



# Undergraduate Journal

## of Service Learning & Community-Based Research

### **Birthing Knowledge Production as Resistance: Centering Black Mississippians' Maternal Care in Psychosocial Support**

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#### **Abstract**

This article explores the utility of a burgeoning Black doula and midwife movement began in 2018 by the Mississippi Birth Coalition by juxtaposing doula care with the now ubiquitous, medicalized healthcare system. I trace the regulation and subsequent displacement of Black midwives in the 1920-1950 government regulation of midwifery in Mississippi. I acknowledge the way public health interventions codified Anti-African American sentiment and discounted Black female birthing epistemologies. Black mothers in Mississippi, especially those on Medicare seeking community-based supports in the form of Baby Cafés, doulas, and midwives, desire culturally competent supports that focus on mental health and holistic care services. Specifically, analyzing reproduction in Black communities in Mississippi emphasizing the subversion of patriarchal authorities often located in medicalized hospital care, by reinscribing power to the Black female community. How did these Black birthing communities comprised primarily of Black women disappear? How can these communities of care become integrated into holistic maternal healthcare in Mississippi?

#### **Introduction**

The disparities that Black women face in the United States are frightening, but to many Black women in Mississippi—unsurprising. Recent research identifies Black mothers as being over 2.5 times more likely to experience a pregnancy-related death than white women with a maternal mortality rate of 37.1 deaths per 100,000 live births for Black mothers compared to 13 deaths per 100,000 live births among white women (CDC 2019). Moreover, Black women are more likely to experience preventable maternal death compared with white women. In Mississippi, the state ranked as the least healthy state for women, infants, and children. The maternal mortality for Black women is 30.5 per 100,000 live births compared to 27.7 per 100,000 live births for white women (CDC 2019). While these statistics pinpoint a grievous problem, they fail to identify the unequal birthing landscape that Black mothers must traverse in Mississippi. The systemic racism as evidenced by food deserts, the limited Medicaid funding with 60% of mothers on WIC and Medicaid, and the limited access to hospital care, both due to limited transportation and also to the dearth of hospitals in the region are all structural risk factors that place Black women at higher risk of maternal mortality. Moreover, these risk factors on top of racial injustice and racism contribute to the “toxic stress” that places Black mothers at higher risk of pre-eclampsia and eclampsia which are major risk factors for maternal mortality (Giurgescu, C et. al 2014).

#### **Regulation of Midwifery in Mississippi**

In 1920, Mississippi was a site in which public health and traditional medicine seemed to be integrated. The development of a public health system in Mississippi was a response to high maternal mortality rates, as the state had the highest infant mortality rate of 30% (Sano 2019).

Yet, sometimes government structures that are supposed to provide care, have unintended consequences. The following discussion draws a terrain of the bureaucratic measures in Mississippi that discounted Black midwives' birth knowledge through midwife training that contained Anti-Black sentiment. I articulate the way the regulation of midwives replaced Black midwives with predominantly white nurses and stratified birthing epistemologies unfairly deeming Black midwives' birthing knowledge and methods of care as invalid.

In the early 1900s, doctors attended approximately half of all births in the United States, predominantly by wealthy and middle-class White families. About 5,000 predominantly Black midwives delivered Mississippi's midwives delivered 84 percent of Black infants, the largest percentage in the country in 1920 (Mississippi State Department of Health 2019; Sano 2019). However, Mississippi also had the highest maternal and infant mortality rate at the time. A Children's Bureau study of two rural Mississippi counties in 1916 to 1918, found multiple factors were responsible for the low quality of maternity care, yet they primarily pinpointed the "Midwife problem" and condemned 'untrained, ignorant, and careless' midwives who relied on 'primitive' and 'unsanitary methods' (Sano 2019). Felix Underwood the executive officer of the Mississippi State Board of Health, echoed this sentiment stating, "Ninety percent of [midwives] could not read or write, and a great number were old and filled with superstitious ideas" (Sano 2019). Future training and health campaigns would aim to provide legitimacy to racist narratives of Black midwives.

From 1920 to 1950, training requirements targeted Black midwives through education requirements, physical and mental fitness, and cleanliness standards (Ferguson 1950). Director of Public Health Nursing, Mary Osborne, created the "Manual for Midwives" in 1922 to use as a teaching guide on proper hygiene for midwives, but alluded to the racist ideology that presented Black midwives as unsanitary (Mississippi State Department of Health 2020). New midwives were only accepted after a period of training, a record of a high school diploma, and increased education that many experienced Black midwives could not attain due to segregated schooling and few resources dedicated to schooling for African Americans. Moreover, they had to report to predominantly white public health nurses, nurse midwives, and doctors, which often resulted in many low-income and old Black midwives being turned away (Ferguson 1950).

The intervention was successful in improving birth outcomes more generally. The maternal mortality rate decreased from 9.6 per 1,000 live births in 1920 to 6.7 per 1,000 live births in 1935 (Mississippi State Department of Health 2019). Yet, the regulatory processes by which Black midwives were phased out of the maternal care sector were imprinted with racist and classist messaging. The unintended consequences included racial prejudice against Black women in healthcare, displacement of social support in maternal health, and community. These biased regulations disbanded Black communities that Black midwives delivered and cared for.

#### **Aftermath of Midwife Regulation**

Through the history of this regulation arises the story of the African American midwife that was not incorporated into the Mississippi public health system and "had no national professional organizations to defend their existence within the field of medicine" (Sano 2019, 394). Moreover, the process of medicalization of birth and encouraging hospital births was formed, by the 1960s, over 95% of births took place in hospitals with physicians (Rooks 1997). Subsequently, the medicalization<sup>1</sup> of public health "reframed childbirth as a dangerous medical

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<sup>1</sup> Medicalization: the process by which human conditions and problems come to be defined and treated as medical conditions

process that was best managed by a physician-specialist in a hospital rather than an ‘untrained’ midwife at home” (Sano 2019, 395). These regulatory laws were established under the guise of decreasing the risk of maternal and infant mortality, but also functioned as a field with medicalized and racialized undertones that devalued and deemed Black women’s knowledge production as insufficient.

Though Black midwives were told that their knowledge production around maternal health was invalid, many were caretakers for White families during slavery. Black mothers were forced to care for white children and depended on income made as caretakers during the Jim Crow era (Lee 1996). As a consequence, the “Mammy” caricature arose as a depiction of the Black woman as a loyal servant in White households forced to care for White children—neglecting her own. The caricature was completely desexualized, often obese, dark-skinned, and faithful to the White family. She was a surrogate mother/grandmother to white families. This caricature represented the dialectical role of the midwife, caretaker figure that simultaneously had amassed knowledge on birthing and childcare through delivering her communities’ babies, and caring for other children, yet somehow did not have knowledge production worthy of maternal healthcare. This figure was simultaneously the embodiment of knowledge Black mothers had in caring for other people’s children and symbolic of undervalued and unappreciated Black women. Through this account of midwifery, we see the creation of a monitored reproductive medical care system that did not provide the same social, emotional, and spiritual support that midwives did. The traditional midwifery role became replaced by the medical model of maternal care dependent on pathology.

#### **Establishment of Limited Healthcare Access for Black Patients**

This structural violence continues to have repercussions on health outcomes, especially maternal health outcomes in Mississippi today. In Mississippi, the Jim Crow Era resulted in structural segregation that forced black people to be dependent on an insufficient healthcare system that excluded them. The white hospitals in the region did not admit Black people or gave them inferior treatment. Often, Black patients were required to bring their own utensils, toothbrushes, and linen and to hire a black nurse if one was not on staff. In 1929, there were only 6 hospitals that offered limited services to Black folk and all were in southern Mississippi, and not the Delta (Beito 2006). In 1947- 1969, Black entrepreneurs set out to increase the number of hospitals available to Black Mississippians. In “Let Down your Bucket Where you Are,” David Beito and Linda Royster Beito, discuss the development of the black fraternal hospital system, first founded by Thomas Huddleston (Beito 2006). He formed the Afro-American Sons and Daughters in 1924, a fraternal society that grew to expand the number of Black hospitals available for Black Mississippians. The demise of the system can be attributed to lack of funding, burdensome regulation, competitive pressure from government, and third-party health care alternatives characteristic of the neoliberal shift in medical insurance funding.

These same economic shifts in the late 1960s resulted in a system of care in which Black Mississippians were dependent on state-funded hospitals. Simultaneously, newly racially integrated hospitals were miles away from their communities and less accessible. However, a focus on community-based care unfolded in Jackson, Mississippi not too long ago. In 1970, Black pediatrician Dr. Aaron Shirley helped to establish the Jackson Hinds Comprehensive Health Center, which became the largest community health center in the state (Jackson Medical

Mall Foundation 2019).<sup>2</sup> In 1996, Aaron Shirley founded the Jackson Medical Mall, the first medical mall of its kind in the US, to provide accessible healthcare in Black communities in Jackson. The Medical Mall is the location of the only high-risk maternal health clinic in the city that serves women on Medicaid and WIC. While Shirley was a trailblazer in community health that focused on bridging gaps in healthcare access for African Americans with a school-based clinic to provide health and counseling services to help reduce teen pregnancy, drug abuse, teen violence, sexually transmitted diseases, and mental health issues, many women still complain of 3 hour wait times for OBGYN prenatal visits at the Jackson Medical Mall due to understaffing and underfunding. Overall, the healthcare system in Mississippi that Black mothers must traverse was made unequal, and insufficient.

### **Distrust in Mississippi: Wariness of Bureaucratic Indifference**

During ethnographic research, I entered a fraught maternal care landscape divided especially by socioeconomic status and race as I conducted fieldwork in Jackson, Indianola, and Greenville, Mississippi. In particular, I entered a region of unspoken, coded trauma that encompassed Black women's historic battle for bodily agency, and reproductive justice. Given the exploitative history of Black female reproduction in the region, my form of community-based research was grounded in decolonized methodology and acknowledged a hope-centered approach to community care. Instead of focusing on the damage caused by systemic racism within healthcare systems, I aim to reimagine birthing support located outside the hospital that women hope to attain. Indigenous education scholar Eve Tuck describes communities in which damaged centered research has taken place as both "over-researched" and "invisible" (Tuck 2009). Many Mississippians decry research that is often done on what happened to mothers, as opposed to who makes up these communities, their agency within their communities, as well as the important knowledge production and care that Black women give their communities. Entering the field, my interlocutors were wary of my presence as a researcher given the historic irresponsibility of medical researchers in the region.

During the slavery era in Mississippi, the enslaved female body became a "means of production" and African American women were viewed as objects whose purpose was to provide a steady slave workforce through childbearing (Luke 2018, 19). In *Medical Apartheid*, historian Harriet Washington discusses the "slaveholder-physician dyad" in which White doctors employed medical tactics through monitoring women's menstrual cycles, sterilization, amputation, and other procedures (Washington 2006, 46). In addition to this reproductive surveillance, doctors utilized Black enslaved peoples in medical experiments. African Americans came to associate "western medicine with punishment, loss of control over their most intimate bodily functions and degrading public displays" (Washington 2006, 113-114). The reproductive surveillance characteristic of slavery became located in medical experiments. In *Medical Bondage*, history professor Dierdre Cooper Owens outlines the rise of gynecological practice in the US that depended on Black enslaved women as test subjects, to establish healthcare protocol (Owens 2017). Black mothers were typified as having a robust reproductive function and being incapable of pain, and these notions racialized maternal care. When mothers miscarried or had stillbirths, slaveowners blamed Black mothers' behaviors for the loss. This history is significant in understanding gynecology which was built on these notions of hyperfertility.

Finally, in the 1970s, Black women of low-income were targets of forced

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<sup>2</sup> Dr. Aaron Shirley took his pediatrics residency at the University of Mississippi in 1965 and became the first African American to accomplish this feat.

appendectomies. In *Killing the Black Body*, law professor Dorothy Roberts discussed the widespread sterilizations that occurred in the 1970s-1980s. Roberts describes this hyperfertility trope as defining Black women's bodies as vessels for procreation. Mississippi in particular passed a sterilization law in 1928 that allowed for the "sexual sterilization of inmates of state institutions" (State of Mississippi 1928). In the beginning, those victims of this law were predominantly individuals with mental health disorders. Moreover, Parchman farm, Mississippi's notoriously harsh prison, where leading public health service providers provided female convicts, predominantly Black women reproductive medical operations (Shankar 2020). In the 1920-1980s, this sterilization would continue and expand to Black mothers, predominantly mothers on welfare outside the prison system and become known as "Mississippi appendectomies."<sup>3</sup> These unnecessary hysterectomies performed at teaching hospitals in the South on women of color as practice for medical students both stripped Black mothers of their agency and choice over their bodies, while much of the discourse labeled these mothers as hyper fertile, or promiscuous—undeserved of reproduction that incurred high welfare costs (Roberts 1997).

Given this history, my work draws connections to structural legacies of the Jim Crow and slavery era. Yet, instead of knowledge that reinforces the dialectic of oppressor and oppressed, I draw inspiration from subaltern locations of knowledge production such as Black birthing support groups. Within these stories are the significance of recollection and memory. Illustrating Black mothers' negotiation of agency in birthing through community-based support networks is a response to the increased call for intersectional work. As a researcher entering Mississippi, I depended heavily on being vetted by community sources, given the unique kinship structures and culture of grassroots organizing in Mississippi that is careful about who they let into their organizations. I opted for a method that completely depended on the desires of community-based organizations grounded in systems outside government and medical bureaucratic control. This entailed working with the Urban League of Jackson at a free program for women called the Baby Café, Diaper Banks, interviewing doulas, midwives, and other psychosocial support networks for mothers. While I opted for methods of community service learning such as grassroots organizing, and political canvassing, I acknowledge that this was not enough. There is no escaping the extractive nature that often undergirds research. I entered the field to be of use, but even in-service learning and community-based research, there is always a power dynamic between the researcher and those researched. Therefore, for much of my work, I recognized the sacredness of women's birth stories and the stories that go unspoken, shrouded in silence and memory—too difficult to share.

### **"The Public Health Racket"**

In Mississippi, reproduction is a sensitive topic, as it bears intergenerational trauma and memory that can often elicit defensive responses. Mississippi has only one abortion clinic known as "the Pink House" that is located in Jackson. Anti-abortion protestors obstruct the entryway to the building and heckle women as clinic escorts guide them safely to the building every day (Allen 2017). The abstinence-only sexual education is limited. Simply, there is a sense of secrecy in maternal and sexual health. In Mississippi, reproductive control is intertwined with history, especially in Black communities.

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<sup>3</sup> In Mississippi appendectomies, women were told they needed to remove their appendix and instead were sterilized (Hutchison 2011).

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One Black doula and reproductive justice advocate named Michelle reiterates the regional difficulty when discussing reproductive justice in Mississippi, especially with Northerners that view reproductive rights expansion in the state as impossible. She said, “Those Northerners repeatedly used to ignore and judge us in the South. They are only involved in reproductive justice now because it is popular.” This regional distrust that Michelle explicated motivated my research to focus on grassroots organizations and advocates that have been working in the reproductive justice space for decades. Given this topic can be territorial and sensitive, I wanted to elevate the rich voices that go unheard.

Consequently, I interviewed nonprofit owners at Sisters in Birth and the Baby Café which I will describe in this section, as well as Black mothers, doulas, and midwives. Given this distrust for government regarding Black reproductive health, extends to healthcare institutions that are viewed as continuations of bureaucratic indifference—I interviewed only a few nurses, doctors, and health insurance companies. Getty Israel, the founder of Sisters in Birth, a nonprofit public health organization that pairs community health workers to women with low incomes and provides support in the form of birthing classes, yoga classes, health education, and prenatal to postpartum care. When asked about her relationship with public health departments, she responded, “what are these organizations doing to use best practices? Nothing. These are white people earning these salaries off of Black bodies. It’s a racket—a public health racket.”

The director of the mother support group, the Baby Café, shared a similar dissatisfaction with hospitals.<sup>4</sup> She said, “hospitals do not invite people in. They are not ‘community’ friendly. What these hospitals should do is stop sending people into our organizations to just research and take from the ‘community.’” This space was empowering for Black mothers, but every time representatives from the University of Mississippi Medical Center were present to complete community needs assessments or data, there was a clear rift in comfort.

In both of these cases, there was an institutional distrust that goes beyond the personal interactions or instances that Black women have with sole care providers. Rather, there was a greater narrative amongst these women: that these public health officials and hospitals were structurally removed from the communities they claimed to serve. Moreover, there was a negative view that the same institutions that were supposed to care for women, actually harmed them and were more interested in controlling them rather than listening to their concerns. This disconnect between Black community-based support groups and the healthcare system is a historic one that continues to be passed from generation to generation and has repercussions biologically and socially.

### **Intergenerational Trauma and Coded Fear in Birthing**

In her book, *Lose your Mother*, history professor Saidiya Hartman contends that ideas about Black women that have historically circulated in the medical field must be understood as an extension of what she calls “the afterlife of slavery” and situated in the history of “Black women’s reproductive exploitation” (Hartman 2007, 6; Davis 2019, 13). In conversations with community organizers native to Mississippi, this “afterlife” Hartman discusses is generationally transmitted through birthing stories. Maternal mortality and loss enshroud many families in Mississippi. Such trauma as collectively known by Black expectant mothers in Mississippi is seemingly written off with sayings such as, “*well, that’s Mississippi.*” While this could seem

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<sup>4</sup> Baby Café of Jackson: a free support group of predominantly Black mothers on WIC, that I spent every week working within which mothers would meet every week to discuss their pregnancy, eat, and gain the tools needed to advocate for their birth process.

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like a locution of complacency or defeat, within this phrase used by every single one of my interviewees, there is an unspoken memory of past events. This utterance is an acknowledgment of the distinct nature with which loss molds and shapes Black Mississippians' past and present.

Niketra acknowledged grief in her family's birthing story. As a Black mother of two children, she elucidated the implication of intergenerational trauma in her documentary called "Laboring with Hope" (Burse 2019). She discussed how she lost her aunt when her cousins were born, and it was particularly grievous because it was a preventable loss due to racism in the hospital room. Niketra recalled how her mother raised her cousin and spoke little about the topic of birth. She said, "I interviewed my mom and my husband's mother, and so many others—there were a lot of tears. Sometimes I would ask my mom questions and she just couldn't share, so we skipped them."

For this family, discussing Black motherhood meant also discussing loss. Her family structure changed and with it the perspective on maternal health. While socially, this embodiment of terror was unspoken, pregnancy incurred a realm of the biological embodiment of inequity and transmitted unequal social treatment to offspring. Evolutionary biology research confirms the way this trauma is ingrained in the makeup of DNA expression through epigenetics (Carey 2018). In evolutionary biology, changes as one's body are exposed to energetic stressors such as air pollution, psychosocial stress, and smoking negatively impact lifespan (Burriss and Vick 2017). Black mothers are more likely to live in these areas with higher pollution, limited nutritious food access, and limited access to hospitals that increase these epigenetic changes (Giurgescu, et.al. 2014).

In addition to the personal trauma that spans generations, the structural removal of Black birthing communities through public health development in Mississippi continues to reverberate through Black families today. One elderly Black woman in her 60s that is a certified lactation consultant from Indianola discussed that she and her 5 siblings were all delivered by midwives, yet she noticed that few midwives are left. She spoke longingly of midwifery, "This used to be people's lifeline. When midwives would deliver babies, the whole community would make sure the mother did nothing for a month. They would clean, cook, fix up the house, and more. Now, we don't have that. When they removed the midwives, they removed our community." This quote is powerful. The woman views the midwife as symbolic of a past time, in which Black mothers had birthing support—physically, emotionally, and spiritually. This alludes to the yearning for a community in birthing that is not located in the healthcare system. While birth became focused in hospital settings, pregnancy care must be bolstered outside healthcare institutions. My interlocutors yearn for this community to be restored once again. With a greater analysis of interviews and field observations, a greater picture of the limitations in locating birth in the context of the hospital arises. The next section provides analysis in the form of policy recommendations centered on the hopes of my interviewees.

### Analysis

Given the way loss and trauma are intertwined with many Mississippians birthing stories, an analysis of the psychosocial support that women receive is of paramount importance. Through juxtaposing the present medicalized landscape of pregnancy care and the traditional, I uncover the multiple structures and birthing methodologies at play. Continuing a hope-focused lens of research, each recommendation highlights the aspirations of my interviewees for a restructured the birth landscape in Mississippi.

### Decry Stratified Birthing Epistemologies through Encouraging Birth Plans

First, the oppositional, tenuous relationship between doctors and doulas in Mississippi, is best remedied when mothers lead their birth plans. For many of my interlocutors that were Black mothers on Medicaid in Mississippi, they came to the Baby Café because they felt empowered as they were encouraged to ask questions about anything ranging from fibroids to mental health. One woman stated, “before this group, when I was pregnant, I felt alone. I was told by my sperm donor that he wished something bad happened to my baby...As a single parent, it is lonely, so this place gave me the support I needed and gave me hope.”

Outside of the Baby Café, mothers felt disempowered in prenatal checkups because they said their doctors do not listen to their concerns or rush them, given doctors' appointments often only range from 15-30 min. One mother, named Niketa recalls a conversation she had at the Jackson Medical Mall, the only high-risk pregnancy clinic for women on Medicaid in Jackson. She made the decision not to have an epidural in her pregnancy, but the “physician told me that they only do epidurals in the hospital, though I repeated many times I did not want one.” Niketa had to bring her doula to advocate, after which they found out the physician was incorrect, and she can birth without an epidural.

One doula and labor and delivery nurse named Raquel elucidated the reason behind this tension, she said, “whenever my coworkers get a patient with a birth plan or doula, they send them to me. Some doctors view these patients as difficult.” She said some doctors in Mississippi view birth plans as complicating their job. Many doctors she worked with disregard the health education, knowledge, and requests of mothers and doulas. This leads to dissatisfaction in maternal care because mothers are not given this agency and control over their birth decisions. My findings indicate that birth plans are beneficial as they involve mothers in their own care. Therefore, maternal healthcare that acknowledges the legitimacy of midwives and doulas from which mothers get health education, is culturally significant and beneficial. Especially in Mississippi in which birthing knowledge is produced, modified, and passed through generations.

### Integration of doula and community birth workers within the healthcare model

Next, the disparities in Black maternal health call for institutionalized advocacy in maternal healthcare through integrating the doula role in the healthcare model. To provide consistent and standardized care, doulas and midwives must be vetted. In Mississippi, though there was a history of traditional midwifery, there is a lack of regulation or standardization of doula care which makes standardizing care difficult. One mother describes her encounter with one doula who she had to file a restraining order against. She said her doula brought someone into her appointment without her permission and continued to harass her once she got a new doula. Charnice said, “I had to file a restraining order against her, and my doctor followed suit for his practice. You just never know what kind of doula you will get.” Charnice's story is representative of how variable the experience can be and the lack of standardization places mothers in further danger.

Cassandra, doula, nurse practitioner, and president of the Mississippi Birth Coalition, echoes this same lack of standardization and regulation in the doula community that places doulas in financial and legal instability.<sup>5</sup> She said, “some doulas argue with doctors and make things so hard. The issue is doulas are unregulated. I can think of some who I would not

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<sup>5</sup> Mississippi Birth Coalition: Formed in 2018, the MS Birth Coalition is a group of doulas, midwives, and reproductive justice advocates

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recommend. Some make the relationship between doctors and doulas more volatile.” This lack of regulation or requirements makes everything more difficult for mothers when choosing birth workers.

The Mamas First Act introduced by Congress in May 2019 proposed an expansion of Medicaid coverage to expectant mothers who seek services provided by doulas and midwives (Congress HR2751). This act, if passed would standardize a payment system for doulas nationwide and provide infrastructure for the burgeoning movement in Mississippi. Through integration, women have the opportunity to create a catered care plan that is socially and environmentally relevant to mothers and doulas are. Specifically, doulas enter the homes and daily environments of their clients, acting as community health workers to educate and provide psychosocial support for expectant mothers whenever mothers call. This type of knowledge production and transmission at the community level fulfills a distinct need that doctors, and healthcare professionals cannot due to insufficient time with patients and the often inaccessibility of hospitals and clinics to mothers' homes.

### Social Medicine Approach: Mitigating Unnecessary Medical Intervention

Minimizing medical intervention is especially significant since the c-section rate in the US is 31.9% which is higher than the recommended 10-15% by the WHO (The Lancet 2018). Specifically, Mississippi has the highest rates of c-section of any state with 37.8% (CDC 2019). While conditions such as diabetes, hypertension, and pre-eclampsia can increase this risk of c-section, increased stress levels, and lack of advocacy and support in delivery rooms can leave mothers more susceptible. Totiana, a Black mother with three children, stated that she became a doula because during her childbirth, her doctor tried to conduct an unnecessary episiotomy until her “husband stopped the doctor and confronted him.” For single mothers, this type of unnecessary medical intervention can be more prevalent. Precious echoes this fear, “I just put everything in God's hands. Down here it is natural for them to put medicine. That's the instinct.”

In *Reproductive Injustice*, Anthropologist Dana-Ain Davis verifies Precious's claim and states c-sections validate and suggest that when doctors see Black women they tend to “corral the evidence needed to insist she will need a c-section” (Davis 2019, 67). Black women are disproportionately more likely to have c-sections not only due to maternal and infant mortality risk factors (such as diabetes, and high blood pressure), but also doctors' racial prejudice that rush Black childbirth (Belluz 2018). Cassandra labels this as an inadequacy in the systemic way healthcare institutions approach maternal care. She said, “the [birthing] classes offered by the hospital are just to make the birth in the hospital easier and prepare women for epidurals. They rescue you away from the medicine they gave you...When babies' heart rates drop due to the epidural, [doctors] then have to do an emergency c-section for the issue they caused.”

Research on the efficacy of doulas and midwives have been shown to decrease the chronic stress that birthing persons face in childbirth. The biological pathway is outlined in a study by RP Lederman et al, showing women in active labor who reported anxiety and toxic stress had significantly increased levels of endogenous epinephrine, which is a hormone associated with decreased contractile activity and longer labors (Lederman, R.P et. al 1978). Doulas presence during labor decrease anxiety and create an environment of comfort that reduces the levels of these aforementioned hormones, facilitating contractions, uterine blood flow, shorter labor times, and fetal well-being. Doulas act as preventative measures to ensure women are advocated for and have the psychosocial support that improves labor outcomes.

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### Centering Maternal Care Outside the Hospital in Community-based and psychosocial support programs

For the doulas, and nonprofit owners I interviewed that provide psychosocial support to expectant Black mothers on WIC in Mississippi, they look to invest not in the healthcare system, but in their own communities—in the daily spaces that mothers occupy. Using the tenants of reproductive justice ideology, they believe that housing, food access, and especially work environment contribute to a mother's ability to have safe pregnancies. For one nonprofit owner, Beneta, it is about ensuring that mothers have a space to call their own, where degrees, prestige, or the power dynamic inherent in the doctor-patient relationship does not exist. Her work includes “Baby-Friendly designation” of workplaces, malls, airports, and more daily spaces to normalize Black mothering in the form of breastfeeding, childcare, and maternal leave. She emphasizes the normalization of discussing pregnancy and birthing to cause a cultural shift in the way Black mothers are treated. She insists that healthcare workers, “cannot help the community without being in it. You cannot improve community health without community.”

One participant in the Baby Café when asked about how the Baby Café changes the culture around motherhood, said, “The Baby Café reaches out to businesses and calls my workplace to make sure they are baby-friendly, which is great.” In many support group sessions Beneta would ask mothers if they have employers that let them have time off for prenatal checkups and spaces for expelling breastmilk in their workplaces and she would call their employers if this was not the case.

This “Baby-friendly designation” seems to be a solution to what Getty describes as managed-care health organizations being “so far removed from the reality of the people and communities they are working with. Mississippi invests little in primary prevention.” Preventative care requires addressing the social determinants that result in dismal birth outcomes which include stress-related symptoms of hospital care ranging from clinic wait times, and adverse nurse or doctor interactions. Hillary, a high-risk patient that is a Black woman, kidney transplant recipient, Lupus, history of high blood pressure, and IVF therapy patient, described the effect her experience in her clinic had on her health: “At the Jackson Medical Mall, I was so stressed since I would wait for about 3 hours every time for my prenatal visit. My doctor was worried about my high blood pressure at every visit at the Jackson Medical Mall, but my blood pressure lowered shortly after this switch to the private clinic. It has been low ever since.”

For Black doctor and mother, Dr. Collier, the community-based support groups are so important because of the limitations of depending on OBGYNs to fulfill advocacy or psychosocial support for mothers. She states, “there are limitations to the ability of doctors to balance their world view that is heavily geared to risk-management with the world view of emotional and social support that expectant mothers' value.” In preventative maternal care, using local moral world theory identifies the distinct worlds doctors reside in. Doctors are geared towards managing diseases, mitigating risk, and controlling illness. These goals require surveillance or management of bodies, and sometimes lack care that is catered specifically to expectant mothers and focuses on stress management or psychosocial support. Thus, increased groups for Black mothers provide important outlets mothers cannot get elsewhere.

### Using reproductive justice as the foundation of the continuum of care and unpacking silently coded intergenerational trauma

Finally, it became abundantly clear that statistics do not give a clear representation of the barriers to care, specifically the psychosocial elements of physical and emotional wellbeing.

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This was revealed through ethnographic research, working in communities and being involved in the intimate daily lives of my interviewees, and the realization that pregnancy care especially doctor visits places a focus on childbirth, and often ignores the total what I theorize to be the continuum of motherhood. Utilizing the “continuum of care” framework in medicine that defines an integrated system of care that guides and tracks patients over time, the continuum of motherhood focuses on the significance of engagement in care both temporally and spatially. However, it emphasizes motherhood in maternal care. By placing the emphasis on the mother, the “fourth trimester,” or postpartum care, that often goes unnoticed calls for support in breastfeeding and tasks of motherhood that many of my interviewees feel the healthcare system did not advise.

One mother named Ronda described this dilemma stating, “The hospital does not [teach health education] enough. I do not think they really care. They rush us up out of there. They’re like, ‘take the baby, bye!’” She articulates this feeling that many mothers echoed stating that the hospital cared mostly about ensuring babies were safe and delivered but did not support or care for Black mothers. In addition, one mother named Jules demonstrated the limitations of hospital care. She said she often felt judged and “criticized” in healthcare settings for having kids because she was a single Black mother on WIC with four kids, pregnant with a fifth. One day, this mother attended a Baby Café session dilated, with a hospital band on her wrist. She said that rather than stay in the hospital, she would prefer to wait in the Baby Café until she went into labor. She told the group, “I have not told many people about my pregnancy, not even my family, I am just scared. I found out that this child is missing an arm and I have no one—I do not say this aloud, it’s hard.” Her choice to go to the Baby Café instead of staying in the hospital while dilated presented her priorities in childbirth—psychosocial, emotional support, comfort, empowerment, and camaraderie.

Many mothers stated that the hospital cared mostly about ensuring babies were safe and delivered but did not support or care for Black mothers. For most mothers and children, the first appointment is 6 weeks after childbirth, this does not consider breastfeeding lessons or maternal mental health. In addition, hospitals have minimal role in ensuring the workplace environment or home to which mothers return are comforting or supportive.

Utilizing the continuum of motherhood to understand maternal health helps to acknowledge the temporality of birthing. The effects of the mother’s own childhood and their mother’s own birthing processes are important in unpacking trauma and ensuring women feel empowered to be mothers at any stage in the process. For Precious, when she was an expecting mother, there was a wealth of information, traditional folk curatives, and “West African birth traditions,” she had to choose from that she found alarming and confusing. She said, “if I research too much, I will literally put my baby in a bubble. And we will go out there to the country and we will live on the land.” While Precious states this vertigo from the many sources from which she gets information, she states that she has a group chat with her sister, aunt, and mother that she turns to for support. She says an app with cultural sayings or curatives passed down in Black birthing communities would be so useful because though she has a team of OBGYN, nephrologists, and endocrinologists that are all women, she still depends on the Black female family members for support, tips, and recommendations. For Black single mothers, creating this community of Black mothers is culturally significant and comforting

Simply, my findings emphasize that maternal health begins with reproductive justice. The story of a mother’s journey begins with comprehensive sex education to food access and stable psychosocial support networks to prenatal visits, adequate maternal leave, childbirth, and support

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from healthcare professionals in the fourth trimester. Moreover, the mental health of mothers and their views on reproduction are important as the stress, trauma and memories of mothers, grandmothers, aunts, or friends that have birthed in fear threaten to live on in expectant mother's psyches. It is important for women to have advocacy and support.

### Final Recommendations

Overall, the community-based research in Baby Café support groups and interviews with doulas, doctors, and expectant mothers provided insight into the landscape of maternal healthcare in Mississippi for Black women, both within the ubiquitous medical institutions, and in their homes and community-based support groups. The characteristics of quality care are grounded in a relationship in which women feel in control of their birth plan, empowered by their healthcare provider, and have psychosocial support networks located in their communities of color. The main findings from the 3 months of ethnographic work can be summarized by 5 main policy recommendations that address structural improvements to maternal healthcare in Mississippi that will meet the needs of Black mothers. Outlined as aspirations, these structural changes include: (1) acknowledge the displacement of Black birthing communities in Mississippi and institutionalize Black birth work and psychosocial support, (2) standardize doula care, (3) interrogate modernity and the adverse effects of medicalized birthing, (4) understand "toxic stress" and its relationship to intergenerational trauma (5), focus on the continuum of motherhood.

Future research would focus on multiple aspects, specifically, delving into familial support structures for Black mothers and understanding the role of partners more fully. I would aim to focus on partners and the role that they play in motherhood. While many of the mothers I interviewed were single mothers, it would be useful to understand how interactions within the healthcare system from prenatal checkups to delivery change when partners are more present in the birthing process.

Moreover, I would analyze mental health and the effect of maternal health on women's mental well-being. While postpartum depression is a topic of burgeoning interest, it has not been fully researched in Black communities. There are existing barriers to mental healthcare in Black communities that range from the limited number of Black psychiatrists to the cultural stigma around seeking mental health services. Interviewing Black expectant mothers more candidly about their mental health and how it progresses throughout pregnancy and postpartum would help to further develop a case for increased psychosocial support in Black birth communities.

Finally, I hope to expand my research population to be more representative of intersectional identities which includes transgender birthing persons. Also, I hope to understand more fully complications in support for more marginalized groups that are not Black, heterosexual, cis women. In addition to expanding the research population, I would interrogate the significance of spatial orientation and location further. In the future, I aim to look more closely at rural communities that have no choice but to depend more on care located outside the hospital given the limited number of healthcare institutions in these areas. This would include researching the limitations of telemedicine in maternal care for Black mothers.

Overall, further research on intersectional Black communities, mental health, and the barriers in rural regions would allow for a greater understanding of the barriers to care amongst Black mothers. Moreover, this would expand the role of moderators such as transportation to community-based support groups, or incorporation of doulas in Medicare coverage in Mississippi that would all play a role in improving Black birth outcomes. Altogether, these

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findings and further topics of focus, contribute to the larger narrative shift in Black maternal care that must incorporate community-based support networks outside the inequality ingrained in healthcare institutions.

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