temple medical students, Vittoria Boni and Kurt Koehler, joined the initiative to spearhead the recruitment of over 120 volunteers from Temple Schools of Medicine and Public Health. Koehler and Boni were responsible for coordinating week-long shifts during which volunteers picked up mask supplies from a central location on Temple's Health Sciences Campus, made masks in their homes, and returned their completed masks at the end of the week, typically making between 50 to 100 masks per shift (Boni et al., 2020). The leadership team further expanded to include Meghan Swyryn, a second- year medical student, and Theresa McShea, a senior undergraduate in the College of Public Health, both former student volunteers. By the summer of 2020, the team grew to include Michelle Liu, public health undergraduate, Brian Fertig, a fourth-year engineering undergraduate, and myself as a third-year medical student.

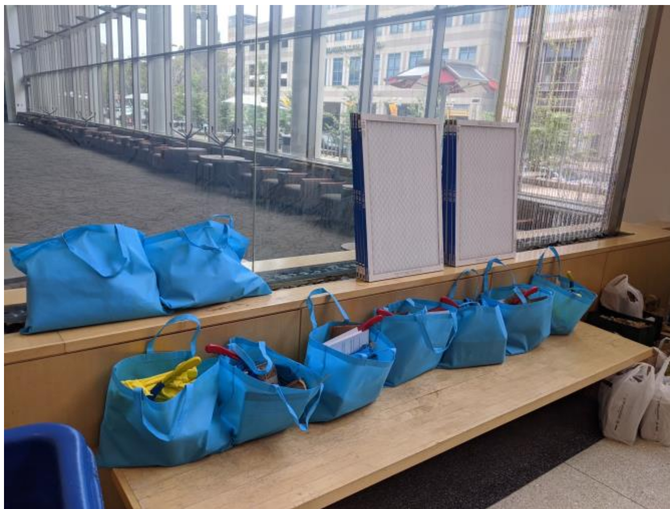

Figure 4. Weekly Mask Making Supplies For Student Volunteers.

Figure 5. Example Of The Grommet Machines Used To Create Fabric Masks.

In total, FMNP made and distributed almost 15,000 face masks to over 35 organizations in North Philadelphia free of charge. In addition to tracking distribution numbers, FMNP also collected information from the organizations they partnered with to learn about their mask utilization. Deborah Jowers from Zion Baptist Church shared: "Our current operations are following the CDC (Centers for Disease Control and Prevention) guidelines and so we are worshiping via Zoom and Facebook. We do, however, use face masks for the support staff of the church who do day-to-day work in the church. We appreciate the supply of masks provided to us by the [Temple] medical students which continues to help them remain safe… Our community outreach team [Called to Serve] ... also utilizes the masks provided by Temple" (Boni et al., 2020). Another one of our partners, Denise Robinson from Church of the Advocate told us: "... with COVID-19, the only program currently running is our soup kitchen—also known as the Advocate Cafe. The masks have been a godsend as most of our patrons to the soup kitchen...cannot obtain a mask on their own. Secondly, they like that they are lightweight and not so snug fitting that it makes it hard to breathe. We love the fact that we can help them and in doing so are protecting ourselves" (Boni et al., 2020).

Figure 6. Completed Fabric Mask Order Ready For Pickup

Part Two of Chapter Three: Meet Vittoria, Co-founder of Fabric Masks for North Philly

Figure 7. Vittoria Boni, Fabric Masks for North Philly

Vittoria was born in Naples, Italy before her family immigrated to the United States when she was three years old. The daughter of a jewelry store owner and pharmaceutical engineer, she lived what she described as a privileged childhood in the suburbs of Philadelphia. Her parents would make comments about their privilege saying, "make sure you eat all of your food, there are people who are hungry," but this became more salient for her as she got older. As a child, Vittoria was an avid reader, so books were her window into the world around her. "I remember feeling very sheltered by my parents…there was a point where I felt like I was living in a bubble. I knew that the experiences I was living weren't necessarily what everyone else was living." This bubble seemed to burst with the passing of her mother due to lung cancer while she was in college.

Immigrating from Italy in her late thirties with a small family in tow, Vittoria's mom was adamant that her children go to college. She herself pursued higher education

in the United States despite not being fluent in English and stressed the importance of knowledge as power since it could never be taken away. Her mom was her best friend and losing her was disorienting as she felt like her world had ended. Shortly after, Vittoria's grandfather passed and she herself had her own health scare with a concern for a cancerous growth in her femur. These experiences ultimately led to her decision to become a physician. "I wanted to put meaning to all the pain my family and I experienced."

Over the years, Vittoria has had the opportunity to expand her worldview and learn some valuable lessons—the hard way. Her path to medicine was far from easy. She took two gap years to bolster her application for medical school and quickly learned that if you truly want something bad enough, you make it happen even if it takes you longer than expected. During those gap years, Vittoria traveled abroad interning in a community hospital in India learning about healthcare delivery in under-resourced settings. She also worked as an insurance prior authorization representative fighting for coverage of essential medication for patients. In a one-month trip to Ecuador, Vittoria taught public health education in local schools where topics included the importance of brushing your teeth and tending to vegetable gardens. Here, she saw firsthand how the lack of access to essential resources impacted the lives of the children she was able to work with. In response, she partnered with other volunteers to raise money and build two libraries for the school children—a meaningful experience to change something she felt was wrong. This has been one of her proudest accomplishments—the other being Fabric Masks for North Philly (FMNP).

Similar to building libraries in Ecuador, this project required building something from the ground up with a group of like-minded people who wanted to make a change in what they were seeing around them. For Vittoria, the COVID-19 pandemic hit home as she was separated from her family in Italy who were especially vulnerable due to medical comorbidities. She channeled her fears into action as she sought to find a way to help those who were medically vulnerable around her. Before joining FMNP, Vittoria was sewing masks and finding ways to create personal protective equipment at home with her own supplies. This is ultimately what started her involvement with FMNP in April 2020. Though the project ended in December 2020, the demands of the pandemic continued to evolve. As PPE became widely available, purchasing disposable masks was more cost effective than producing the fabric masks. If it were up to Vittoria, FMNP would have pivoted its work to purchasing and distributing these disposable masks and included community education programs around risk mitigation strategies and vaccine hesitancy. While she has many more ideas of various initiatives to start, one priority for Vittoria is centering communities as experts on what they need with the hope of facilitating what is being asked for.

CHAPTER 4: MATERNAL WELLNESS VILLAGE

Part One of Chapter Four: Access to Perinatal Mental Health and Social Support

The World Health Organization asserts that contextually relevant community-level action inclusive of underserved populations is fundamental to the development of interventions aimed at achieving equitable health, particularly as it pertains to maternal and newborn health (Marston et al., 2016). During the onset of the COVID-19 pandemic, policy changes in healthcare delivery to try to protect individuals had unintended consequences for vulnerable groups including pregnant women. These consequences included, but were not limited to, reduced access to perinatal care impacting screenings for physical, psychological, and social health (Lucas & Bamber, 2021). Pregnant women, postpartum individuals, and those at risk of intimate partner violence were at high risk of developing mental health problems during the pandemic. These issues were worsened by the social stresses associated with the pandemic such as job layoffs, lockdowns, and lack of social support (Lucas & Bamber, 2021). Research also demonstrates that social isolation is associated with inequalities in maternal morbidity and mortality (Lucas & Bamber, 2021). Due to the COVID-19 pandemic, several restrictions were put in place limiting access to familial, community and professional support systems around pregnancy and childbirth.

Compounding this fact, racial and ethnic minority populations reported greater disparities in accessing culturally relevant mental healthcare to cope with the psychosocial stress of the pandemic (Ruprecht et al., 2020). Social isolation was positively associated with depression with individuals showing symptoms several months

after isolation (Koyucu & Karaca, 2021). Notably, maternal depression has been associated with adverse pregnancy outcomes including low birth weight and preterm birth (Marston, et al., 2016). Black pregnant women and birthing people exist at the intersection of identities that are shown to be particularly vulnerable to the stressors associated with social isolation in a pandemic while simultaneously lacking the appropriate resources to cope with these stressors. Recognizing this, it is essential to expand access to quality, affordable, and culturally relevant healthcare located within these communities to ensure transformation towards health equity (Ruprecht et al., 2020).

Figure 8. Founding Members Of Maternal Wellness Village
Left to right: Diona Murray, Tekara Gainey, Rayna Hughes, Saleemah McNeil, Shukriyyah Mitchell-Hinton, Selena Washington, Sabrina Keeton, Jabina Coleman, Iris Kimbrough, and Porsche Holland

Black birth workers serve as racially concordant, culturally relevant providers for Black birthing people who disparately experience maternal morbidity and mortality (Minehart et al., 2020). In response to these disparities, Saleemah McNeil, a Reproductive Psychotherapist, Certified Lactation Consultant, professionally trained

Birth Doula, traumatic birth survivor and Chief Executive Officer of Oshun Family Center, spent over a year recruiting a team of Black birth workers through social media and professional meetings. With pandemic constraints on in-person support, Maternal Wellness Village, a Philadelphia-based group of Black doulas, psychotherapists, and lactation consultants, launched Village Connect in 2020. This incredible group, comprised of founding members and other partners, included Saleemah McNeil, Jabina Coleman, Porsche Holland, Shukriyyah Mitchell-Hinton, Tekara Gainey, Victoria Moon, and others, who shared a vision to create a comprehensive program for Black and brown women, by Black and brown women in response to the social isolation due to the pandemic leading to decreased access to in person familial and professional support, especially doula support. Recognizing the additional stressors placed on the postpartum period, for example depression and anxiety, and inequities in maternal morbidity and mortality disproportionately affecting Black women and birthing people, this group of birth workers came together to address a problem in their community. Logistical and program evaluation support were provided through a partnership with CUB's Program for Maternal Health Equity. This multidisciplinary team of clinicians, birth workers and researchers has a mission to conduct ethical, antiracist, and community-engaged research to advance and nurture the health, wellbeing, and agency of Black, Latinx, and Indigenous birthing families in Philadelphia and beyond through collaborative program action and leveraging of resources in service of community needs.

Village Connect offered Black pregnant people in the third trimester four virtual group childbirth education sessions, either live or recorded, covering topics such as nutrition and comfort measures in labor. Understanding the fact that depression in

perinatal women is linked to a decreased likelihood of seeking professional help, Village Connect also offered twelve individual virtual counseling sessions through six months postpartum to allow for timely detection and intervention during this critical period of reduced access to medical care due to pandemic restrictions (Shi et al., 2018). Risk factors implicated in the diagnosis of maternal depression include positive history of prenatal depression, higher levels of perceived stress, lower access to social support, lower education attainment levels, and socio-economic status, further emphasizing the need for professional mental health screening and access to care for women in the perinatal period (Shi et al., 2018). Participants also had the option to access telehealth visits for infant feeding support with the understanding of the significant benefits of breastfeeding/chestfeeding for infant nutrition, growth, and maturation of their immune system (Vassilopoulou et al., 2021). Research demonstrates that Black women in particular have the lowest rates of breastfeeding/chestfeeding initiation (approximately 60%), as well as continuation at 6 months and 12 months (28% and 13%, respectively), compared to all other racial/ethnic groups in the United States (Jones et al., 2015). Black mothers are 2.5 times less likely to breastfeed than their White counterparts (Jones et al., 2015). Human milk has been shown to have anti-inflammatory properties as well as transfer maternal immune cells and proteins providing viral and bacterial protection to infants who are innately immune immature, a crucial defense mechanism during the COVID-19 pandemic (Vassilopoulou et al., 2021).

Black women were recruited for the program through social media and through referrals from providers at the Special Supplemental Nutrition Program for Women, Infants, and Children, commonly known as WIC. Example of recruitment message:

"Thank you for your interest in joining Maternal Wellness Village's newest program, The Village Connect! We hope to provide you and other Black moms in Philly with the support, education, and community you need to have a healthy baby and a positive pregnancy, birth and postpartum. Our program is offered to all Black women regardless of income and access to resources. The program includes:

- ***Four group education sessions led by Village community doulas during your third trimester covering topics like nutrition and healthy eating, comfort measures in labor, and feeding your baby.***
- ***Up to twelve individual virtual counseling sessions with Village therapists as well as mental health support groups through 6 months postpartum***
- ***Telehealth visits with Village Lactation Professionals to support you with breastfeeding or other ways to nourish your baby.***

Please answer the questions below if you are interested in participating. Someone from our team will reach out to you soon with more information."

Inclusion criteria for the program included enrollment by 28 weeks of pregnancy with a maximum limit of 32 weeks, age 18 years or older, a resident of Pennsylvania, and self-identifying as Black/African American. Non-Hispanic Black women are three to four times more likely to die from pregnancy-related causes than non-Hispanic White women in the United States. This disparity in maternal death, defined as occurring within one year of pregnancy due to a pregnancy related condition or complication, or a physiologic process exacerbated by being pregnant, has widened over the last century representing the largest disparity among population perinatal health measures (Howell, 2018). Notably, research suggests that the increased risk of maternal death among racial and ethnic minority women is independent of sociodemographic risk, meaning Black women cannot earn or learn their way into improved outcomes (Howell, 2018). As such, a critical

aspect of the recruitment effort was the intentional lack of income or insurance requirements so the program could be accessible to all.

In 2022, we analyzed participant engagement in each component of Village Connect as well as perceptions about what was most helpful in the program. Among the 19 Village Connect attendees, 89% reported they attended or viewed at least 50% of the childbirth education sessions, 85% attended at least 6 therapy sessions, and 28% utilized the optional lactation support. Psychotherapy, being part of a community with other Black moms and birthing people and having support from Black providers were identified as the most helpful parts of the Village Connect program by 67%, 72%, and 78% of participants, respectively. Additionally, the virtual format, no cost for participation and having support during pregnancy and after childbirth were also mentioned as helpful aspects of the program. These results suggest that the therapy component of Village Connect was seen as most valuable, perhaps due to the mental health strains of the pandemic and the ease of offering therapy via telehealth given in-person restrictions. Data further affirm that community-driven “for us, by us” models of perinatal care are especially beneficial in efforts to provide support for Black birthing people (Duncan et al., 2022). One participant specifically commented on a provider’s “ability to see me in all of the multitudes of my identities and experiences.” Regarding the therapy component of Village Connect, one participant shared that, "having a Black therapist was a great experience. I felt safe and comfortable in that space and sharing my life and experiences. It was nice to be able to relate to my therapist as well when it came down to generational cycles and the community." When asked to reflect on the childbirth education sessions, another participant stated that, "as a first-time mom, this program not

only educated me on the basics of childbirth but also was a safe environment to ask questions and have uncomfortable conversations."

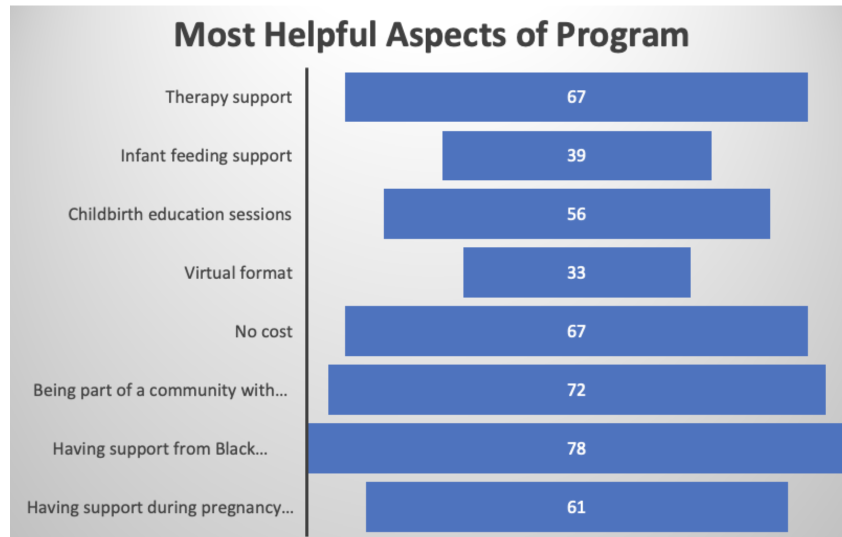

Figure 9. Participant Survey Responses Showing Most Helpful Aspects Of Village Connect

Building on the foundation of Village Connect, Maternal Wellness Village and Temple's Program for Maternal Health Equity have continued their shared vision of optimizing Black maternal health in Philadelphia through community-engaged research. In 2021, they were awarded a five-year, $5.4 million award from Patient-Centered Outcomes Research Institute (PCORI) to compare approaches for reducing heart disease risk factors among Black women and birthing people with the goal of eliminating disparities in pregnancy-related heart disease, including heart attack and stroke.

Part Two of Chapter Four: Meet Porsche, Founding Member of Maternal Wellness Village

Figure 10. Porsche Holland, Maternal Wellness Village

Porsche was born at Booth Maternity Center in Philadelphia and raised in the northeast section of the city. Her neighborhood was a predominantly White space that was growing more diverse during the 90s. She thinks of her childhood fondly, growing up in a beautiful community where her family always had what they needed, and more. Her family was loving and supportive and she was blessed with good friends and church community. Growing up, she knew her neighbors, played games on her block, and stayed out until the streetlights came on. “People paid attention to us as kids, and we could be encouraged and corrected by any adults our parents knew.” Porsche went to school in the Philadelphia public school system and excelled both in and outside of the classroom. Despite her success, and the great opportunities afforded to her, she was aware of the subtle, but present racism playing out in the predominantly White spaces where she attended school.

She aspired to become a neurosurgeon as a child and her journey took her to Tuskegee University, “one of the greatest HBCUs (Historically Black Colleges and Universities) in the state of Alabama.” There she studied biology as a premedical student, but realized this wasn’t the right path for her during her sophomore year. Her focus then shifted to public health and electives that were related to community health concerns with a concentration in nutritional science. Presently, her primary passions are in Black maternal health and parenting, recognizing deficits in access to support and experiences of racism. She has a burning passion and desire to see Black people not only survive their parenting journeys but thrive. Her personal experience of an unplanned pregnancy as a single mother at the age of 30 turned her world upside down. The journey was filled with emotional lows, during the pregnancy and postpartum period, but also much love and support from her community. These experiences completely changed her view of motherhood, particularly while single, and expanded her awareness of the various needs and challenges along the way.

She has channeled her experiences into passion for her work and has been privileged to see the fruits of her labor to promote Black maternal health and parenting. “My community is being valued and equipped with the tools they need to advocate for themselves and their families.” In pursuit of these goals, Porsche founded Reclaim Black Motherhood, an organization committed to ensuring Black families thrive and investing in the birth workers that support them. She was also one of the founding members of Maternal Wellness Village and creators of Village Connect, serving as one of the facilitators of the Childbirth Education sessions. She credits her HBCU education for teaching her the power of networking and building community—lessons that she

continues to hold dear to the present day. She uses her entrepreneurship as a tool for freedom and focused impact, directing her efforts to the items she is skilled in and passionate about. It also gives her the opportunity to set the bar for her salary and handpick who she will collaborate with on various projects. Her hope for her work is to further move the needle towards reproductive justice and better maternal health outcomes for Black people.

CHAPTER 5: MY REFLECTIONS

Part One of Chapter Five: Navigating My Self-Awareness and Personal Identity

As a Black woman living in North Philadelphia during the COVID-19 pandemic and simultaneous community mobilization and activism in response to yet another wrongful death of Black people at the hands of law enforcement, I saw myself reckoning with what seemed to be opposing identities. On the one hand, part of my identity was being a medical student at a well-known academic institution with access to various resources. In this space, I would typically stand out as being outside of the norm for this profession as Black individuals, and more specifically, Black women are underrepresented in the medical field relative to their proportion of the population. On the other hand, I am a Black woman living in a neighborhood of primarily other Black individuals who don't necessarily have access to the same resources. And while I more physically resemble the people in the neighborhood and share common experiences with living in similar areas (i.e., living in a food desert, lack of accessible green spaces, and concerns around gun violence in the city), it is also important to recognize myself as someone who was there to obtain an education and could easily extricate myself from those spaces. I would often do exactly that. When I needed to purchase groceries or wanted to go to a park, I was able to drive to another area to meet those needs.

Similar to the experience of people globally, the pandemic severely restricted in person meetings and engagements during my medical education. At the same time, I was starting my research year with the Center for Urban Bioethics (CUB) at Temple University. I joined this program because I knew my passions were rooted in serving in

underserved communities and caring for Black women throughout all stages of their reproductive and sexual health. These passions were what ultimately led me to take this research year. It wasn't a requirement for my degree, but we were initially looking to create a project in collaboration with our OBGYN department to evaluate disparities in maternal morbidity and mortality due to obstetric racism. Unfortunately, that project never came to fruition, so I worked on several of the other projects going on through CUB.

This is how I was introduced to the three organizations described in this thesis and had the opportunity to serve each in different capacities. For the food distribution efforts, I had a bird's eye view of the work CUB was doing before transitioning over to North10. I joined the weekly North Philadelphia Community Collective calls weekly and saw firsthand how this partnership allowed for the exchange of information regarding COVID-19 and the challenges facing the community— with food insecurity being a top priority. For FMNP, I served as the Community Outreach Coordinator responsible for managing face mask orders and arranging for distribution to the various community sites. For the Maternal Wellness Village, I was part of the evaluation team for the pilot of Village Connect and supported their work from the recruitment and enrollment of participants, to programming our surveys to assess their progression and participation throughout the program, as well as obtaining feedback for how we could improve it for the next cohort. Each day I spent my time supporting some of our efforts whether that be stepping in to deliver food boxes, joining calls to solidify our research questions, or packaging orders of 400 face masks for pick up from our school. What was common in all of these roles was the constant reflecting on my identities. I was often confronted,

mostly internally, but other times externally, with the reality of the harms a large institution can cause in the surrounding community and trying to reckon with that past while finding a path forward for meaningful collaboration. All while trying to avoid being the token Black woman that draws community members into a partnership, only to suffer additional harm.

Recognizing this, it was important for me to continue to show up each day to hold my other team members accountable for the work we as an institution needed to be doing, while at the same time understanding that ultimately the community organizations we worked with were keeping us accountable. Ensuring that the resources we had access to could be shared throughout the community from individuals who are experts on the lived experiences of those forced to live in the shadow of our university was essential to providing support to those most vulnerable during the pandemic and beyond. I gained so much in my time spent working with each of these groups. Lessons learned about myself and the person I hope to continue to grow into, the community around me and their unique challenges, and arguably most important, how we as individuals and institutions can partner with each other with a commitment to ensuring the health and wellbeing of those who do not have access to the same resources. Reflecting on the impact of these experiences on the future directions of my personal journey and work as a physician, I envision these might include:

- Presenting on the process and findings of the Village Connect program at the 2023 National Meeting for the American Medical Women's Association which has set public health initiatives regarding reproductive justice as a priority.

- Expanding institutional participation in culturally relevant group perinatal support that prioritizes a multidisciplinary approach to meeting the healthcare needs of Black women and birthing people while reducing barriers to participation i.e., inability to attend in person meetings and prohibitive costs for participation.
- Advocating for the inclusion of multidisciplinary healthcare team members (midwives, doulas, lactation consultants, social workers, etc.,), if not already present, to ensure patients have access to comprehensive screening, intervention and follow up options for various health and psychosocial issues.
- Staying informed of community-based resources to connect patients I will encounter in the healthcare system who are in need of additional support to promote their overall health and wellbeing.
- Leading by example for future medical trainees, demonstrating the importance of including social determinants of health in the clinical assessment for all patients to allow for early screening and possible intervention.
- Seeking and advocating for opportunities for the creation of community - academic partnerships in solidarity with community led mutual aid initiatives addressing public health infrastructure gaps that disproportionately impact communities of color.
- Prioritizing multiple avenues for community engagement outside of the clinical setting.

My hope is that this thesis serves as a reminder of the amazing work that communities can do for themselves and the fact that they shouldn’t have to. I will forever

be grateful to the North Philadelphia community for the person and physician I am and will become.

Part Two of Chapter Five: Mutual Aid through an Urban Bioethics Lens

"One of the most challenging questions faced in the shifting context of the COVID-19 pandemic is how these efforts and this awareness about the power of mutual aid can last beyond crisis" (Delano Alonso & Samway, 2022). The effects of health disparities created and reinforced by systemic racism were made evident by the societal constraints of the pandemic. The inability to follow public health risk mitigation strategies such as masking and social distancing, lack of access to affordable, fresh foods and psychosocial burdens of pandemic constraints disproportionately impacted Black and Latinx populations living in urban settings. During this time, the creation and expansion of mutual aid efforts redistributed resources amongst community members who were familiar with the unique barriers to achieving health in their community.

In stark contrast to the deeply rooted institutions that concentrate privilege in some communities versus others, these community-based efforts are at risk of dwindling, especially as the acuity of the impetus for their creation lessens. The resilience of communities to meet their own needs serves as a critical component of disaster response strategy through timely resource mobilization. Community resilience is best conceptualized as the formal and informal means for attaining physical and social capital that provides the "potential to recover from dramatic change, sustain… adaptability, and support new growth" (Ungar, 2011). Physical capital refers specifically to the community

infrastructure and built environment which have been previously discussed as having inequity in allocation of spaces for housing, employment, and recreation due to the lasting impact of systemic racism. Intimately related to this physical capital, is social capital which relates more to the interconnectedness of community members that fosters networks of social support around essential services such as childcare and public safety, mutual aid, and the norms of reciprocity (Ungar, 2011). An urban community that is more likely to be resilient in the face of adversity, such as a global pandemic, has the means to develop this capital prior to needing it. This requires building capacity of communities to be resilient through coordination of culturally relevant services that are designed to be easily accessible to the community and sustainable (Ungar, 2011). What has been seen in North Philadelphia, and other communities globally, is the ability for mutual aid groups to mobilize in response to the COVID-19 pandemic, but also illustrates the need to consider how such efforts can be supported so these community resources continue to be available long after pandemic restrictions are lifted.

In line with all of the bioethical principles, especially that of solidarity, these mutual aid efforts should be formalized within established groups to ensure their longevity. In the case studies described in this thesis, North10 Philadelphia, Fabric Masks for North Philly, and Maternal Wellness Village had the support of individuals and organizations aligned in their respective missions. Whether the support be in the form of funding, programmatic evaluation, provision of volunteers, or other efforts, structures of accountability and activism offer a vital opportunity to create a firm foundation for the continuation of these projects.

While it may seem antithetical to the definition of mutual aid efforts to partner with formalized agencies and organizations for the promise of longevity and sustainability, I would argue that it is our responsibility as people and institutions in positions of power and access to offer our resources to support these efforts. Traditionally, mutual aid is a community level practice of individuals urgently working together to meet each other's needs, understanding that society's current systems often do not fulfill these needs. As such, mutual aid is inextricably tied to bioethics, and urban bioethics in particular offers a lens to review how these efforts were developed and sustained in areas such as North Philadelphia. Bioethics, a branch of ethics, primarily focuses on the ethical considerations related to health encompassing medicine, biology, and health science research. The field is based on four main principles: autonomy - the right of an individual to make decisions about their body; beneficence - to help and promote the wellbeing of others; non-maleficence - the duty to do no harm to others; and (distributive) justice - to do what is fair and just, especially as it relates to the distribution of limited resources. Urban bioethics takes these same principles and applies them further in a multicultural context of areas that are diverse, densely populated and have evidence of disparities or inequities that may highlight conflict between respect for individual autonomy and the interests of the overall public good (Blustein & Fleischman, 2004).

With this in mind, the principle of autonomy is expanded to agency which focuses on a person's capacity to exert control over their health and wellbeing. Mutual aid organizations seek to bridge gaps in the ability of communities to exercise their personal agency due to sociopolitical conditions that leave them without the capacity to do so. For example, the history of redlining and creation of food deserts in urban spaces makes it

difficult for these communities to access fresh and nutritious foods for the health of themselves and their families. Similarly, the principle of distributive justice is expanded to social justice which necessitates an equity-based approach to individuals with different lived experiences. As illustrated by the difference between equality and equity, some individuals have greater needs and thus require additional support and resources than their counterparts to achieve the same level of wellbeing. To that end, mutual aid groups address inequities in access to essential goods and services by removing the power of distributing resources from political agents and returning it to the communities who are left under-resourced. For example, the food distribution efforts described earlier in this thesis were focused primarily on serving zip codes disproportionately impacted by food insecurity during the pandemic as individuals living in other areas of the city are better able to meet this need for themselves for various reasons i.e., proximity to grocery stores or ability to pay for food delivery services. The final principle of urban bioethics and arguably the most central to mutual aid efforts is solidarity. Solidarity asserts that individuals within a society are interconnected, and thus, their actions directly impact one another. In a society in which resources are limited, in order for some members to have access to more resources, i.e., wealth, the opposite must also be true in that other members of the same society will experience lack of that access, i.e., poverty. Solidarity calls for individuals to invest in the wellbeing of the community as a whole. Mutual aid groups serve to equitably redistribute access to resources, such as food, recognizing the intentional design of society to disproportionately benefit certain groups without regard for merit or necessity.

From an urban bioethics perspective, it would be unethical to recognize health inequities as a consequence of unequal access to resources without working to address it. The COVID-19 pandemic brought these inequalities in disease and risk burden to the forefront of the national conversation and sparked historic grassroots efforts to address these. The increased visibility of public health infrastructure gaps disproportionately placing communities of color in urban settings at increased risk called for urgent action that was met by community led initiatives to bridge these gaps. I have described a few of the various efforts to address inequities in access to affordable, nutritious food, personal protective equipment, and culturally salient perinatal mental health and social support services during the pandemic.

America is long overdue for reckoning with the enduring effects of institutionalized racism that have marginalized communities, namely Black and Latinx individuals in urban areas, from accessing their full potential for their health and wellbeing. Mutual aid efforts afford us the opportunity to circumvent these systems to meet the immediate needs of those around us, however, more work needs to be done in order to ensure the continued success and longevity of these efforts. In doing so, we must also ensure to not absolve large institutions and political agents from their responsibilities to provide support to those most at risk in society.

> Charity is no substitute for justice. If we never challenge a social order that allows some to accumulate wealth — even if they decide to help the less fortunate — while others are short-changed, then even acts of kindness end up supporting unjust arrangements. We must never ignore the injustices that make charity necessary, or the inequalities that make it possible.
>
> – Michael Eric Dyson

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