

**Perceptions of Pain and Pleasure: Historical Implications of Disparities in
Childbirth Experiences for African American and White Women in the
United States**

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The path to this thesis and its topic was not linear. I found a passion for women's health in my first years in college but felt restricted by the requirements of a degree in Women's and Gender Studies. When I found the Social Theory and Practice major I recognized an opportunity to combine multiple disciplines into one personalized and more comprehensive major plan. Through classes such as Childbirth and Culture and Reproductive Health and Justice in the Anthropology department as well as Women's Health and an independent study on doula services in the Women's and Gender Studies department I have been able to build a foundation from which my research into the interlocking histories of childbirth, medicine, and race began.

In my first semester of my senior year I had the structure of a mandatory senior project class to help me begin work on the thesis and was also able to rely on my peers and professor for regular review and editing. In my second semester, however, I have had to figure out how to motivate and regulate myself to continue working on the project and be able to do this topic justice through extensive research and analysis. This thesis has pushed me to new limits and has allowed me to create a body of work that acts as a culmination of my entire time at the University. For that opportunity, and for the people who have guided me through the process of thesis writing I am endlessly grateful.

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Introduction

A healthcare system that is deeply rooted in racial inequality has compromised the sexual and reproductive health of African American women from slavery through the post-Civil Rights era and into the present day. Only recently have studies begun to consider how the historical underpinnings of racism negatively influence the present-day health outcomes of African American women. Although some improvements to ensure equitable healthcare have been made, these historical influences provide an unexplored context for illuminating present-day epidemiology of sexual and reproductive health disparities among African American women. The legacy of medical experimentation and inadequate healthcare coupled with social determinants has exacerbated African American women's complex relationship with healthcare systems. The social determinants of health associated with institutionalized and interpersonal racism, including poverty, unemployment, and residential segregation, make African American women more vulnerable to negative sexual and reproductive health outcomes. There is no way to quantify or fully express the collective and individual pain experienced through these inequalities. When I speak of pain in this context I approach the topic very broadly so as to encompass the ways it has been felt collectively and individually not just in physical but also in emotional, generational, and traumatic terms, including painful historical experiences and memories.

According to a study done in 2017, the maternal mortality rate for non-Hispanic Black women is more than 3.5 times that for non-Hispanic White women (MacDorman et al. 2021). Many of the differences in how African American and White¹ mothers experience childbirth stem from deeply ingrained discrepancies of access to medical care, education, and support. As an important alternative option, midwifery has been an integral part of childbirth throughout the history of American childbirth and continues to persist as a valuable counterpart to our medicalized society. A midwife-accompanied birth has many effects on a birthing person's experience of pain or pleasure and alternatives to hospital births will play an integral role in my analysis of this topic. Birth centers specifically led by Black, Indigenous, and people of color are a key solution to reversing the maternal health crisis by providing safe and culturally relevant care in communities of color (birthcenterequity.org). Researchers have shown how important it is to prioritize communication, partnership, respect, and trust within the clinician-patient relationship (Hardeman 2020). Such a relationship allows for more vulnerable, safe, and secure birthing experiences which could even be experienced as pleasurable.

This thesis explores the relationship between pain and pleasure during the childbirth process within a bio-psycho-social framework. In other words, I consider the experience of birth sensations as occurring in the body, mind, and cultural milieu of a birthing person. Given

¹ I have made the conscious decision to capitalize the term "White" throughout this thesis based on recent dialogue about capitalization of racial/ethnic identifiers in pieces of writing. From the McArthur Foundation: "Choosing to not capitalize White while capitalizing other racial and ethnic identifiers would implicitly affirm Whiteness as the standard and norm. Keeping White lowercase ignores the way Whiteness functions in institutions and communities" (macfound.org)

increasing evidence that these experiences vary by social factors such as race and economic background, I wish to distinguish between the experiences of African American and White mothers² and bring to light how their differing histories of childbirth may cause disparities in thresholds of pain and pleasure today. Concurrently I look at the process of the medicalization of childbirth, which has brought a range of analgesics and various pain management techniques to bear on the experiences of mothers in general. I aim to describe and explain the diverse reasons for their increased use and demand for them within the framework of modern medicine and its practitioners' approach to childbirth.

I also explore sensations of pleasure during childbirth. Pleasure is not a word that is often associated with childbirth, but there are several studies that find a possibility for a pleasurable childbirth. I will discuss how the type of provider, physical space, and social realm impact whether or not pleasure can be experienced in childbirth. I will also detail how structural violence and systemic racism have created discrepancies in access to these spaces, providers, and networks.

In my research on childbirth both in the scholarly literature and within hospitals I began to see the concept of a “humanized childbirth” in various contexts. I was puzzled by this concept - why does a term need to exist for such seemingly a basic, inherent, innate practice and

² A note of clarity: while our society has progressed past parenthood ascribed to only one gender, I refer to birthing persons as mothers throughout this thesis. I am in awe of the progress that our society has made to allow people to express their gender identity in the ways that they feel is right for them and by the medical advancements that allow these identities to be experienced physiologically. While non-binary or transgender persons may not want to be called mothers because of the gender connotation, I want to make clear that I am not using this term in a gendered manner, but rather an experiential way.

biological function as childbirth? The urge to “humanize” childbirth has risen in reaction to the excesses of the more medicalized, technocratic model of medicine. It is an effort driven by nurses and physicians who work within the medical system to reform it from the inside (Davis-Floyd 2001). In this context, humanizing birth means “considering women’s values, beliefs, and feelings, and respecting their dignity and autonomy during the birthing process” (Behruzi et al. 2010).

The forces that “dehumanize” birth lie within the hospital system - where legal and medical frameworks legitimize, even valorize, intervention, even when unnecessary. The medicalization of childbirth triumphs over the birthing person’s experiences and autonomy. The policies and procedures in place at a particular hospital, inadequate staffing, technology-focused care, and a lack of continuity of care are barriers to a more humanized birth approach. In their study on the facilitators and barriers in the humanization of childbirth practice, Behruzi et al. found that the most important barriers identified in humanized birth care were the institutional rules and strategies that restricted the presence of a birth companion.

I begin this thesis with a brief history of childbirth in America beginning in the colonial era and spanning the 17th through the 21st century. Within this historical context I will illustrate the differences in childbirth practices between White and African American women and the roots of these practices in American slavery and the eugenics movement. I will describe more current approaches and then begin to explore discrepancies in access to alternative birthing methods. In discussing pleasure during childbirth, I plan to explain the physiological similarities between

childbirth and orgasm that allow for feelings of ecstasy during childbirth and will further probe who is being included in this research and who is left out.

This thesis will tie together analysis of biological, psychological, and social factors that contribute to adverse birthing experiences for African American women in comparison to White women. I will examine the historical processes at play within each factor. A discussion of pleasurable birth experiences will also highlight how these factors have put African American women at a disadvantage to experiencing birth as an intimate, sensual experience, and have forced them to suffer the consequences of decades of racialized mistreatment even in as personal a moment as labor and birth.

Review of Literature

This study began with an engagement with Dorothy and Richard Wertz's *Lying-In: A History of Childbirth in America*, a foundational text on the topic announced in its subtitle. But for all its breadth, I found stories of African American childbirth to be missing. Nowhere does this book do justice to the brutal but important history of African American midwifery and healthcare practices. Thus, I use the information provided by Wertz and Wertz as a starting point and add in vital information from other, more contemporary sources such as Harriet Washinton's *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*, which helps to fill this critical gap. This book offers the first full history of the abuse and mistreatment of African Americans at the hands of the medical establishment, revealing stark disparities when set in contrast to the experiences of White women detailed in Wertz and Wertz's historical overview.

In addition to these two monographs, my project draws on several other books and journal articles. These include works such as "Health Disparities: Gaps in Access, Quality, and Affordability of Medical Care" by Riley Wayne, which highlights the dimensions and extent of racial and ethnic health inequities in the United States; "The Giving Voices to Mothers Study" conducted by Vedam et al., which statistically quantifies mistreatment by race, socio-demographics, mode of birth, place of birth, and context of care, and describes the intersectional relationships between these variables; and Keisha La'Nesha Goode's PhD dissertation, "Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities

of Institutional Racism,” which explores the social operation of racism, the continued racist denigration of Black midwives in the early 20th century, and impacts on poor Black birth outcomes today.

It has been difficult to find much work on pleasurable birth, and this goes to the heart of my argument in this thesis: a healthcare system that does not address its roots in slavery and eugenics could not even begin to consider the potential for pleasure during childbirth. The work that is available certainly does not address racial disparities but I aim to chart the path from the healthcare system’s shortcomings to the benefits of midwifery and the value of safe, comfortable birthing practices as a precursor to pleasurable birthing experiences. Some of the works that I utilize to do so include Debra Pascali-Bonaro’s documentary *Orgasmic Birth: The Best Kept Secret*, which follows eleven women through blissful labor and includes important interviews with experts, doctors, midwives, and more; as well as Marjan Khajehei and Maryanne Doherty’s article “Childbirth in Pleasure and Ecstasy: A Fountain of Hormones and Chemicals,” which details the similarities between the process of childbirth and orgasm specifically in terms of hormonal and chemical structures.

Of central importance for drawing these connections was Deirdre Cooper Owens’ *Medical Bondage: Race, Gender, and the Origins of American Gynecology*, which tracks some of the historical phenomena central to the experiences I aim to elaborate in this work. Owens completes what I wish I could have completed but time restrictions and juggling courses and graduation requirements hindered me from doing. Her book begins, like my own, with the *birth*

of American gynecology and she examines the pioneering accomplishments of famous nineteenth-century surgeons including Dr. James Marion Sims and others. She then goes on to discuss American gynecology on plantations in the Old South, Black women's experiences in slavery and medicine, the contested interplay of slavery, sex, and medicine, Irish immigrant women's experiences in American gynecology, the use of what Cooper Owens terms historical Black *superbodies*, and the *medical gaze*. In the afterword, the author describes her own painful experiences within the American healthcare system and writes that "it seems that [she] could not escape James Marion Sims's historical gaze but also the lessons he left for doctors who worked on the descendants of the original American 'mothers of gynecology,' held in medical bondage" (Cooper Owens 2017, 124). Through my own analysis, I hope to further specify this reference to the stagnancy of the healthcare system and its continued stubborn rootedness in racist practices.

All of these works train specific lenses on childbirth and its surrounding practices, and many of them more broadly address health disparities as a whole. My work aims to synthesize some of these different perspectives, bringing together research on hospitals, midwifery care, United States history, eugenics, pleasure during birth, and more to elicit new findings that specifically address how historically embedded, systematic racism continues to produce disparities in childbirth outcomes between African American and White women in the United States. Ultimately, I am guided by the basic question of what can be done to address these disparities in order to allow for safe, accessible, even pleasurable birthing experiences for all.

Methodology

This thesis relies on historical overviews, a review of relevant research, as well as ethnographic work of my own. In keeping with the design of my chosen major in Social Theory and Practice (STP), I approach this thesis with knowledge I have gained from scholarly work within various disciplines and several perspectives. STP allows students to craft their own, personalized study plan and take courses in many different departments. I have benefited from this flexibility and interdisciplinarity, allowing it to inform my thesis, which draws on publications from various contexts, literatures, and departments. This includes anthropological ethnographic work, historical documents, legal cases, a sociology dissertation, and much more. Bringing these forms of scholarship together, specifically in the context of birth – a human experience with myriad social, psychological, legal, and other dimensions – allows me to illuminate different facets from multiple angles. When these forms of scholarship are not in conversation with one another it becomes very easy to fall into binary oppositions or to succumb to tunnel vision and miss out on the nuance behind a subject.

My ethnographic work takes the form of an interview I was able to conduct with certified professional midwife Cynthia Jackson, as well as a shorter interview with childbirth educator and doula Katy Gladwin. Having no prior experience with birth work I felt it important to speak with people who interact with the hospital system and birthing persons and who can comment on the ways in which they see my research topics at play in their work. I had initially wanted to speak with midwives and workers at the Birth Detroit midwifery center but they are still in their first

years of organizing themselves as the first freestanding birthing center in Detroit and thus did not have the time and energy to speak with me.

Through interviews with the two birthing experts I consulted, I was able to ground the research I have done for this thesis in a real-world setting. I include the list of questions I asked them in the appendix, and I provide an ethnographic write-up at the end of the paper.

Chapter 1: A History of Childbirth in the United States

A review of the existing literature has led me to periodize the history of childbirth in America in this thesis by distinguishing between pre-19th century events in which midwifery was the primary mode of giving birth, childbirth during the 19th and into the early 20th centuries which saw a transition to physician-assisted, more scientific birth, and an ongoing phase from the 1920s onward which includes the medicalization of childbirth and a technocratic turn.

In their book, *Lying-In: A History of Childbirth in America* (1977), Richard and Dorothy Wertz provide an extensive overview of the origins of midwifery and the gradual shift to medicalized birth. Until the late eighteenth century, birth was seen as a social event rather than a medical phenomenon. Childbirth management was in the hands of midwives and the entire process was a female-only experience. Midwifery in Colonial America began as an extension of long-standing European rituals of birth: skills learned in Britain were brought to the American colonies by White midwives while West African midwives came to America as slaves and attended the births of both Black and White women in the antebellum South. At this time, childbirth was a social event - expectant mothers turned toward other female friends, mothers, and relatives for aid and comfort and toward midwives for their skill. Social childbirth continued into the nineteenth century to be the “primary occasion on which women expressed their love and care for one another and their mutual experience of life” (Wertz 1977, 2, Ulrich 1989). Because childrearing was much more prevalent and frequent at this time, the practices of social childbirth were very important to the health and wellbeing of mothers. Having a circle of women

who not only provided emotional support but also aided in household chores during the *lying in* period, when the mother stayed in bed for three to four weeks, allowed her to regain strength and eventually resume the duties of her home and family (Ulrich 1989). Without such support, attempting to manage a household with children through pregnancy, delivery, and postpartum could weaken and even kill a woman. Husbands often would be the ones to gather the women from the town and bring them to their home when their wives went into labor. Through these practices, “the event of birth presented an important, perhaps the primary occasion for female solidarity” at the time (Wertz 1977, 4). One of the most important presences was that of the mother of the laboring woman, who would often travel to her daughter and stay for several months. The communal experience of a social childbirth allowed for a stronger sense of confidence in the laboring woman; the presence of women who had experience and empathy provided reassurance during a woman’s birthing process which helped her to relax and thus ease her pain (Jordan 1993). Furthermore, the midwife or mother offered the laboring woman the reassurance of having witnessed many births and her presence was considered beneficial.

Before and during the colonial period, midwives were not considered part of the medical establishment or other professions, but rather held a position performing a specific social function. They trained one another and selected each other to carry on their work. Midwives did not necessarily have *certified* expertise or knowledge but were distinguished by “such intangibles as manual dexterity, sensitivity, and luck” (Wertz 1977, 6). Many of them were of older age as this meant they had more time to attend to the birth and aftercare.

Slavery and African American Midwifery

Often left out of research and books on the history of midwifery is the important role of African American midwives throughout slavery and beyond. Keisha La’Nesha Goode addressed this lacuna with her work “Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism” (2014). As Goode describes, during the Antebellum period, so-called *granny* midwives were older, presumably wiser women who were transported from Africa to the Americas on slave ships in the 17th century. The term *granny* is closely related to the idea of the *mammy* - a caricature created by and for mainstream White Americans which portrayed a grinning, maternal Black woman who was meant to act as proof that Black women were contented, even happy, as slaves (Goode 2014, 57). There has been a shift to refer to *granny* midwives as grand midwives instead to reclaim the term and gather respect for their important work and intelligence (Pérez, 2015). In solidarity with this movement and recognition of their contributions, I will also use this term in my writing.

During American slavery, starting in 1619 and lasting through the mid 19th century, African midwives served both other African women as well as White women in birth. In 1808, Congress abolished the importation of slaves, but this did not have any particular effect on the abolition of slavery. Instead, in response, Black women were pushed to have more children, in essence they were forced to *breed slaves* (Chakraborty 2017).

Enslaved midwives drew upon traditional healing knowledge and practices passed down through generations or learned through watching others in their communities. Midwives were

important figures in emerging African American communities who “actively worked to preserve the sanctity of childbirth and motherhood in the midst of a system of slavery that insisted black children were commodities rather than kin” (Lampert 2020, 7). Enslaved midwives created and maintained physical and communicative connections across plantation boundaries and helped to facilitate the formation of a broader African American community.

The Gradual Medicalization of Childbirth

After 1750, American men began to return from medical education abroad and brought with them new knowledge and skills to aid women in birth in ways that distinguished them from the practices of American midwives. Bringing knowledge of science and medicine into the birthing process, men pushed their way into the birthing process and women began to look to them for new information regarding their birthing process, thereby affording these male doctors a place in the labor and delivery system. The first advances in understanding birth resulted from opportunities to observe and attend births in the hospital-schools in Paris which were established to train midwives. Learning from anatomical studies of the uterus and birth canal, doctors studied how the fetus moves from inside of a woman through the birth canal and began to devise various manual manipulations to ease this passage. These French doctors believed that natural processes were “machine-like” and regarded the uterus as a “complex mechanism to be measured precisely” (Wertz 1977, 32-33).

Between 1750 and 1810, “new midwifery” was a process shared between trained American midwives and doctors. The idea was that trained midwives would attend normal deliveries and doctors would be called in if there were irregularities or difficulties. American women viewed male midwives as inappropriate and invasive, but the “man-midwife” rapidly gained a hold on the greater part of the best-paid midwifery in conjunction with the spread of new English obstetrics to America. This shift was largely divided by class.

The shift from midwifery to medical birth continued rapidly and by the later 1800s doctors had moved away from the view of the science and arts of midwifery and toward a view that undermined the importance of natural tendencies, focusing instead on the need for more extensive interventions in birth (Wendland 2007). They believed that mastery was needed to assist in birth and argued that women were unable to achieve it. Men began to dominate the sphere of childbirth and as women and men were not to be trained together, female midwifery began to disappear. Middle-and upper-class women saw the more science-based childbirth procedures as safer and more respectable and thus midwives ceased to attend their births.

In the early days of the transition to medicalized, in-hospital childbirth, U.S. deaths in childbirth actually increased progressively until the 1930s. Women of Color were nearly twice as likely to die as White women (Grove & Hetzel 1968).

Creating Barriers: Silencing and Marginalizing African American Midwives

As childbirth became medicalized and physicians emerged as the primary birth attendants, the early 20th century also saw higher rates of maternal and infant mortality. Despite evidence that midwife-attended births accounted for fewer maternal deaths than those attended by general practitioners, obstetricians and public health and social welfare reformers sought ways to blame the midwives. They specifically singled out Black, indigenous, and immigrant midwives, calling them “incompetent, unsanitary, and dangerous” (Tobbell 2021, Fraser 1998). During this process, grand midwives became either infantilized or demonized. On the one hand African American women were seen as “natural nurses” who were “tractable” and teachable,” while on the other hand, they were considered to be “dangerous, dirty and ‘superstitious’ practitioners” (Goode 2014, 58). Medicalization of childbirth meant that midwives who wanted to continue their work had to attend classes and trainings. Functional literacy and participation in medical procedures became a mandatory part of their learning which led to the elimination of older grand midwives. Mandatory monthly trainings, state-assigned mandatory retirement, and constant surveillance of practices were further barriers to sustained African American midwifery practice. At a time when germ theory was rapidly spreading and hygiene became a leading principle of medicine, the associations of dirtiness, untidiness, disorder, and impurity tied to cultural understandings of racial identity left little room for Black midwifery to survive.

The Lasting Impacts of the Eugenics Movement

Central to harmful and erroneous assumptions about race-based experiences of pain today are 19th-century eugenicist justifications for the institution of slavery, as well as slaver-era practices dismissing the autonomy of Black slaves and reducing the value of their bodies to material for scientific advancement. The 1830s abolitionist movement led to backlash in the form of *Negro medicine*, or efforts to identify Black inferiority in order to justify slavery. Polygenists tried to use both science and the Bible to find proof that races evolved from different origins. This also marked the beginning of recorded experimentations on Black women's bodies. In the 1836 *Southern Medical and Surgical Journal*, half of the original articles dealt with experiments on Black people (Washington 2008, 57).

Known as the “father of modern gynecology,” James Marion Sims remains a famous American physician not in the least because of his invention, the speculum, which is still used today. Sims also developed a surgical repair for vesicovaginal fistulas, a severe complication of obstructed childbirth. Venerated perhaps more than his legacy should allow given his controversial status in the annals of medical history (Lerner, 2003), a statue of Sims stood large and proud at the edge of Central Park until it was removed in 2018. His controversial standing stems, in part, from the fact that Sims's medical advancements were the result of a series of excruciating experimental surgeries he conducted on enslaved women over the course of his career in the mid-1800s. Between 1845 and 1849, Sims began performing experimental surgeries on a 17-year-old slave named Anarcha. He eventually performed 30 operations on Anarcha and

more on 11 other female slaves. Though anesthesia was introduced in 1846, Sims chose not to use it for his experimentation on the enslaved women. His practices echoed one of the most prevalent and dangerous beliefs in medicine at the time – that Black people did not feel pain or anxiety and could be used as experimental subjects for medical advancement (Cooper Owens 2017, 35). These incorrect beliefs continue to impact birth experiences today.

Doctors like Sims were not outliers. Historically, southern doctors who used Black bodies for troubling experiments were the norm. Experimentation on, and disregard for, Black bodies continued into the 20th century and was legitimized through the eugenics movement which was formed during the late 19th century and continued as late as the 1940s.

The 1900s brought a wave of immigrants to the US sparking a race panic which coincided with the beginning of the American eugenics movement. One of the movement's key objectives was to reduce the childbearing potential of the poor and disabled – to “eliminate undesirable genetic traits in the human being through selective breeding” (Carlaw 2019). One attempt to reduce these undesirable traits was through forced sterilization of people whose continued propagation was considered to dilute the “quality” of the human race. These so-called *degenerates* were identified as non-White, of lower economic status, physically or mentally disabled, and those deemed “feeble-minded” - people with low IQs, abnormal behavior, sexual promiscuity, criminal behavior, and social dependency. Sterilization laws allowed for the involuntary sterilization of those who were “hereditarily defective,” and the result of these laws allowed more than 30,000 people to be sterilized unknowingly or without consent between 1907

and 1939 (Carlaw 2019). Along with forced sterilization, laws that banned interracial marriages were put in place to hinder biracial children, as they were deemed genetically inferior to children that were of a single race (Bouche & Rivard 2014).

In one historical case, *Buck v. Bell*³ (1927), the Supreme Court granted the ability to sterilize others, confirming the constitutionality of Virginia's statute of forced sterilization. Carrie Buck was a (White) "feeble minded woman" who was committed to a Virginia state mental institution at a time when Virginia law allowed for the sexual sterilization of inmates of institutions to promote the "health of the patient and the welfare of society" (Oyez.org). Carrie Buck's lawyers argued that both the US Constitution's due process clause - which guarantees all adults the right to procreate - as well as the Equal Protection Clause in the 14th Amendment were being violated because the sterilization law was only for the "feeble-minded" at certain state institutions and did not mention those who were not in an institution. In the ruling, the U.S. Supreme Court decided by a vote of 8 to 1 to uphold a state's right to forcibly sterilize a person considered unfit to procreate. This ruling was considered a victory for America's eugenics movement and the writer of the ruling, Justice Oliver Wendell Holmes, affirmed the value of a law like Virginia's in order to prevent the nation from "being swamped with incompetence ... Three generations of imbeciles are enough" (Oyez.org). More than 70,000 forced sterilizations throughout the 20th century can be traced back to this Supreme Court ruling (National Public Radio 2016).

³ See *Buck v. Bell*, 274 U.S. 200 (1927)

The eugenics movement was, at its core, a vehicle for racism and nativism. While birth control can be seen as one of the only positive outcomes of this movement, it is rooted in racist beliefs of White supremacy, which perpetuates the notion that the lives of people of color are less important than the lives of the Anglo-Saxon population. Margaret Sanger (1879-1966), famed American birth control activist, sex educator, writer, and nurse, was also the creator of family planning centers that pushed birth control in the Black South. In fact, it was she who is credited with coining the term “birth control” in 1914 (PBS.org). While she was an avid advocate for birth control for all women, she also aligned herself with negative eugenics views, which aimed to improve human hereditary traits through social intervention by reducing the reproduction of those who were considered unfit. Unlike many eugenicists, Sanger did not speak specifically to the idea of race or ethnicity being determining factors - instead, she defined fitness in individual rather than racial terms (Chesler 2007). Nevertheless, whether specifically addressing racially biased birth control or not, her advocacy and beliefs skewed toward interventions that disproportionately affected African American women’s reproductive rights.

In the mid-1930s, more than half of the states passed pro-sterilization laws. Often, the sterilization was forced. In 1961, Civil Rights activist Fannie Lou Hamer received a hysterectomy by a White doctor without her consent while undergoing surgery to remove a uterine tumor. These instances were so common that members of the Black community began referring to forced sterilization as the “Mississippi appendectomy” (PBS.org).

Another government-issued coercive tactic involved the push of the contraceptive Norplant. Norplant became commercially available in 1991 and, while it aided in allowing women options in what contraception they wished to use and thus enhancing their reproductive freedom, it also was used as a vehicle for infringing on the reproductive autonomy of women (Burke 1992, 208). Norplant was selectively marketed toward Black teenagers in Baltimore schools. Louisiana House Representative and more notably former KKK Grand Wizard David Duke and others like him introduced legislation specifically targeting women on welfare that offered them an annual reward of \$100 if they agreed to get Norplant (Burke 1992, 212). This bill never passed but it makes clear that the implant was designed to be used as a form of social engineering when pushed to specific communities.

Slavery, eugenics, sterilization laws, and other painful histories and practices have become embedded into our society and are still visible today, specifically in the healthcare system. Explicit examples such as the Tuskegee Experiment⁴ that lasted into the 1970s as well as implicit and systemic experiences sew mistrust in and fear of the United States medical system for People of Color. These deep-rooted anxieties can directly impact maternal and infant health outcomes.

⁴ The Tuskegee experiment, which lasted from 1932-1972, was a project aimed to study the full progression of syphilis which at the beginning of the experiment had no known treatment. 600 African American men were enrolled in the project with the promise of free medical care and though penicillin became the recommended treatment for syphilis in 1947 the researchers continued to leave the men untreated with the goal of tracking the participants until all had died, autopsies were performed and the project data could be analyzed (tuskegee.edu)

In the next chapter I detail some of the stark statistical disparities that exist between White and African American mothers' childbirth experiences which further emphasize the need for radical acknowledgement and reform.

Chapter 2: Natal Politics

In some ways, James Marion Sims epitomizes the story of American medicine for Black women, a system that is failing them to this day. Divides in maternal mortality can be traced back to doctors like Sims who contributed to a long, largely overlooked history of institutional racism in medicine. In studies of differential access to medical care, treatment modalities, and disparate outcomes among various racial and ethnic groups Wayne Riley shows how deeply ingrained racial disparities in health care are. Minority patients even tend to receive lower quality care than non-minorities even when they have the same types of health insurance or the same ability to pay for care (Riley 2012).

A 2015 study conducted in the United States on racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between African American and White patients found that Black people are less likely to be treated for pain, particularly in the ER. The authors of this study, Hoffmann et al, point out that Black Americans are systemically undertreated for pain relative to White Americans (Hoffmann 2016). Their research points to a common misconception that African American and White people are fundamentally and biologically different - a belief that dates back to scientists, physicians, and slave owners alike to justify slavery and the inhumane treatment of black men and women in medical research. Such justification was used by James Marion Sims throughout his torture of Anarcha and other enslaved women throughout his career.

These beliefs have never entirely disappeared from the medical field. Well into the 20th century, researchers continued to experiment on Black people based in part on the assumption that the Black body was more resistant to pain and injury. Research by Hoffmann et. al has shown that biological conceptions and related beliefs are associated with greater acceptance of racial disparities and even racial bias in pain perception (Hoffmann 2016). The study found that medical students and residents who endorsed the beliefs about biological differences between African American and White people rated the African American patients' pain as lower and made less accurate treatments recommendations.

While this data is not specific to childbirth, it leads directly back to many discrepancies in birth outcomes between African American and White women. We can draw parallels between the study and data that exists on infant mortality, birth weight, and analgesic administration comparing African American and White mother's experiences and outcomes.

According to the CDC's infant mortality statistics, in 2018 African Americans have 2.3 times the infant mortality rate as non-Hispanic Whites, their infants are 4 times as likely to die from complications related to low birth weight as compared to non-Hispanic White infants, and African American mothers were twice as likely to receive late or no prenatal care as compared to non-Hispanic White mothers (Ely & Driscoll, 2020). Low birth weight was the top leading cause of infant mortality for African American infants with a death rate of 247.5/100,000 live births as compared to only 62.1/100,000 for White mothers. This creates a shocking Black to White infant mortality rate ratio of 4 to 1 (Ely & Driscoll, 2020).

In an article for the *American Journal of Epidemiology*, Collins, Wu, & David researched differing intergenerational birth weights among the descendants of US-born and foreign-born White people and African Americans. While the data showed expected trends that, among the descendants of both first generation US-born and European-born White women, the birth weight of the third generation's infants shifted upward from that of their second generation mothers, an intergenerational improvement in birth weight of a substantially smaller magnitude occurred among the descendants of first generation US-born African American women. The most striking find, however, was that among the direct female descendants of first generation foreign-born African-American women, the birth weight of the third generation infants shifted *downward* from that of their generation 2 mothers (Collins et al. 2001). In other words, immigrating to the United States caused an overall increase in birth weight for second and third generation White European women's infants but caused *lower* birth weights for African American descendants of African grandmothers.

The article does not delve very deeply into the possible reasoning behind this discrepancy, but the authors do point out that the disparate intergenerational birth weight patterns between White and African Americans provide evidence that pregnancy, while occurring during a limited period of a woman's life, should not be considered an isolated event independent of prior life experiences.

Childbirth Complications and Obstetric Violence

Stories of birthing experiences from famous or important Women of Color help to draw attention to the discrepancies they face in the healthcare system. Take tennis star Serena Williams, for example⁵. The day after giving birth to her daughter in a hospital, Williams felt short of breath. She had a history of pulmonary embolisms so she alerted a nurse to her symptoms and requested a CT scan with contrast and a blood thinner. The nurse disregarded her and the doctor she alerted did an ultrasound of her legs instead of the CT she adamantly requested. When she eventually was sent for a CT, she already had several small blood clots settled in her lungs. Furthermore, Williams coughed frequently due to the embolisms and the coughs were forceful enough to cause her C-section wound to rupture which led to surgery in which doctors found that a hematoma had filled her abdomen. All of these complications could have been curbed had the doctors listened to Williams and acknowledged her knowledge and perception of her own body and needs. Black women are disproportionately likely to face pregnancy-related complications and are three to four times more likely than White women to die from pregnancy-related complications (CDC.gov 2022).

In response to Serena Williams' birth story, many readers and commentators have asked: what does it convey about our healthcare system if *even* Serena Williams can't get proper care? Her story helped to create wide-spread awareness of medical racism and pregnancy-related

⁵ Serena Williams wrote about her birth story in an article for *Elle* in April, 2022: <https://www.elle.com/life-love/a39586444/how-serena-williams-saved-her-own-life/>

complications but it is also important to keep in mind that these issues are further exacerbated by other factors including disability and social class.

Another story that gained national attention was that of activist Erica Garner's postpartum death. Garner's story is that of a woman giving her life in the long, emotionally and physically tolling fight for racial justice in the United States. She is among an alarming number of Women of Color in the US who die during pregnancy or within one year of childbirth. At the time of her death, Garner had an 8-year-old daughter and a 4-month-old son whom she named after her father who had been murdered by the police in 2014. Garner died from cardiac arrest following an asthma attack after which she was placed in a medically induced coma and suffered extensive brain damage due to a lack of oxygen. African American women are more likely than white women to experience chronic stressors and, according to an article written by Katie Mitchell, people close to Erica Garner believe that it was a combination of institutionalized racism, chronic stress, and the physical stress of childbirth that led to Garner's tragic death (Giurgescu et al. 2014, Mitchell 2017).

The US has very high maternal mortality rates compared to other *first world* countries. According to a study by MacDorman et al., the estimated maternal mortality rate (per 100,000 live births) for 48 states (excluding California and Texas) increased by 26.6% from 18.8 in 2000 to 23.8 in 2014. Meanwhile most other countries trended in the opposite direction. Within this data there is a growing gap between the deaths of Black mothers and their White peers. Research has shown that a number of factors, including poor access to pre- and postnatal care, chronic

stress, and the effects of racism and inadequate medical treatment in the years preceding childbirth are all likely to play a role in a Black woman's risk to suffer life-threatening complications in the months that come before and after childbirth.

Even being an expert on racial disparities in health care did not prevent Shalon Irving, lieutenant commander of the Commissioned Corps of the U.S. Public Health Service, from passing away just three weeks after giving birth. As an epidemiologist at the Centers for Disease Control and Prevention, Irving had dedicated herself to trying to understand how structural inequality, trauma and violence made people sick (NPR.org 2017). Much of her research had focused on how childhood experiences affect health later on (Purnell et al. 2022). But despite her vast amounts of knowledge and her dedication to addressing racial disparities in complications of pregnancy and childbirth, Shalon Irving collapsed and died from complications of high blood pressure only three weeks after giving birth.

The degree to which People of Color are experiencing trauma and mistreatment during childbirth has caused a new term to enter the discourse: *obstetric violence*. In short, obstetric violence occurs anytime a person in labor or birth experiences mistreatment or disrespect of their rights, including being forced into procedures against their will, at the hands of medical personnel (Cara 2018). Obstetric violence can be found in hospitals throughout the world and across the United States. It can include the denial of treatment, verbal humiliations, invasive practices, or a disregard for pain, as well as a lack of privacy during vaginal exams, unnecessary use of medication and sexual assault. In Lydia Dixon's article on obstetric violence in Mexico

she points out that “the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women” (Dixon 2015, 443). Dixon makes an important connection between treatment in the delivery room and the reflection of this more broadly in a woman’s life. Implicit bias and racism have been directly linked to the unconscionably high Black maternal and infant mortality rates. Ill-treatments and abuses create a psychological distance between the woman and care providers which then drive women away from formal health care systems in fear of being subjected to such violence.

It is shocking to see how the racialized legacies of doctors and physicians can carry through up until today into our healthcare systems. Care providers and the hospital system as a whole must undergo massive ground level shifts before we can begin to uncouple the racist histories of childbirth practices and move toward more just, safe experiences, specifically for birthing Persons of Color. In the following chapter I address the possibilities that could come out of this acknowledgement and effort.

Chapter 3: Pleasure During Childbirth

While pain is widely researched and medical interventions are seen as second-nature to a birth, pleasure is rarely discussed in association with childbirth and does not seem to be an option for an expectant mother. The fear of pain can lead to distressing dreams and feelings, physical and mental health problems, and more elective Cesarean-sections. Experienced midwives, however, are able to differentiate the ways in which the body reacts to labor and provide a countermodel to this distressing model of childbirth. Through their intimate knowledge many midwives have begun to write about and disseminate work on the possibility of pain-free or pleasurable, even orgasmic birth. Their writings point out that, birth at its core is an erotic, intimate event (Gaskin 2011).

There are many similarities between the hormones and chemicals present during childbirth and during orgasm. One of the more well-known connections between pleasure and childbirth is the use of orgasm to induce labor. This method has been researched extensively and has even been depicted in popular media like *Grey's Anatomy*⁶. There are, in fact, studies that prove that sexual intercourse is a scientifically credible and reasonable method of inducing and augmenting uterine contracts, thus aiding the induction of labor (Marjan and Doherty 2012).

Some proven causes for the argument that sexual intercourse is beneficial during the birthing

⁶ In Season 14 Episode 3 of the popular medical drama series, *Grey's Anatomy*, a woman comes into the hospital to give birth but is allergic to Pitocin so when her labor stalls and her cervix refuses to dilate past 4 inches, the doctors explore alternative options. Seeking to switch from synthetic oxytocin to natural oxytocin, one doctor points out that “what gets the baby in also gets the baby out!” and they recommend orgasm which quite quickly leads to the baby crowning.

process are that semen has natural prostaglandin E which acts as a muscle relaxant, breast stimulation promotes labor onset, and orgasm increases uterine activity. As Maryanne Doherty points out, “the best way babies come out is the way they come in. If you allow intimacy and sexuality, birth just moves much faster” (Marjan and Doherty 2012).

The history that keeps pleasure apart from childbirth has much to do with the medicalization of birth and the puritanical view of sex that many Americans hold. For most women, the link between giving birth and feeling an orgasm is perceived as an inconceivable myth or even an attack on their identities as mothers and women. And it is true that pain cannot be separated from giving life. But medicalization and the rise of contraception has tended to dissociate procreation from pleasure, maternity from sexuality. The lack of a scientific body of knowledge on corporeal sensations during childbirth from mothers’ points of view has left out an important aspect of childbirth studies today.

Pain Relief Methods: From Medicine to Meditation

In a hospital setting there are generally two types of drugs for pain relief - analgesics and anesthetics. Anesthetics relieve pain by blocking most feeling (including pain), whereas analgesics lessen pain but do not remove feeling or muscle movement. Pain relief medications can be systemic, regional, or local: systemic medications affect the entire body, regional medications affect only a region of the body, and local medications affect only a small area of the body. Systemic analgesics are often used in early labor – if they are given right before delivery

they may slow the baby's breathing and reflexes. Systemic analgesics are either injected into a muscle or vein or inhaled with a mixture of oxygen. Regional analgesics are the most common way to relieve pain during labor in the United States. They take the form of either epidurals, spinal blocks, or combined spinal-epidural blocks. Epidural analgesia is injected near the spinal cord and after about 10-20 minutes causes loss of feeling in the lower body while the patient stays awake. A spinal block is an injection of a much smaller amount of the drug into the sac of spinal fluid around the spine. This type of analgesic works immediately but is only given once during labor. A combined spinal-epidural block relieves pain immediately through the spinal part while the epidural part allows drugs to be given throughout labor (betterhealth.gov).

Given the prevalence of these methods, it seems important to recall that there are many non-medical ways of relieving pain during labor as well. Staying active during the birth – moving freely and rocking the pelvis – is one of the most helpful things a birthing person can do to manage the pain of labor and birth. Massages can help distract from pain, and heat packs can help the body release endorphins that work as natural painkillers. Warm baths or showers or even a fully immersed water birth can be very helpful in aiding contraction and back pain.

Aromatherapy, acupuncture, meditation, and breathing techniques are other non-medical methods of controlling pain.

The natural birth movement has introduced several methods of childbirth preparation such as lamaze and hypnobirth. Lamaze is a popular method of childbirth preparation that uses controlled breathing, educational classes, and relaxation as tools to help people cope with labor. Hypnobirth is a childbirth education course that utilizes self-hypnosis, guided imagery techniques, affirmations and education for easier, more comfortable childbirth. With both of

these methods the goal is to reduce fear and tension that many women have around giving birth and reduce the pain and discomfort of labor. While not directly addressing sensations of pleasure during birth, these techniques open the door to such experiences.

Different methods of birth and delivery have had their moments of popularity depending on how they fit into current feminist movements. Specifically in the case of pain management, feminist discourse on what *should* or *could* be experienced has helped bring about various pain-free birth movements. One shocking case is that of *twilight sleep*, produced by a scopolamine-morphine mixture that was created by two German doctors. When administered properly this drug cocktail induces a drowsy state and relieves pain only partially, while creating amnesia so that the woman giving birth will forget the entire birthing experience. Twilight sleep spread in popularity in the United States through the first-wave feminism movement. Connecting the fight for pain management in childbirth to gender equality, twilight sleep was seen as liberating women from unnecessary pain (Leavitt 1980). These treatments were only available to upper-class White women, though, and the use of twilight sleep began to decline only 10 years after it had begun due to various instabilities, a high rate of errors, and the fact that twilight sleep did not actually cause a painless childbirth - the scopolamine just produced amnesia so that the user remembered neither the pain - nor the birth.

Another movement with close ties to the *crunchy* (read: White, liberal, upper middle-class) feminists emerged as the *orgasmic birth* movement, in which birth is experienced as *ecstatic*. The driving idea is that some people may be able to experience an orgasm (or several) during childbirth. Many things need to be in place in order for this level of intimacy and experience during birth to be possible: laboring women need to have enough knowledge and

comprehension about the physiology of birth, the birth process, the nature of sex, and the power of sexual sensation during labor. They also need to be assured that childbirth may be an intimate experience and that sexual activity and gratification are parts of it. In a hospital setting this is practically impossible.

A 2009 documentary film titled *Orgasmic Birth: The Best-Kept Secret* examines the intimate nature of birth. Following the journey of eleven women through labor, the film presents an alternative, blissful experience of childbirth as opposed to most popular media depictions of screaming, crying, and epidural-heavy labor scenes. One woman is quoted as saying that to take the pain away is “not giving yourself the full experience ... it’s supposed to be that way, supposed to have intensity. It’s a rite of passage, it’s part of being a woman” (Pascali-Bonaro 2009). One birth worker points out that “birth is part of a woman’s sexual life” and that during childbirth there is an extraordinary need for love and contact between the parents. An ecstatic birth is one in which the birthing person is able to transcend the space that they are in and move to a “more positive place.” But this leaves me wondering: how could someone who has previous trauma or who is historically dehumanized be able to gain access to such sensation?

The role of the birthing environment plays a large role in the potential for a pleasurable birth. The orchestration of ecstatic birth hormones is delicate and subject to interference from the environment in which a woman births. Intimate settings are essential for women to engage with the sexual qualities of birth, and therefore the clinical environment of the hospital does not necessarily recognize or encourage sexuality in childbirth. One study found that ecstatic birth is likely only achievable when the neocortex of the brain is at rest, with stimulants such as light,

conversation, lack of privacy, and danger all inhibiting the natural hormonal cycle and affecting labor progress, all of which are inescapable in most hospital settings (Crossing 2021). The home environment is often the one that supports sensuality and sexuality of birth best. Today, however, homebirth represents less than 1% of births in the United States (ACOG.org 2017).

Another difficulty in accessing the potentially pleasurable dimensions of the birthing process lies in the fact idea that “if a woman believes sexuality is shameful, she will find it difficult to spread legs and give birth to a child who is the result of sex” (Shanley 1994, p. 69). This speaks to the impact of preconceived notions and beliefs on the childbirth experience and process. Socio-cultural values and beliefs about birth can deeply affect the way birth is experienced. Further, pain perception differs from one person to the next and is influenced by the individual’s physical, psychological, and cultural conditions. Recalling the role of hormones present at birth, it bears noting that anxiety and fear increase catecholamine concentration in the plasma, which is associated with enervated uterine contractility (Alipour 2011).. In other words, the uterus does not contract as strongly as is normal.

What underlies these findings is that more pleasurable birth is a phenomenon experienced in very specific settings with specific knowledge and access. Research indicates that the possibility of having a pleasurable birthing experience is highly contingent upon a mother’s access to alternative birthing practices, specifically midwifery (Cook 2012, p. 159). There is substantial evidence supporting beneficial outcomes of midwifery care and the shortcomings of medicalized pregnancy and childbirth. And yes, access is still blocked or unavailable due to incomplete coverage by insurance companies. Many insurance companies do not cover

midwifery or doula care during birth and patients must pay out of pocket for these services. In the U.S. only 11 states provide Medicaid coverage for the services of certified professional midwives. One of the barriers for insurers is that home-birth midwives are not required to have (and often cannot afford the high rates for) liability insurance. In a national survey of women who gave birth in 2011-2012, 69% of African American respondents “reported a desire for an out-of-hospital birth” but birth certificate data show that only 0.49% of non-Hispanic African American women had an out-of-hospital birth (Hardeman 2020, p. 1-2) - a staggering discrepancy. The lack of access to alternative birthing spaces unfairly skews access toward those with higher socio-economic status and blatantly disregards the necessary and equitable principle that home birth should be an option for all.

The Importance of Culturally Congruent Care

In Colorado today, of more than 14,000 practicing physicians, the Colorado Black Health Collaborative can count only 91 who are Black (CBHC, 2020). Of the State’s 253 medical school graduates in 2016, only three were Black (AAMC, 2016). The chances of finding a Black healthcare provider are already low but when it comes to midwives, there is only one Black home-birth midwife in the entire state of Colorado: Demetra Seriki. Seriki is convinced that the health care system is failing Black mothers, and wants to do better for the people who seek her out. In an interview with Collective Colorado, Seriki states “if I knew then what I know now, I would not have had five children... Every time you walk into a hospital as a Black woman to

give birth, you're rolling the dice" (Jones 2020). In her philosophy of care she emphasizes the importance of listening to Black mothers and believing them when they say that something is a problem. Seriki and her partner at her midwifery service, A Mother's Choice, advertise on their website that they offer discounted services to families with Medicaid, Tricare, and families who are uninsured or experiencing homelessness despite Colorado not being one of the 11 states in which home-birth is covered by Medicaid. Most of their clients are People of Color.

Seriki states that when she committed to her work, she "knew that White families were gifted the ability and the right to choice, whereas Black families were not. A home birth is a privilege. [She] wanted to afford [her] community the same opportunity" (Jones 2020). Due to their subsidized offers, neither Seriki nor Sibert are able to make a living doing only home birth midwifery. They both have jobs on the side.

Measuring Inequality

The limitations on home births are putting new parents - and especially People of Color - at risk by pushing them into hospitals. While the risks of hospitals are usually quantified in mortality numbers, weight measurements, and other statistics, there is also an immeasurable risk of trauma - both to the parent and to the baby. A 2013 report of the third national U.S. Survey of Women's Childbearing Experiences titled *Listening to Mothers III* found substantial evidence on the difference in childbearing experiences between Black and White mothers. Black mothers were found to be most likely to report that they had used WIC (Women, Infants, and Children)

benefits (as opposed to White women who were found to be least likely to rely on Medicaid); that they were interested in doula care; and that they were always or usually treated poorly in the hospital because of their race, ethnicity, cultural background, or language (Declercq et al. 2013). Black mothers had the highest level of agreement with the statement that birth should not be interfered with unless medically necessary. Care statistics further underline these reported disparities: out of 1,279 White mothers, 18% had not met their birth attendant until birth as opposed to 26% of 356 Black mothers.

The “Giving Voice to Mothers Study” on inequity and mistreatment during pregnancy and childbirth in the United States found that one in six women surveyed reported experiencing one or more types of mistreatment such as loss of autonomy, being shouted at, scolded, or threatened, and being ignored, refused, or receiving no response to requests for help (Vedam et al. 2019). Experiences of mistreatment differed significantly by place of birth, though: only 5.1% of women who gave birth at home reported such mistreatment, versus 28.1% of women who gave birth in a hospital. The study also cites factors associated with a lower likelihood of mistreatment. These include having a vaginal birth, a community birth, and/or a midwife – and being White. Rates of mistreatment for Women of Color were consistently higher even when accounting for interactions between race and other maternal characteristics. 30% of Black primiparous women but only 21% of White women who delivered in hospitals in the United States reported that they sometimes or always felt treated poorly because of a difference of opinion with their caregivers about the right care for themselves or their baby (Vedam et al. 2019).

The Benefits of Alternative Birthing Spaces

One promising avenue for combatting such location-based mistreatments are community birth centers. Birth center care improves birth outcomes, increases satisfaction - and, if it is culturally responsive, it can make a life-or-death difference for people of color by reducing disparities in care, as pregnant African American individuals at the intersection of vulnerable racial and gender identities are particularly susceptible to lower quality clinician-patient relationships (Hardeman 2020). Yet communities of color are least likely to have access to birth center care. Of the more than 384 birth centers in the United States, less than 5% are owned or led by Black, Indigenous and people of color (birthcenterequity.org). One of these centers is Roots Community Birth Center, an African American-owned, midwife-led freestanding birth center in North Minneapolis. Roots has adopted a “culturally-centered care model” which is community based, accepts Medicaid, and provides prenatal and postpartum visits that are customized to the needs of the birthing individual (Hardeman 2020). Roots is a clear example of the benefits of the birth center model of care - over the last four years Roots has had 284 families with zero preterm births (Hardeman 2020). Unfortunately, there are no Black-led birth centers in Michigan, and there are no birth centers at all in the city of Detroit. Midwives at Birth Detroit are working hard to open a birth center with the belief that Detroiters deserve the option of birth center care. They are seeking to provide safe, culturally reverent midwifery-led maternal health care for all.

A 2017 article on the “Mothers on Respect index” (MORi) measured quality, safety, and human rights in childbirth. The MORi can be used to measure women’s experiences of respect and self-determination when interacting with their maternity care providers. The researchers found that women from vulnerable populations and women with medical or social risk factors during pregnancy had lower MORi scores. Women under the care of midwives had higher scores, and those who planned home births reported the most respectful care (Vedam et al. 2017). Women’s decisions about childbirth are an expression of their personal autonomy but the ability to make informed decisions depends upon the woman having both adequate information and respect for her decision-making capacity. As the researchers state, “in marginalized populations, women may not feel they can exercise their agency because of systematic erosion of self-confidence and self-worth” (Vedam et al. 2017).

Poor treatment during childbirth can have lasting consequences for mothers and babies. Poor treatment has been linked to postpartum depression, post-traumatic stress and fear of childbirth during subsequent pregnancies (Lukasse et al. 2015). Lack of involvement in decision-making, perceptions of inadequate care, and feelings of powerlessness can all result in post-traumatic stress disorder (PTSD) (Creedy et al. 2001). The fear associated with pregnancy may result in anxiety and stress, manifesting as changes in emotions, behavior, or physical symptoms. Fear of childbirth in general has been associated with proneness to anxiety disorder. General anxiety, lack of social support, and unemployment are common risk factors for fear of childbirth and anxiety of pregnancy. To explore these issues in practice today, I turn now to conversations with birth workers in my local setting.

Ethnographic Work: Voices of Local Birth Workers

From the moment I decided to pursue this topic for my thesis I felt very aware of my position within the project. As a White woman with no prior experience with birth work, I have a distinct distance from the issues I am writing about. But it was precisely that distance which propelled me to work on this. Knowing that birth work is something that I could see myself pursuing after college, I seek to understand the structures and histories of childbirth so that I can be an informed advocate for safe, comfortable, and even pleasurable birthing experiences.

I know that reading, digesting, interweaving and reproducing existing research and knowledge is an effective way of approaching this thesis project, but I also wanted to leave space for more ethnographic work - allowing stories and perspectives of people to be heard who work in this world, see these structures in place, or even experience these things themselves. I turned to midwives, doulas, and patients in the Metro Detroit/Washtenaw County area for this.

1. Cynthia Jackson

Cynthia Jackson is a midwife, doula, and founder of Sacred Rose Birthing Services. She provides homebirth midwifery care and hospital doula support for Metro Detroit families, having experienced over 200 home births and over 150 hospital births during her career. In 2017, Cynthia was awarded “Doula of the Decade” by the Black Mothers’ Breastfeeding Association (BMBFA) for her tireless work in the community as a volunteer doula and as an independent professional doula. She is also a co-founder of Mosaic Midwifery Collective, a group of 3 homebirth midwives of color serving Metro Detroit/Washtenaw county families.

The Sacred Rose Midwife motto is “Birth Like a R.O.S.E. - Reclaim Our Sacred Experiences - Birth at Home!” (sacredrosemidwifery.com). Cynthia believes in the historically deep-rooted and sacred experience of homebirth and does all that she can in order to make her clients feel safe and comfortable. Her practice offers respectful and compassionate care that is tailored to individual needs and she provides evidence-based education to help mothers and partners make informed choices throughout their pregnancy, labor and delivery, and postpartum experiences. Even just in our informal conversation about the work I was doing I could tell how devoted a midwife she must be - I immediately felt at ease and heard and she responded to all of my questions excitedly, full of knowledge, and warmly.

Before reaching out to her for a formal interview I had heard Cynthia talk about her career path and experiences as a doula and midwife several times in different classes on campus. She was a guest lecturer in two different classes over Zoom during my junior year but I had the pleasure of meeting her in person when she came to speak for my advisor’s course this semester. The first thing you notice about Cynthia - whether over Zoom or even in person behind the mask - is her genuine, delighted smile. Just watching her speak and be so generous with her time, energy, and excitement is infectious.

For our one-on-one interview we met over Zoom. During her talks at the University she shares her “typical” work week and notes the many irregularities and need for flexibility that come with a job of accompanying expectant mothers and delivering babies. I was grateful to slip into an open spot on a Wednesday, a day of the week generally left open for meeting with prospective families, working her monthly desk shift at the Birth Detroit midwifery center, and paying home visits to current families. Though I was nervous to meet with her and was glad to

have prepared an extensive list of questions beforehand, I noticed myself relaxing quite quickly and we soon fell into an easy conversational flow.

Cynthia describes the hospital as a business. In some ways, her work is comparable to that of a hospital's prenatal care program, but she spends more time getting to know her clients - really focusing on the individual's wants and needs. In a talk on campus she pointed out that Black women are treated worst in hospitals because of a combination of institutionalized racism and sexism - a point that I had also found across the scholarly literature, as detailed above. Unlike a hospital setting where nurses come and go and doctors work in shifts (thus not allowing for any type of close bond and comfort with your care provider), Cynthia and her team accompany mothers through their entire birthing process. She says that she is just like a sister or aunt to them who just happens to also know how to deliver a baby. A key distinction that she makes is that she believes in the power of the woman's body whereas hospitals don't and rather believe in their tools.

Cynthia Jackson trained to be a midwife under Stacia Proefrock, certified professional midwife and owner of Trillium Birth Services in Ypsilanti, MI. Stacia's clients were primarily from the Ann Arbor/Ypsi/Detroit downriver area and were predominantly White. When people found out Cynthia was training to be a midwife herself they automatically assumed that she would be servicing the Detroit area. She pointed out to me that that was never her specific goal, nor has her goal been to have an almost 100% Black clientele. What she realized over time was that White women simply did not seek her out. She was a doula to more White women but as a midwife has been involved in only one or two White couple's births out of the approximately 150 babies she has delivered. As a doula, she noted, it did not seem to matter what she looked

like because she was not calling the shots on the pregnancy and was only acting as support and guidance; but once she was in charge of the birthing process the view of her became infused with the identity politics of race.

There are two other midwives of color who service the Detroit area alongside Cynthia, both of whom are biracial. Together, the three of them make up Mosaic Midwifery Collective. Cynthia says that her two partners have more White clients than she does. She also noted that she does wish her practice was more diverse.

Cynthia described only one bad (racially motivated) experience in her time working as a doula and midwife. At the time she was working alongside Kate Mazzara, certified professional midwife of Mazzara Midwifery. The two of them were taking care of a White client in Howell, MI and the client was extremely uncomfortable with Cynthia touching her even for routine check ups like palpating the belly. When Kate performed the procedures the woman was completely fine, but when Cynthia took a turn the client began hysterically crying and screaming. Cynthia said that she is still dealing with not being trusted as a midwife in 2022. She pointed out that, although this was clearly a racially charged adverse experience for her, had it been in a hospital it probably would not have happened because the client would not have been allowed any choice in who was her care provider. Even in a situation where she was treated unfairly in a racially discriminatory way, Cynthia continued to believe in and advocate for the power of homebirth and midwifery.

In her home births Cynthia does not administer any form of pain medication. She has various techniques that she will utilize to ease discomfort – including massages, different positioning, and recommending birthing pools or bathtubs. Rather than rely on medication,

Cynthia believes in the power of support. This is built over time, through many conversations, visits, openness, shared meals, and trust. These strategies may create space for pleasure to re-enter the birth experiences of Black women after generations of obstetric violence and racist treatment in standard health care.

2. Katy Gladwin

Katy Gladwin is a mother, wife, doula, wellness coach, childbirth educator, woman advocate, medical advocate, and activist of various sorts according to her biography. We met over Zoom and quickly made several connections (including a shared homeopathic doctor), as is common among Ann Arbor natives. Her pink hair flashed brightly through the screen and we exchanged tips on our experiences with recurrent-UTIs before diving into the interview.

When I brought up my interest in the potential for pleasurable birth Katy pointed out that in her own experience with birth she did not even broach the subject because she did not want to get her hopes up and be let down. She noted the power of thought and its ability to affect physiology: our thoughts influence our bodies directly because the body interprets the messages coming from the brain to prepare us for whatever is expected. Confirming and informing my overall findings in this thesis, Katy pointed out that in hospital settings it is virtually impossible to go into the space of extreme vulnerability that she considers a precondition for an ecstatic birth. In a hospital the doctor has their hands inside of you, the smell of antiseptic wafts through the room, and surgical masks blur the staff to the point that she feels they no longer have a face. She did point out that self pleasure during labor can come in many forms. Some examples she stated, speaking from her own experience and from her work as a doula, were things like foot

rubs, a warm shower, or clitoral stimulation. The issue that she finds with the prospect of sexual self pleasure during birth is the fact that the tissue that is used to being stimulated sensually to cause pleasure is being manipulated by the many facets of labor and it is thus an extra hurdle to have to conquer to reach pleasure or orgasm.

As a childbirth educator, Katy Gladwin teaches courses to expectant parents and provides a firm, evidence-based foundation of knowledge in hopes that students leave the class empowered to use the tools that feel best for them. The first four weeks of her seven week series are focused on understanding labor and birth. This goes over the “nuts and bolts” of how labor works including a demonstration with props, how to make informed choices that are best for the individual birthing person, “how to make it go well” and enhance comfort in labor and birth. Katy said week two covers the “unpleasant stuff” of triage, IV placement, vaginal exams, and interventions of all varieties up to inductions and C-section. The comfort measures range from epidurals to breath work.

The second three weeks are focused on nurturing mother, baby, and family. The class is designed to help families prepare for a healthy postpartum and a new normal. These classes cover breastfeeding basics, developing secure attachment, postpartum healing, and healthy transitions when adding a new member to your family.

Katy is also a homebirth assistant and all of those clients attend her childbirth education classes regardless of whether or not they plan to be in a hospital setting for their births. Home birth students make up around 10% of her students. Katy points out that the second class about the “unpleasant stuff” is very important specifically for the home birth students because many of them choose home birth for their birth setting due to trauma from previous experiences which are

often based in not being heard or not knowing how to properly advocate for themselves in a hospital setting. Katy is deeply passionate about self-advocacy and we discussed how the United States hospital system moves so quickly that it is practically impossible to properly advocate for yourself. She went as far as to say that our hospital system breeds traumatized workers, noting the importance of trauma-informed care. The main point of her self advocacy teaching is that the most important thing you can do for yourself is find ways to slow things down. Asking for time and encouraging a pause for breath are some of the main things she does as a doula along with encouraging partners to be the ones to lead this. She stated that for first time parents it can feel impossible to slow things down especially if you do not have the knowledge or support to do so and that is where doulas become a necessity.

Another important subject that she touched on was how to choose the right care provider. She described birth care providers as falling on a “birthing spectrum” which ranges from “birth is dangerous and needs to be managed” to “birth is inherently safe and anything you do to intervene will mess it up.” She said “it’s 2022” - everyone should be able to choose how much pain they feel is right for them to experience during childbirth and should find the care provider who falls on the same part of the birthing spectrum as they do. When we broached the topic of advocacy for Women of Color in the birthing world she pointed out that her birth statistics are the inverse of Cynthia’s - of more than 200 births she has had fewer than 10 African American women. She does see a strong need for subsidized doula care and wishes that there were specifically more initiatives for doulas of color.

CONCLUSION

It is difficult to summarize and do justice to the centuries of pain that has been inflicted upon People of Color throughout United States history. I am especially humbled to be doing this work knowing that I have benefited from the systems of power that have caused this trauma. Nevertheless, I believe that the work that is being done, including mine, has the potential to begin to undo deeply embedded false narratives of inferiority or unworthiness. I am submitting this thesis just two days after the end of the fifth annual Black Maternal Health Week (BMHW) which was founded by the Black Mamas Matter Alliance - premier leaders of the Black Maternal Health, Rights, and Justice Movement (blackmamasmatter.org). Black Maternal Health Week is dedicated to amplifying the voices of African American mothers' voices, needs, and experiences and it is my hope that this project can add to this ongoing advocacy work and scholarship.

I may be graduating in ten days but I know that I still have much to learn. I also know that there is a long way to go before we see any true change in the United States medical system. There is a need for systems-level changes to reduce (and eventually, hopefully, eliminate) structural racism in health care delivery and improve equity in childbirth outcomes. I advocate for a shift away from the hospital system and towards a more holistic and approachable system of care. For the best places to enact these necessary changes, I imagine smaller birthing places within and outside hospitals that are providing support for mother-centered birth, and that are carried by midwives, doulas, and partners, and – if necessary – also doctors.

On the state and congressional level some plans are already under way. It is important that all states enact Medicaid reimbursement legislation for doula and midwifery care at rates that support a living wage. Birth workers are already giving so much of their energy to providing

safe, comprehensive care to their clients - the least they deserve is a living wage. Additionally, congress should reintroduce and pass the Mamas First Act which would amend the Social Security Act to provide coverage under the Medicaid program for services provided by doulas and midwives (U.S. Congress 2019). This subsidization would open up access to alternative birth care and, importantly, give agency to birthing persons when it comes to where and how they feel best giving birth. The Black Maternal Health Momnibus is also a critical package of legislation that was reintroduced in the 117th Congress in February, 2021. This bill includes the Perinatal Workforce Act which would establish grants to diversify the perinatal workforce, including doulas and midwives. The Momnibus also addresses maternal health issues related to COVID-19 (U.S. Congress 2021).

While there is a definitive need for recruiting and training more midwives of color throughout the United States, the burden of birth equity cannot lie on the shoulders of the few Black birth workers that exist alone. Creating supportive environments should be the focus of all birthworkers - “creating and nurturing pregnancy experiences wherein African American patients feel that their racial and ethnic identity is being centered and celebrated is a goal that all clinicians, regardless of racial identity, can [and should] strive toward” (Karbeah 2019, p. 596). It is my hope that once those spaces of safety, support, and celebration have been created, Black women’s birthing experiences can shift from painful to pleasurable.

Appendix:

Interview questions for local birth workers:

1. Why did you choose to be a midwife/doula?
2. Training, experience?
3. How is your work grounded in a social justice framework?
4. Do you see birth as a politically charged topic? If so, in what ways is this manifested?
5. What are some forms of pain management, if any, that you generally see utilized?
6. How do you view the connection between pain and labor?
7. What do you tell your patients about the role of pain in birth?
8. Have you ever witnessed a pleasurable birth?
9. If so, can you tell me a bit about the environment in which it took place?
10. What do you think would be required for a birth to be pleasurable?
11. Who has access to your services?
12. Who, typically, is left out of this access?
13. How do you make your services accessible?
14. In what ways does your work affect your positionality within your community?

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