Article

Reproductive Justice, Public Black Feminism in Practice: A Reflection on Community-Based Participatory Research in Cincinnati

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Abstract: Research on reproductive justice has mainly, but not exclusively, appeared in academic literature in the context of grassroots social justice movements and as a theoretical framework for understanding the limitations of "reproductive choice" in the absence of social justice. But how can scholars design research to explore and understand reproductive (in)justice in the real lives of women of color? How can research partnerships between university scholars and community stewards be formed and sustained? What tensions and challenges are inherent in these efforts? And how can we find more equitable ways of sharing research findings and creating change *with and not on behalf of* our community? This paper reflects on the use of Community-Based Participatory Research (CBPR) in a reproductive justice research project focused on Black women residing in Cincinnati.

1. Introduction

Reproductive justice is public Black feminism in practice. Conceptualized by 12 African American women in 1994, just before the United Nations Conference on Population and Development in Cairo, reproductive justice, a grassroots feminist movement that directly transforms the lives of women of color in diverse communities across the United States was born [1]. Reproductive justice community activists also transform the academy, compelling feminist scholars to reimagine mainstream frameworks that promote "reproductive choice" in the absence of human rights and social justice [2].

Black feminist epistemology calls on scholars and activists alike to center the lived experiences of Black women (cisgender, transgender, and gender non-conforming persons). As "outsiders-within", Black women's standpoint is subjugated knowledge. This subjugated knowledge is inherently confrontational, as it inherently challenges mainstream constructions of knowledge, ideologies, and interpretations of the world [3]. The Black feminist standpoint offers an intersectional analysis that accounts for social identities, privilege, and opportunities and how these converge with law and policies to compound experiences of discrimination. The intersecting oppressions of race, gender, and class produce (and reproduce) social injustices and consequently justify violations of human rights, such as laws and policies that restrict bodily and reproductive autonomy.

Like Black feminism, reproductive justice values subjugated knowledge and centers the lived experiences of minoritized women. As a movement, reproductive justice fundamentally understands that reproductive and sexual health care and rights are deeply connected to broader issues of social, economic, health and environmental (in)justices. And

while access to birth control and legal, safe abortions is paramount, so too are welfare and prison reform, housing and food security, and humane immigration policy [4]. Lives punctuated by structural racism, xenophobia, heterosexism, classism, and other forms of oppression require a reproductive health agenda that centers *justice* and *rights* and is politically nuanced. Reproductive justice is a community-informed movement, led by those most impacted by anti-reproductive legislation and policy. It is essentially a movement for bodily autonomy that emphasizes birth justice principled on if, when, how, and with whom to have a family. Equally, it is a movement that prioritizes the right to *parent* with dignity, in the absence of violence and in a safe environment. In this paper, we reflect on the use of Community-Based Participatory Research (CBPR) in a reproductive justice research project focused on Black women residing in Cincinnati.

2. A Century of Reproductive (In)Justice in Cincinnati

For more than a century, Cincinnati has led the nation in adverse Black infant and maternal outcomes. Due to persistently high Black infant and maternal mortality, Cincinnati was chosen to be Ohio's urban site for Sheppard–Towner Maternity and Infancy funding. The Sheppard–Towner Act provided federal funds to states to cover cost of programs established to address the high maternal and infant death rates. While the State of Ohio passed bills approving the Towner grant in November 1921, monies were not dispersed until 1922. According to the city's Health Department Commissioner at the time, William M. Peters M.D., Black infants were dying at three times the rate of White infants, which made Black maternity and infancy health a priority [5]. Of the four Ohio locations selected for Sheppard–Towner funding (a mining settlement, a small town, a rural district, and an urban center), Cincinnati was the only location to specifically focus on saving the lives of Black mothers and their babies.

The Cincinnati Sheppard–Towner grant period started in 1923 and ended in 1925. The city of Cincinnati received $8000 for two years of service. These monies were used to cover salaries of two full-time Black nurses, fees for Black physicians, transportation, and medical equipment for two newly established community health centers. The health clinics were held at the Frederick Douglas and Harriet Beecher Stowe schools located downtown in the West End community, where 70% of Cincinnati's Black community resided. The nurses conducted home visits to administer prenatal care and provide health instruction to mothers. Because hospital births were more common than delivery by midwife in 1920s Cincinnati [6], another major goal attached to Sheppard–Towner funding was to institutionalize birth registration. While the Cincinnati Sheppard–Towner programs had virtually no impact on maternal mortality [6], a 1926 study showed some improvement in Black infant mortality rates (IMR), decreasing from three to two times the rate of White infants [7]. Yet, in the same year, 1926, Cincinnati was recorded as having the highest IMR in the nation (in cities with populations over 250,000) at 89 deaths per 1000 live births, followed by Washington (85), Detroit (84), Buffalo (84), and Boston (84) [8].

Nearly a century later, the Cincinnati metropolitan area and the state of Ohio still have some of the highest Black IMR rates in the United States. According to a National Center of Health Statistics (2018) report, Ohio (13.46 deaths per 1000 live births) had the second-highest Black IMR in the nation, following Wisconsin (14.28 deaths per 1000 live births). In 2019, Ohio's Black IMR increased to 14.3 deaths per 1000 live births. Like a century earlier, the Cincinnati Black IMR is three times that of Whites [9]. The Black IMR is evidence of the everyday, mundane racial hostility, trauma, and stress Black women in Cincinnati endure. Cincinnati remains highly segregated [10] and as evident by the longstanding racial health disparities, works minimally to improve the living and health conditions of its Black residents.

While infant mortality rates for all women irrespective of race and ethnicity have decreased over time, racial health disparities have not; instead, they have amplified. In 1916, for example, Black IMR in the United States was 184.9 deaths per 1000 live births—87% higher than that of Whites, whose IMR was 90 deaths per 1000 births [11]. In

2017, the Black IMR was 10.8 deaths per 1000 live births, compared to 4.9 per 1000 for Whites [11]. This disparity amounts to a 122% higher IMR for Black infants [11,12]. Similarly, 21st century U.S. Black women are 243% more likely to die from a pregnancy-related cause than White women [4].

What is profoundly disheartening is reconciling that Black enslaved mothers and their infants were more likely to survive childbirth than Black women living in the post-slavery era [8]. As compellingly noted in Dana Ain Davis's [13] (2019) *Reproductive Injustices: Racism, Pregnancy, and Premature Child Birth*:

> "In 1850, the Black infant mortality rate was one and a half times higher than the rate for white infants. In 2000, the disparity was two and a half times higher. It is astonishing to see that even under the strictures of enslavement, Black women had significantly better birth outcomes than they do today".

The primary driver of infant deaths in Ohio is prematurity, followed by congenital anomalies, obstetric conditions, external injuries, and sudden infant death syndrome (SIDS). Targeted state programs, such as safe sleep education and birth defect surveillance, do not adequately address prematurity (e.g., preterm birth and low birth weight). Nor are perinatal smoking cessation programs adequate when it comes to African American mothers and disparities in preterm birthing. While Moore and colleagues [14] (2016) find that smoking cessation campaigns in Ohio had similar influence for Black and White mothers, as [15] Braverman and colleagues (2021) note, "Black women of reproductive age are *less* likely than their White counterparts to smoke, engage in heavy drinking, or use marijuana". As such targeted programing to address preterm births in Ohio should not be a one-size fit all approach, instead should be tailored to specific racial and ethnic communities. Further, most Ohio infant deaths are concentrated in the Cincinnati metropolitan area, which includes Hamilton, Butler, and Montgomery counties [16]. Additionally, within Cincinnati, certain neighborhoods are far more vulnerable to adverse birthing outcomes than others [7,17].

Like other public Black feminist-led movements (such as Black Lives Matter, #MeToo, and TIME'S UP), community lived experience, knowledge, and participation are essential for the movement's success. RJ recognizes that those most impacted by anti-reproductive legislation and policy must have a voice and hold leadership roles in the movement. As such, the RJ movement is quintessentially a grassroots social justice movement deeply burrowed within local communities. As a result, RJ research cannot be conducted in the absence of community inclusion, which makes Community-Based Participatory Research (CBPR) the perfect methodological tool to study the reproductive health, rights, and justice of Black and minoritized women.

3. CBPR Reproductive Justice Review

Overcoming racial health inequities requires a paradigm shift in sexual and reproductive health research conceptualization, implementation, and dissemination. Such a shift is possible when it is based on solid principles. In 2021, a multidisciplinary group of reproductive health researchers, practitioners, and community leaders met to create a framework and recommendations for the future of their field. They identified six interwoven principles for reproductive health equity, the first of which is to "center the needs of and redistribute power to marginalized individuals and communities" [18]. The authors stressed the need for community-engaged research methods that center marginalized populations in decisions about what is studied, how research is conducted, and how results are interpreted. Their principles are consistent with the World Health Organization's guidelines for reproductive and sexual health research to be conducted in partnership with community stakeholders [19].

As Monica McLemore [20,21] (2021) points out, Black women scholars have already developed community-engaged methodologies that produce higher-quality data and more effective, sustainable interventions than methodologies that rely on existing datasets. Prioritizing marginalized women in reproductive and sexual health research is best articulated

by the *Black Mamas Matter Alliance* (BMMA), a partnership project between the Center for Reproductive Rights and SisterSong Women of Color Reproductive Justice Collective. BMMA centers Black mamas to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice. The BMMA research working group conceived a new vision for Black Maternal Health research that calls for:

> a scientific revolution that centers Black Mamas and communities to determine which research questions are most important to them, what research questions should be prioritized, and what methods and analytic procedures should be used to provide meaningful data that should inform policy, funding decisions, and health services provision [22].

> Foundational in their list of best practices for Black maternal health research is the need to honor and commit to engaging with Black mamas throughout the entire research process.

Although the push for community representation in sexual and reproductive health research is gradually becoming more mainstream, there is a long history of community-engaged and participatory approaches in the field. Internationally, women have worked with researchers to develop interventions and programs that reflect their experiences and priorities. For example, teams of young people have conducted research to understand community attitudes about sexual health to inform sexual and reproductive health initiatives in Zimbabwe [23]. Community–academic partnerships in Australia and New Zealand worked on iterative research and action projects to improve reproductive health of refugees from Africa and the Middle East [24]. Women with disabilities in the Philippines worked in participatory action teams to develop an intervention and evaluate its effectiveness [25,26]. Young women in Ethiopia, Tanzania, and Nigeria used human-centered design to identify strategies to reduce unmet need for contraception [27] and adolescent girls in Iran designed, implemented, and evaluated a reproductive health program [28].

In the United States, community-engaged research around sexual health is widespread, particularly in HIV/AIDS prevention [16]. Perhaps the most notable example are peer-led health interventions that acknowledge and respect barbershops as a trusted setting in African American communities. Barbershop-partnered sexual health interventions have gained popularity over the last decade and research supports their effectiveness. For example, a large randomized, controlled trial of a barbershop-based HIV prevention program in Brooklyn, NY demonstrated decreased sexual risk behavior among men who participated, providing rigorous scientific evidence for the feasibility and effectiveness of these community-based interventions [29]. Participatory sexual and reproductive health research has also been conducted with women, particularly partnerships aimed to reach young people. Recent examples include an intercultural, multi-sector research partnership between stakeholders in the United States and Mexico that led to a peer-led intervention to reduce adolescent pregnancy [30] and an arts-based participatory research project in Hawaii with female youth experiencing homelessness, which led to a contextually specific sexual and reproductive health intervention [31].

Community-engaged and participatory research has a well-established history and is increasingly valued as the most feasible way toward health equity in reproductive health. Research that engages stakeholders as partners in the research process exists across academic disciplines under many different names [32]. Within public health and other health-related fields, the most widely used umbrella term for research conducted in collaboration with stakeholders is Community-Based Participatory Research (CBPR), defined as:

> a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities [33].

CBPR is an increasingly common orientation to sexual and reproductive health research. One review identified 24 CBPR studies that partnered with racial and ethnic minorities in sexual health interventions [34]. Overall, these projects positively impacted the thoughts, attitudes, and/or behaviors of participants, though only about one half of the studies had a high level of collaboration with community stakeholders. Overall, the review provides promising evidence that CBPR can reduce sexual health inequities.

There are some existing examples of CBPR approaches to sexual and reproductive health research that have centered Black women as leaders of change. Some collaborations have focused on centering the perspectives of Black women, including studies to understand community perceptions of infant mortality [35], prenatal care [36], breastfeeding barriers [37], and structural racism in reproductive health [38]. Other partnerships have focused on improving reproductive health care services for Black women [39,40]. CBPR has been prioritized as the orientation to research most appropriate for work with African American communities, who have long suffered from research injustices [41]. The National Black Leadership Initiative on Cancer at Morehouse University has even developed principles for doing CBPR with African American communities [42]. The Black Mamas Matter Initiative and the group that created the Reproductive Health Equity Framework both specifically call out CBPR as the orientation to research that should be used going forward [18,22]. It is in this spirit that we created a CBPR team.

4. Building a Community Partnership

This Ohio Policy Evaluation Network (OPEN) study, funded by a grant from an anonymous foundation, was initially conceptualized to focus on Cincinnati's lowest-income communities' reproductive health needs, specifically to explore how low-income women's access to abortion services were hindered by Ohio's increasingly hostile reproductive rights landscape. Since 2011, Ohio has passed 15 laws restricting abortion or targeting abortion providers; four of these laws are still currently enjoined [43] (OPEN 2021). These laws include the following notable restrictions: prohibiting Affordable Care Act health care plans from covering abortion, banning abortion after 22 weeks from one's last menstrual period, banning abortion after six weeks gestation (enjoined), banning dilation and evacuation procedures (partially enjoined), banning the use of telemedicine for medication abortion (enjoined), requiring fetal tissue to be cremated or interred (enjoined), and prohibiting abortion if the patient's reason for the abortion is a diagnosis or indication of Down syndrome. This extremely restrictive legal climate continues to intensify, as demonstrated by the introduction of trigger ban legislation (Senate Bill 123) and a bill to completely ban abortion in the state (House Bill 480) during the 134th General Assembly session (2021–2022).

To better understand the persistence of reproductive health injustices for Black Cincinnatians, a reproductive justice research team, which includes the authors of this article, was established. We recognize that reproductive and sexual health are not disconnected from the intersecting violence (structural, spatial, and interpersonal) that shapes the lives of Black women [44] (Norwood, 2018). From the onset, the research project was envisioned as a Community-Based Participatory Research project inspired by the aforementioned restrictive abortion laws, but not to the exclusion of race, class, and sexual injustices that shape the lives of women of color. Building a community advisory board (CAB) was an essential first step. But how and where to start? It was important that our CAB be diverse with regard to race, ethnicity, gender identity, sexual identity, geography, social class, educational background, and occupation. The one commonality shared between persons recruited to be CAB members was a commitment to feminist and anti-racist praxis and thought. The 12 individuals that ultimately constituted our CAB—Nikita Anderson, Key Beck, Lauren Bostick, Thembi Carr, Amber David, Paola Garrido, AZ (anonymized), Rashida Manuel, Meredith Shockley-Smith, Le Thompson, Amy Tuttle, and Jane Doe (anonymized)—were mothers, artisans, professionals, women, non-binary people, and gender non-conforming individuals who expressed an interest in reproductive justice work. All were concerned

with the persistent prevalence of sexual and reproductive health disparities within, and between, low-income Cincinnati neighborhoods and populations.

It was important to build a relationship with every CAB member. We met over meals and coffee. We learned about each other and the work that was important to us. We listened to each other. We willfully chose to respect our differences and draw on our shared passions. We understood that team building is about the individual relationships we have with each other and that cultivating these relations was important for the CAB's sustainability. This also helped with maintaining positive and active communication among members. Deliberate, conscious team-building effort was essential for us as we advanced through the various stages of the research. Graduate students (assigned as research assistants by OPEN), Stef Murawsky and Molly Broscoe, played an essential role in facilitating CAB meetings, assisting with literature reviews, managing the IRB status, and communicating with the team.

CAB members were chosen in part based on their rich knowledge of Cincinnati's neighborhood communities. There was a strong preference for those who were already working on issues related to "justice"—broadly defined, and inclusive but not limited to human rights, social, and reproductive justice. It was also important that individuals had knowledge and/or sensitivities around health disparities and inequalities with respect to racial, ethnic, gender, sexual, economic, as well as religious affiliations. Collectively these were the criteria considered important for serving on the CAB.

After several months of recruiting and building our CAB, Stef Murawsky, a graduate research assistant, created and distributed a Reproductive Justice in Cincinnati Newsletter. This newsletter introduced each CAB member to the others, the CAB members to OPEN, and the CAB members to the CBPR method. The newsletter contained a biography and picture of each CAB member, a summation of OPEN, two research articles about the CBPR method [45], and an article on what it means to be on a CAB [46]. This proved to be very instrumental for creating a group identity, a sense of shared goals, and cohesiveness among members.

The three biggest challenges were: how to maintain harmony among members, how to minimize CAB member attrition, and how to create an environment that would encourage everyone's participation and utilize everyone's expertise. It was especially important to acknowledge that the Project Lead (PL), Carolette Norwood, was not the only "expert" in the room. The PL's expertise was as bounded as anyone else's. We all have strengths and knowledge, different and similar, that we bring to the table, and we mutually gain through our collaboration and respect for differences in knowledge and lived experiences. Above all, there was shared agreement and a firm understanding that we were co- and or peer researchers [47] and that all of us had an important role to play in what was researched, how the research would be executed, how the data would be analyzed, and how the research findings would be disseminated.

To help avoid conflict and invite harmony, in our very first meeting as a CAB, we established "ground rules". Our first CAB meeting started simply with introductions; we spent the first hour getting to know each other and establishing ground rules for how to conduct ourselves during meetings. The "ground rules" were a living document that specified basic expectations around collegiality (see Appendix A). For example, being an "active listener", "respecting our diversities", "no honest question is stupid", and "leaning into discomfort" were all proposed. We also talked about what reproductive justice meant to us individually and what that looked like in Cincinnati.

Attrition was another challenge. While every effort was made to welcome and validate our diversities and minimize personality conflicts, some challenges fell outside of the scope of our collective control. Unfortunately, we lost two members of the CAB due to employment relocation. One member chose to remain in contact with the group remotely, despite having relocated to another state. Because the turnover occurred in year 2, after the research design and questionnaire had been developed and at the time data collection was

underway, the CBPR team chose not to recruit new members to replace the ones we lost. The team had already bonded and chose not to disrupt its chemistry.

5. How and Why Some CAB Members Decided to Join This Project?

Reasons for joining OPEN's CBPR project as a Community Advisory Board member varied. Amy Tuttle, a passionate practitioner of Restorative Arts (e.g., Arts and Health), explains she was drawn to being a CAB member on this study because of her interest in the medical humanities and her goal to share findings from this work to help educate the Cincinnati medical community. Amy writes: "the medical community has an opportunity to address [it's] biases and ethical violations. I believe we can use these findings to inform best practices in the field and to reintroduce empathy into medical systems that clearly negatively impact the reproductive health of Black women in our community".

Likewise, Nikita Anderson, a neighborhood mom and resident in one of Cincinnati's most iconic Black neighborhoods, explains she joined this study because she was passionate about challenging social injustices and wanted to create a better life for everyone living in oppression. As a neighborhood health champion, she was determined to learn and empower herself and others in the community. Nikita was particularly frustrated with there being too few conversations in the community about sex and birth control, too much stigma around Black mamas, and too much misinformation about Planned Parenthood health clinics, which Nikita feels are under attack and misrepresented as being singularly focused on abortion. At the time this research study launched, the local Planned Parenthood health clinic was in the national news. Two Cincinnati Planned Parenthood health centers were being forced to close which immediately jeopardized neighborhood women's access to STI testing and treatment, access to birth control and cancer screenings. Cincinnati was just overcoming a "syphilis epidemic" [48] and had the highest rates of chlamydia and gonorrhea infections in the county and in the state of Ohio [49] (Planned Parenthood, 2019).

Other members like Rashida Manuel, Le Thompson, Meredith Shockley-Smith, Key Beck, and Lauren Bostick worked both in the field of reproductive health care and advocacy, so being on a research team dedicated to reproductive justice was already aligned with their professional work. Others were shifting career paths—for instance, Thembi Carr was shifting her work in education studies to focus on female sexual education. When Thembi joined the team, she was debuting a new podcast that addressed women's sexual health. Amber David's knowledge of the Cincinnati community gleaned from her work on Black women and economic development was also a tremendous asset to the project.

As a Latinx woman from Dominican Republic residing in Cincinnati, a city with an expanding and diverse Latinx population, Paola Garrido joined the team because of her interest in women's rights. Paola had prior experience researching the role of women in cities and public spaces as it related to equity, safety, and well-being. Paola also expressed strong beliefs in reproductive justice and access to health care, especially because her Dominican roots led her to realize that "so many women don't even have basic access to [reproductive health] resources".

Finally, AZ (anonymized), whose name is not shared due to her current employer who's a benefactor of Catholic funding, came to this work because of her deep connections in the community, specifically her work with immigrants and women experiencing homelessness. She felt the reproductive health needs of people belonging to these communities are overlooked by mainstream reproductive health movements, and it was important to have this input. The diversity of experiences, and shared commitment to feminist praxis and reproductive access, care, and rights, cumulated in a dynamic CAB team and research experience.

6. Doing Community-Based Participatory Research

This section describes the creation of the research protocol. Explored below are the processes for framing the research question, creating the interview guide, narrowing the

research goals, employing the recruitment strategies, executing data coding, and planning deliberately for community inclusive research translation.

6.1. From Framing the Research Question to Creating the Interview Guide

In exploratory qualitative research, framing a research question in advance of the study is not always possible. Instead, solidifying a research topic is essential. When we began designing this project, we set out to understand how reproductive justice (or the absence of it) manifests in the everyday lives of Black women in Cincinnati. In doing so, we first gathered literature on reproductive justice. This literature encompassed published works written by activists, scholars, activist-scholars, and scholar-activists alike. Some of this literature addressed the movement broadly, while others detailed the ways Black women and feminist reproductive justice advocates responded to the noise of anti-abortionists.

Interestingly, the loudest anti-abortion noise was in our own backyard. Cincinnati is home to the Life Issues Institute, founded by Dr. John Charles Willke (1925–2015), the father of the prolife movement. Willke is considered one of the most influential and strident architects of the modern anti-abortion movement. Willke, a University of Cincinnati Medical school graduate, authored the infamous pamphlet *Handbook on Abortion (1971)* and a decade later, a book entitled *Abortion and Slavery: History Repeats* (1981). In the latter, Willke propagated the injurious claim equating a fetus to a slave, an argument successfully used in establishing fetal personhood and amplifying the Black anti-abortion movement. A second injurious claim was that Planned Parenthood had systematically targeted the Black community in a mission for genocide. In 2006, Willke's organization established *Protecting Black Life* (PBL) as an urban outreach initiative. Black ministers were hired to reach the Black community with antiabortion messaging. This was largely achieved through a 2014 billboard campaign that targeted 10 Black Cincinnati neighborhoods [50] (Norwood, 2021). With this in mind, our interview guide was designed to explore issues around abortion attitudes, access, and past experiences with abortion.

As we delved into the literature, we began to rethink and think more critically about our decision to center low-income communities. Instead, we chose to focus on African Americans, irrespective of socio-economic background. As Dana-Ain Davis's [13] work richly demonstrates, Black maternal and infant health injustices are a problem of racism. Moreover, the Black body, as Dorothy Roberts [51] (1997) notes, has been politically infringed upon and under assault since the antebellum era, irrespective of geography and such social attributes as social class and age [51]. Anti-Black racism knows no boundaries; it impacts and attacks Black people uniformly despite our differences. As such, we chose to include any birthing Black person, age 18–49 who resided in a Cincinnati neighborhood.

Our second meeting's goal was to identify which neighborhoods would be considered for this study. Each member was sent a link to a research study on Cincinnati neighborhood [52] and used documents from the PBL's (a local anti-abortion organization aforementioned) billboard campaign placement strategy. The latter was very useful as the neighborhoods targeted for anti-abortion billboard campaigns were considered as those in zip codes with high abortion prevalence [50]. With knowledge gleaned from the Maloney and Auffrey's (2013) Cincinnati Social Indicators report [52], the CAB knowledge of neighborhoods, and the PBL billboard placement document, we collectively identified the following neighborhoods for this study: Beekman Corridor, Lower and East Price Hill (Brick Stones), Winton Hills, Westwood, Avondale, West End/OTR, and Bond Hill/Roselawn (Glen Meadows) (see Figure 1).

In our third meeting, we narrowed and specified our research goal. This meeting generated robust conversation about local issues and challenges around reproductive and sexual health. True to RJ, our CAB identified a diverse set of topics crucial for understanding the experiences of Cincinnati's low-income communities, such as but not limited to: material well-being such as housing and food insecurity; child care availability/schooling/education; violence; transportation;/mobility and care (preventative and self; cost of health care) gendered racism and stress; perceptions of Black motherhood

(parental rights, LGBT parenting, pregnancy/infant and maternal mortality, stigma) vs. womanhood (are voices heard), access knowledge and use of resources (contraception, reproductive services, and options for abortion/adoption).
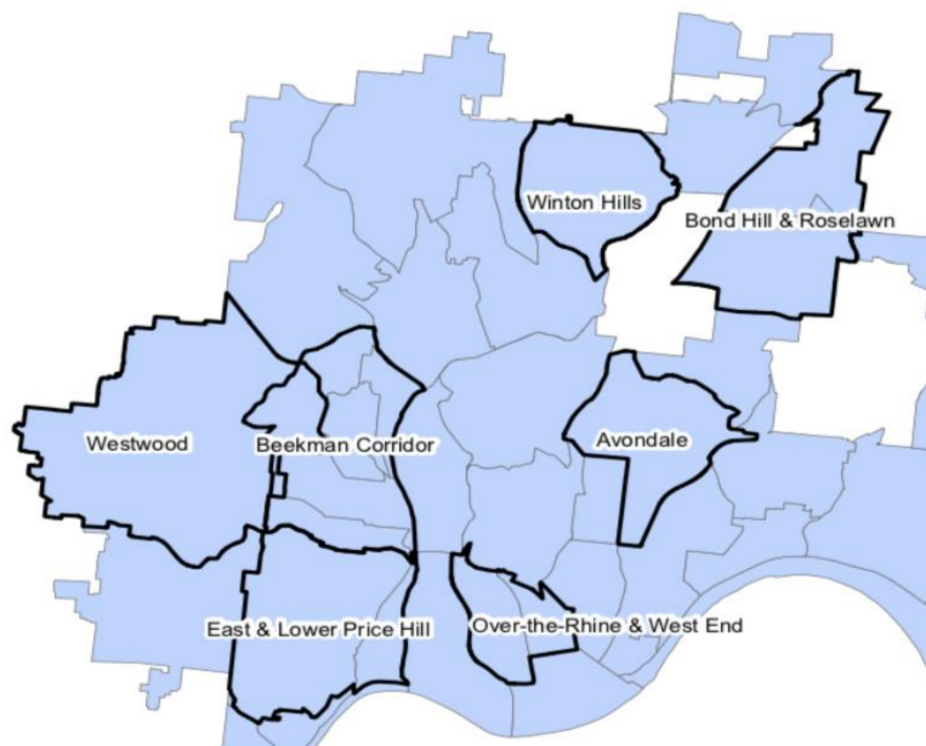

Figure 1. Cincinnati Neighborhoods Understudy.

Additionally, during this meeting, several CAB members expressed interest in continuing their service in year two of this study. They wanted to be full partners in this research as interviewers. This is after all what community-based research is about—bridging the "ivory tower" and "the community" in a joint research endeavor. As a requirement to conduct interviews, CAB members were asked to complete the Institutional Review Board (IRB) training and certification through the University of Cincinnati. By winter, 6 of our 12 CAB members who expressed interest in interviewing had completed their certification. A research training session (the sixth meeting, below mentioned) was administered for CAB members interested in conducting interviews.

In our fourth meeting, we began outlining strategies for recruiting individuals to this study. We discussed venues for posting study flyers and the advertisement itself. The CAB suggested specific neighborhood community civic centers, health centers, churches, bus stops, coffee shops, hair/nail salons, gyms, parks, daycares, etc. And with research topic identified in the prior meeting, we began developing the interview guide that would probe the lived experiences of women and non-binary persons across the life course. It was important that the literature we drew on was not only about Black women but written by Black women and feminist scholars and reproductive justice advocates.

Understanding that reproductive and sexual health begins in childhood, we created questions that would allow respondents to speak their truths unencumbered by assumptions that would otherwise box them into prefabricated normalities inconsistent with their lives, causing them to stand upright in a crooked room, as Melissa Harris-Perry (2011) [53] so eloquently put it. As feminist community researchers, it was important to us to always be mindful that the women we interviewed were the experts on their lives and that it was our job to listen and learn the lessons they were teaching. The interview guide covered childhood (girlhood); adulthood (womanhood); parenthood (motherhood); abortion; and needs and care (material, emotional, financial, spiritual, etc.).

The fifth meeting was dedicated to finalizing the language in the interview guide. The CAB members were sent the interview guide in advance of the meeting so that they could read it in its entirety and come prepared with suggestions. It was important that the guide allowed for gender and sexual diversities and that the language was compatible and consistent with community norms and expressions. One example was a question that asked respondents if they had heard the expressions "womanish" or "mannish", which are well known in southern vernacular. And while many Black Cincinnatians are second and third generation "up-south" in-migrants, these expressions may not be known or used among 21st century generations. As such, we chose to include the term "fast", as in Mikki Kendall's (2020) [4] "fast tailed girls", as an alternative. This kind of vernacular sensitivities to diversity and inclusion was an imperative for this research team.

Our sixth meeting was the last in-person meeting. We met with an OPEN Principal Investigator, Danielle Bessett, in preparation for data collection. Half of the CAB had earned Collaborative Institutional Training Initiative (CITI) certification and completed human subjects training via the University of Cincinnati. This meeting focused on training CAB members with techniques for conducting interviews, for example, how to probe without interrogating an informant and how to move cautiously and gain trust so that persons feel at ease and safe telling their stories. We discussed body language, the importance of acknowledging emotions, as well as how to follow the story so that narratives conveyed (e.g., data) might be cross-verified in real time. Because of COVID-19, this was our last in-person meeting.

6.2. Data Collection: From Recruiting to Interviewing before and after COVID-19

The data collection stage of the research was always imagined including the CAB's full participation to the extent they were able and or willing to participate in this phase of the research. In fact, more than half of CAB members signed on as potential researchers. Many of them completed the CITI certification training and were identified on the IRB as research assistants. With delays in getting IRB approval (nearly five months), the CAB availability to conduct interviews changed. In the end, only one CAB person co-interviewed with the PL, and none interviewed a participant solo.

Data collection began in Summer 2019 and ended in Spring 2020. Before the emergence of the COVID-19 pandemic in Spring 2020, data were collected in person in private rooms at public Cincinnati libraries. Because Cincinnati is very neighborhood centric, most Cincinnati neighborhoods have a public library. These are easy to reach, and nearly all of them offer a private study room, which can be reserved online in advance. This proved to be an ideal place for collecting interview data. With the emergence of the COVID-19 pandemic, we had to reimagine how data could be collected. We had to modify our IRB application so that interviews could be administered remotely. At the conclusion of each interview, arrangements were made for gift card delivery. In most instances, these were delivered at local Kroger grocery stores, which, like the public library, are centrally located in nearly every Cincinnati neighborhood.

Moving from in-person to remote interviews did not appear to compromise data integrity. While it might be easier to establish a trusting rapport with persons face-to-face, the interview guide as constructed had built-in sensitivities, questions that seemed to foster a connection between the researcher and the informant. As such, conveyed was a respect for the informant's personhood, humanity, and lived experience, which made it possible to maintain data integrity in spite of the unusual circumstances that had made remote data collection necessary.

6.3. Data Analysis: Coding as a Community Insider

From the start, we knew a community partnership was critical. Community persons' grounded knowledge of local issues, expertise in their respective fields, and their citizenship in the very communities we wanted to understand better were essential for informing the

methods (the procedure), the interview guide (the tool) and most importantly the data analysis (interpretation).

While we were prepared to conduct as many as 50 interviews, data saturation occurred much sooner. In total, we collected 24 interviews. From the beginning, the PL, a graduate student and one CAB member, Thembi Car, read and coded interviews as they were completed. It became increasingly obvious that the process of analyzing data about Black women with whom you share community was an uncomfortable exercise as related to the unreal expectation of "research" neutrality.

Thembi explains:

The Personal is Political, and the Political is Personal. When I started this project, I took the stance as anyone interpreting data would: I took the 30,000-foot view of seeing the participants from afar; my only role being that I was strictly just looking for the common themes and evaluating them in relationship to one another (comparing, contrasting, similarities, differences, etc.).

However, as I read, interpreted, read some more, and began to fully immerse myself into these women's lived experiences, I identified with them, not just as a researcher, but as a woman. I saw myself as a participant. So, as I continued to learn more about these women's lives, I had to ask myself (and us): Where do we, as feminist researchers, stand in the midst of this work when we identify with the participants?

We have to acknowledge two things: (1) when we are within the data, and (2) that they are speaking for us/we are speaking for each other. We cannot separate our personal identities and experiences from those of our participants. The idea of being an outsider does not exist when reading about your own lived experiences. You become a participant as well in a way.

Then the question becomes, how does this work affect not only the community, but me? I can take a step back and close myself to the connections among the themes or I can continue to interact with this work from both perspectives (researcher and personal).

Our work will impact the lives of many women, but when you realize that you are one of them, it becomes extremely personal, and you (as the researcher) begin to balance your role and your life in your work. Specifically with the latter, Lawrence-Lightfoot and Davis (1997) [54] discuss this idea of being a part of the research using the concept of voice in portraiture. More specifically, a voice in dialogue in which the researcher and the participant voices merge to create/enrich the data even more. This stood out for me not because I got to physically engage with the participant, but I engaged with them on a different level in which our voices/experiences combined.

Thembi's reflection's above, reminds us that as feminist researchers, standing afar is not an option, nor it is it a goal. Black feminist researchers, in particular, understand that we are inherently tied to our communities, and this second-sightedness [55] gives us special insight for understanding best practices in research on and with our communities. Researchers trained in the positivist tradition, including most sociologists, are taught to mute their politics, to ask questions without bias, and to be value free and personally removed from any particular position in their research. Such researchers are taught to ask a question, pose an educated guess, collect the data, analyze it accordingly, and report the findings.

In contrast, feminist researchers understand that objectivity is a fallacy and that acknowledging one's own positionality is essential for doing honest and or "valid" research. Feminist research scholars argue that one's politics, social location, and identities influence not only the research questions and problems of interest, but also how we interpret the research findings. In effect, a feminist approach to research maintains that a researcher cannot entirely be value free. Instead, the feminist research methodology calls on scholars to acknowledge and reflect on the self and embrace a social justice politic that seeks to unlevel, redress, and ultimately dismantle social inequalities. The goal, therefore, much like the CBPR method, is fundamentally linked to social justice and social transformation [56].

6.4. A Conscious Plan: Research Translation and Community Inclusion

How do we democratize research? How can we share knowledge beyond the silos of the privilege and educated elite? Most importantly, as feminist researchers and community advocates, how do we practice what we preach when it comes to sharing research findings? How do we deliver the knowledge gleaned from work to community folx in a way that make tangible sense in way that mobilizes actions, real actions that translate into real change? How do we move our words to deeds and where and in what formats can we share research findings in the communities?

Key Beck explains:

When doing Community-Based Participatory Research, it is important to ensure those being the subject of the research are a part of the process. Often, when learning about participant observation, the researcher is presented as an omniscient, omnipotent outsider serving as recorder of the other. What action research attempts to do is break down the barrier between researcher and subject and replace it with a collaborative team approach. This often involves all the individuals involved having access to the data, the ability to participate throughout the research project, and also yielding space for them to help write the research. We are trying to disrupt the "if you build it they will come" mentality and "build" the research and disseminate the results to communities who are most affected.

Further, many participants in research do not actually get to see the finished product, or it is presented in a way that is not accessible (e.g., a research paper, thesis, and white paper). It is important, and one may argue essential, that research results are presented in digestible format for the average person (some estimate around high-school reading level) and distributed through social pathways that will reach the most marginalized. This can be achieved by presenting at community councils, health fairs, community gatherings, etc. This also means that researchers should connect with local grassroots organizations that are already doing some of this work. Locally, for example, it would be beneficial for us to share our reproductive justice research work with Cradle Cincinnati's Queens Village. The idea is that you need to actually meet people where they are and not expect them to seek you and your research out. It also means that much of the social connections (social/cultural labor) will fall on researchers to sustain. Skills, such as gathering feedback, public speaking, and research design, may need to be taught to participants so they have the skills needed to productively discuss and present information.

Finally, we find these types of participatory methods are especially important when researching a systemic and historical barrier, such as Reproductive Justice of Black Women. Due to issues such as medical racism, misbelief, and sexual assault, sometimes marginalized folx do not trust the information presented by institutions and systems, instead relying on the social networks of mouth to mouth. This has been well documented in studies of beauty shops [57], churches [58,59], and community centers [60]. So, it is important that participants are the face and voice of the research to reach the widest audience.

Key Beck offers an important road map for sharing results beyond the academy. Local Cincinnati organizations, such as Cradle Cincinnati or Every Child Succeed, are great places to start. However, non-profit organizations can also act as barriers to community success. They can be and often become gatekeepers that undermine progress. After all, nonprofits like for profit organizations operate with the intent of maintaining itself. The goal of non-profits should be to become obsolete; to address and assist with fixing the problem; and not on behalf, but alongside the community. Non-profits often misrepresent itself as the face of the community, oftentimes led by White women (and men) in communities of color. And because non-profit c-suite and administrative leaders, as well as their Board of Directors (BOD), are often community and/or racial/ethnic outsiders, their view of community problems starts with the age-old assumption that the community and its people (ways of being and doing) are both the problem and a deficit. White racism runs deep and unless it is checked and vetted, the solutions and approaches employed by non-profit leaders will inevitably replicate the same failed strategies used a century earlier.

7. Final Thoughts: Future Research Combining Black Feminist Epistemological and Methodological Approaches with Community-Based Participatory Methods

Because reproductive justice is public Black feminism in practice, there are no epistemological incongruences. The goals are the same: center Black women; cultivate Black women's leadership; acknowledge Black women as producers of knowledge; celebrate our differences and remind others we are not monolithic; know and retell our histories so that the present is not disconnected from our past; challenge controlling images and institutionalized structures that work to maintain our economic and political oppression; and finally, always lift as we climb. The CBPR method complements these basic Black Feminist values. It is a method predicated on egalitarianism and inclusion. We recognize and value the knowledge of everyday people. After all, Black feminist thought is based on the lives of everyday Black women, from the domestic worker to the blues/soul singer to the mother and "other mothers" in the neighborhood [3]. It invites the community to have a voice and take a role in designing, implementing, and analyzing the research and disseminating the research findings. Community partners, who are most authentically the best advocates of their own health and well being, are invited to the table as equal partners. The have an important role in the decision-making process, from start to finish and beyond. While "professional researchers" are skilled in diverse methodological techniques, as well as writing papers for publication, what they often lack is a real-life connection to the community, specifically, organic knowledge of the everyday nuances that present unknown challenges to real people. Community folx are best situated to provide this insight, as well as a channel into the communities themselves. In their mutual interest to advance community health and well-being, RJ advocates and activists put Black feminism into action, and the results of this effort have the potential to transform how future community research is conducted.

Appendix A

Cincinnati Reproductive Justice (C1A) Research Team's Ground Rules
CAB Group Rules

- Listen actively—try not to interrupt when others are speaking.
- Try to keep side conversations to a minimum.
- Speak from your own experience rather than generalizing.
- Respect our diversities and extend grace to others. (If you make a mistake, just apologize, learn from it, and move on!)
- Lean in to discomfort, rather than trying to avoid it.
- Question ideas, not people.

- Keep what we talk about in this room confidential, particularly around the traumas folks might have experienced.
- Be sensitive.
- Allow people the right to pass. Sometimes people do not respond immediately to things because they are processing. Not everything needs an immediate answer, and no one owes anyone else anything.
- Ask questions openly and without fear from judgment.
- Be transparent—be real, be your authentic self.
- Build relationships among group members—try to feel close to others. This is our space!

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