Hypatia (2024), **39**, 343–362
doi:10.1017/hyp.2023.112

CAMBRIDGE UNIVERSITY PRESS

ARTICLE

The Politics of Doulas: Black Feminist Collective Action in Response to "Birthing While Black"

Jina Fast

Philosophy Department, Notre Dame of Maryland University, Baltimore, MD, USA
jfast@ndm.edu

(Received 14 July 2021; revised 5 March 2022; accepted 13 March 2022)

Abstract

A central function of the Black Lives Matter (BLM) movement in the United States has been to center and express the lived experiences of Black people within the social and political framework of white supremacy. Regarding reproductive justice, BLM, as well as organizations like the Black Mamas Matter Alliance and Sistersong, have drawn political attention to the oppressive parameters existing for pregnant people "birthing while Black." Attention to disparities in health and birth outcomes for Black persons has necessary positive effects, such as the ability to produce data on the deleterious effects of anti-Blackness. However, discourses surrounding Black birthing persons can function to obfuscate the collective action undertaken by Black women and non-Black women of color. In this paper, I argue the hyper-focus on the *problems* Black pregnant/birthing persons face has at least four issues: (1) it encourages an ontological collapse wherein Black birthers are positioned as problems, rather than human beings facing problems; (2) obscures the collective action and care Black women undertake to support one another; (3) results in state solutions that rely on underpaid and volunteer labor of Black and non-Black women of color; and (4) focuses myopically on the time period of pregnancy and birthing for Black persons.

Introduction

Over the past two decades in the United States, medical researchers and activists groups, like Black Lives Matter, have documented the impact of social determinants—such as the environments in which people are born and live, access to educational resources and economic resources, and reliability of access to safety and security—on health, functioning, and quality of life (CDC 2018; Morgan 2018; WHO 2021; US Dept of Health and Human Services 2020). Furthermore, within scholarship that places epidemics, syndromes, and disabling experiences in nuanced and complex analytic and cultural contexts, there has been increasing recognition that anti-Black racism, discrimination, and mistreatment experienced by Black people in the US have distinct relationships to health outcomes, including those specific to the perinatal and postpartum periods for Black pregnant and birthing folks (Rapp 2019; Prather et al. 2016; Scott et al. 2019). Economic vulnerability, stress, and experiences of discrimination have

© The Author(s), 2024. Published by Cambridge University Press on behalf of Hypatia, a Nonprofit Corporation

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

been named as racism-related risk factors in maternal mortality and have been theorized to contribute to discrepancies in maternal mortality between Black and White pregnant and birthing folks in the US (Prather et al. 2016). Despite this evidence and the growing feminist scholarship on stratified reproduction, "mother-blame" discourses still prevail, in effect functioning to frame Black pregnant and birthing persons as individually responsible for what happens to them and their infants.

In light of the paradox of medicalization, whereby Black birthers and their infants face higher rates of intervention but a "crisis" in outcomes, Black feminist organizations—including Black Lives Matter (BLM), the Black Mamas Matter Alliance (BMMA), Black Women Birthing Justice (BWBJ), and Sistersong—have drawn political attention to the oppressive parameters of stratified reproduction that exist for pregnant people as they "birth while Black" under a white dominant medical system. In resisting (white) dominant narratives of individual responsibility and mother-blame, Black feminist organizations implicate the larger sociopolitical system that stratifies reproduction by hierarchically organizing reproductive health, fecundity, birth experiences, and child rearing according to anti-Black white supremacist capitalist patriarchal norms. Additionally, a stratified system of reproduction supports and rewards the maternity of some women (White, cisgender, heterosexual, non-disabled, etc.), while despising or outright outlawing the mothering work of others (Black/non-White, non-binary/trans, disabled, poor) (Rapp 2019). Women of African descent who have lived and are living in the US face specific forms of violence linked to their capacities for pregnancies and birth, which poses a specific kind of threat to white supremacy—namely the threat to populate the world with Black people (Roberts 1998; Ani 2015; Morgan 2018). Discursively and structurally, Black motherhood has been scrutinized, policed, and confined within a racist and sexist framework since the beginning of the Black African presence within the United States (Roberts 1998; Story 2018).

In response, Black feminist groups whose missions center reproductive justice have called for access to resources to aid in the support they provide. One version of state response, which I will be focusing on here, has been to allocate funds for doula support for pregnant, birthing, and postpartum persons accessing Medicaid benefits. Providing access to doula support during the perinatal and postpartum periods is an approach that national groups, like Sistersong, and local organizations, such as The Baltimore Doula Project, have performed independently over the last decade. Thus, the move to fund on the state and municipal levels a form of reproductive health care for which Black feminist organizations advocate is on the surface quite progressive. As doula support has been routinely linked to positive health outcomes and emotional well-being for pregnant/birthing persons and their infants, providing this option for pregnant and birthing persons accessing Medicaid resources appears to represent advancement. However, as I will consider in this paper, by funding doula projects states are able to circumvent the white supremacist US history that has stolen from Black folks their traditions, such as that of the granny/grand midwife, as well as the social and political accountability for creating and maintaining anti-Black systems that make Black folks sicker and more prone to premature death in the first place while pregnant and birthing, or not. Thus, while Black, feminist, and queer birth justice organizations like Sistersong and The Baltimore Doula Project have revolutionary potential, their projects can become co-opted through state intervention. Furthermore, birthing and postpartum doula support aligns with reproductive justice pursuits only when connected to an entire spectrum of reproductive, economic, social, physical, and emotional health resources and options. For states, relying on doulas as the solution to Black maternal

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

and infant mortality is the cheapest solution that enables states and a (white) medical system to avoid systemic overhaul.

Nevertheless, attention to the disparities in health and birth outcomes can arguably have positive effects, such as the ability to produce further data on the deleterious effects of anti-Blackness, evidence routinely viewed as "hard" rather than "soft," that can function as a form of technology for anti-racist actors (Ahmed 2012). However, discourses surrounding Black births and Black birthing persons in the US today can function to obscure the collective action undertaken by Black women and non-Black women of color as organizers, para-professional medical providers, and caregivers. As it is empirically sound to focus on positive experiences with pregnancy and birth for Black, Indigenous, and people of color (BIPOC) folks to ground consideration of what resources and practices may be employed to further good outcomes,[1] methodologically I will avoid as much as possible restating disparities in maternal and infant mortality. The goal here is to avoid reinforcing the crisis rhetoric I problematize in this paper. In fact, I argue the hyper-focus on the problems Black pregnant/birthing persons face within a white supremacist system can have at least four problematic effects: (1) it encourages an ontological collapse wherein Black women/mothers/birthers are positioned as the problem, rather than human beings who face problems; (2) obscures the collective action and care Black women undertake to support one another and to subvert the white supremacist dehumanization of Black pregnant and birthing persons; (3) has resulted and may continue to result in state solutions that rely primarily on the volunteer labor of other Black and non-Black women of color (WOCs); and (4) focuses myopically on the time period of pregnancy and birthing for Black persons. Importantly, I am not arguing that Sistersong, BMMA, The Baltimore Doula Project, and other like organizations grounded in principles of reproductive justice are the problems. Rather the problem lies with state interventions that do not fund the whole work of radical birth groups, that fail to take broad measures to address the multiple sources of anti-Blackness, and instead exploit WOC doulas to slightly modify discursive and material practices.

First, using the works of the Africana, existential, and phenomenology philosopher Lewis Gordon and Black feminist philosopher Alisa Bierra I consider the production of the Black mother as a political category. Gordon, following W. E. B. Dubois and Franz Fanon, argues Blackness is hermeneutical, it is not merely a designation of the state of being melanated, and must be studied on the level of the interpretive. Thus, researchers, academics, and policymakers are required to simultaneously investigate the problems Black people face while asking how the meaning of Blackness in white supremacist societies has effects on the process of studying as well as the assumptions and prescriptions that arise as a result of the sociohistory of the meaning of Blackness. Following Bierra I consider specifically effects Black women and other Black gender marginalized folks face existentially as the conceptual space for Black women survivors of violence—social, medical, domestic, sexual, etc.—in anti-Black worlds is obscured and erased. Bierra (2014) theorizes about the kinds of agentic actions that oppressed peoples engage to resist, transform, and subvert the dispossession and misrepresentation of intentional action they experience. Thus, despite the dehumanizing effects of anti-Black racism on the levels of systems, institutions, and the interpersonal, Black folks, including pregnant and birthing folks, still express agency. And though agency may be misread and misinterpreted through frameworks of anti-Blackness, it reveals Black pregnant persons as subjects that face problems rather than problems themselves. In the absence of the considerations made in this paper, researchers and policymakers are likely to reproduce

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

the ontological collapse of Blackness/Black people as problematic and make recommendations that do not address fully, if at all, the problems Black people face from white supremacy. Such circumstances leave Black pregnant and birthing folks able to express agency individually, through what Bierra refers to as "insurgent" means, but rarely collectively (2014).

In the following section, I focus on the ways the collective action of Black women is obscured through "crisis rhetoric" or "alarmist framings" deployed by popular news outlets, academic journals, and institutional bodies (Berlant 2007). Using Jennifer Nash's (2019) influential argument that focuses on Chicago, I expand upon her analysis of the rhetorical investment in Black infant and maternal health by looking at my home town of Baltimore, Maryland. In her work, Nash convincingly shows that when doulas are used to mitigate the crisis Black pregnant and birthing persons face, the Black maternal body itself becomes further tied to crisis as a space in need of remediation and repair (2019). Thus, even as women of color doulas seek to perform community work rooted in African philosophical traditions of respect for the maternal figure and the whole-ness of self and community, politically they participate in the rendering of the Black maternal figure, differentiated from the White maternal figure, as in need of state intervention, remediation, and repair (Ani 2015; Nash 2019). Relatedly, Sara Ahmed (2012) considers how the paths that "diverse" persons, including diversity workers, open up rely upon protecting against the ontological collapse of the diversity worker, and the persons for whom she works, and the being of a problem. In order not to become problems themselves diversity and equity workers have to appear to "fit" with and within the institutions they are working for. Notably, the fact they are there to perform the work of diversity and equity indicates they are both needed and yet do not fit with the institution as currently constituted (Ahmed 2012). The diversity worker must seek to open up potential pathways for their work by functioning as a translator who switches between different forms of appeal for their cause (Ahmed 2012). Applying Ahmed's analysis to the case of doula support care for Black pregnant and birthing folks, we should ask why this specific approach has gained in popular support and how doula support "fits" already with state discourses and practices.

In the final section, I consider current responses to the "crisis" of Black pregnant and birthing folks by the Maryland General Assembly in their move to fund a doula pilot program. Like New York, Illinois, and California, the state of Maryland has convened a Maternal Mortality Review Committee to document the state of maternal and infant mortality across the state. In response to both the findings of the Maryland Maternal Mortality Review and the advocacy by local feminist groups such as The Baltimore Doula Project, the Reproductive Health Equity Alliance of Maryland (RHEAM) and NARAL Maryland, the Maryland State Assembly has passed SB 163. This bill establishes a doula pilot program to provide doula services to pregnant and postpartum people who access Medicaid resources in three jurisdictions: Baltimore City, and Charles and Prince George's counties. While the expansion of Medicaid to include doula care as part of reproductive healthcare services appears promising on the surface, the program described in SB 163 has several problems when examined through the intersectional frameworks of feminist and critical race theories. First, the bill requires the professionalization of doulas by requiring state certification of individual doulas, which many reproductive justice organizations worry will limit the number of low-income, low-wealth, women of color (Black and non-Black) from participating. Second, the Medicaid reimbursement allowances are not set at market rates. In the greater Baltimore area, the median price for standard doula care—which

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

includes two perinatal visits, labor and delivery support, and one to two postpartum visits—ranges from $1200 to $1500. SB 163, by contrast, sets the reimbursement at $600. Finally, feminist and anti-racist organizations and for-profit doula companies are concerned about the increasing of state intervention in Black reproductive health. Historically, radical birth work aimed at decolonizing birth has not been enabled through the intervention of the state, but rather has occurred in response to and through subverting state discourses, laws, and practices (Davis 1981; Roberts 1998; Craven 2010).

Preventing ontological collapse: Black mothers are not problems

Academics, activists, state reports, and popular news outlets have produced an alarming and arguably alarmist picture of how medical racism affects specifically Black women's/birthers' health and Black infant prematurity and mortality (Roberts 1998; Hoberman 2012; Villarosa 2018; Suarez 2020). Breaking with the tradition of framing Black parenthood and especially Black motherhood as pathological, recent analysis describes these discrepancies in outcomes and the "loss of Black babies" as products of medical apartheid[2] (Roberts 1998; Nash 2019), where medical apartheid is defined as the systemic oppression and exclusion of Black folks from a white dominant healthcare system (Washington 2007). Black mothers in these emerging contemporary analyses are not explicitly blamed, rather medical racism, defined as "the ideas and practices that perpetuate racial hierarchies and compromise one's health or facilitate vulnerability to premature illness or death," is centered (Davis 2019).

By the measures of the analysis that follows, the moves to name, understand, theorize about, and collect data, both quantitative and qualitative, about the multiple and intersecting effects of medical racism and medical apartheid are necessary. Nevertheless, taking medical racism seriously has not insulated against the ontological collapse of the problems Black pregnant and birthing folks experience with the status of being problematic people. Part of this results from the fact that, in repeating the statistics on discrepancies in birthing/birth outcomes between White and Black folks, Black women especially become yoked to the problems they face and reduced to problems themselves. This of course is not Black women's fault. Rather, the reduction occurs amid an anti-Black racist discursive framework that defines Black subjects' actions, intentions, and desires away from them (Bierra 2014). To begin to understand how and why this ontological collapse remains, I suggest we turn to Lewis Gordon's considerations of the work of W. E. B. Du Bois and Franz Fanon before moving on to a contemporary Black feminist analysis of agency provided by Alisa Bierra (2014).

As Gordon notes (2000), the problem of a problematized people can be understood in existential and phenomenological terms whereby the spirit of seriousness dominates a people's understanding of themselves and others. The spirit of seriousness emerges when the divide between values and the material world collapses. In such cases, the material world itself becomes a cause of values and values become a cause of the material world. Objects, including people, do not merely signify or suggest a particular value or meaning, but rather they become those values or meanings. Gordon writes,

> In cases of a problematic people, the result is straightforward: they cease to be people who might face, signify, or be associated with a set of problems. They become those problems. Thus a problematic people do not signify crime, licentiousness, and other social pathologies; they under such a view, *are* crime, licentiousness, and other social pathologies. (2000, 271, emphasis mine)

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

In the case of Black pregnant and birthing people, although there has been a shift in emphasis and language, the being of Black pregnant people as problematic is still observable. Take, for example, the language describing Black families on the About Us page for Baltimore Healthy Start, one of 15 federally funded Healthy Start programs across the US meant to address disparities in perinatal health and infant mortality. It reads:

> Baltimore Healthy Start families frequently struggle to meet their most basic needs. More than one-third (33%) of the predominantly (98%) African-American residents in the Baltimore Healthy Start, Inc.'s targeted community live in poverty and more than half did not graduate high school. Choosing between paying rent and purchasing diapers is an everyday challenge for our families. (BHS n.d. https://baltimorehealthystart.org/)

The language on the About Us webpage references the "family," which takes on a gendered framework when juxtaposed with the language on other pages such the BHS Story webpage. On these pages, the language explicitly references "new mothers," "maternal life," and "women," stating that BHS recruiters "meet women at their doorsteps and enroll them in a program that provides support through all stages of their maternal life" (BHS n.d.). Thus, it may be the Black/African American family that "lives in poverty" and Black/African American residents that "did not graduate high school" and must "choose" between diapers and rent, but it is through "supporting" (predominantly Black) women as mothers that (Black) babies will be saved. This slippage between terms is significant, as we will see, for though it avoids perspicuous reference to the pathological, dangerous, Black mother figure, the Black family still needs to be saved from itself through intervention at the source of the family problem, i.e., the mother.

Historically, Gordon argues, racialized peoples (i.e. non-whites) tended to be studied in terms of phylogenic or ontogenic considerations, rather than the complexities of social life as a mediating factor (2000). The phylogenic centers species' differences where debate and analysis historically took the form of considering whether Black people were members of the human species. The ontogenic, while not necessarily beginning from the projected lack of humanity of the studied group, reduces its focus to the individual organism that works or fails (Gordon 2000). Black feminist philosopher Alisa Bierra allows us to expand upon Gordon's argument by considering the social dimension of agency and process by which intentions of marginalized folks are socially authored by others' translations and assumptions. Black agents' intentions are socially authored, Bierra argues, through the organizing principles of anti-Black racism, which leads to Black agents' experiences, actions, and intentions being not just "misunderstood" but written away from Black agents themselves and fundamentally altered and corrupted in the process to serve the logos of white supremacy (2014, 131). Black women, Bierra notes, are defined as "criminal, untrustworthy, and pathological" within an anti-Black racist and sexist society that functions as a "silent resource used by other agents to discern what Black women agents really mean" (2014, 133). Additionally, Black women face what Bierra refers to as "institutionally authorized displacement" as their intentions and self-definitions are socially erased by institutional actors such as police officers, medical doctors, hospital staff, educators, social workers, and so forth (2014, 133).

The language employed by organizations like BHS whose self-described goals include "reducing the Baltimore infant mortality rate" and "reducing the disparities in infant mortality between Black and White families" does not approach the study

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

of Black people in terms of the phylogenic, but does function as an ontogenic reduction. In other words, while appearing to take seriously the problem of maternal and infant mortality Black families face, the solutions offered by organizations like BHS reduce the meaning of working and failing to the organism—in this case the Black pregnant/birthing person—themselves. The fact that outreach is individual and that references to "community" or the "social" are relatively limited in their scope and history should lead one to question whether Black mother-blame has truly been eliminated from the collective cultural framing and whether it fits with the community-centered conception of birth work from which many women of color doulas expressly operate (Nash 2021). Federally funded initiatives to "fix" and "save" Black pregnant persons and their families through the utilization of intervention services generally do not consider the ways white supremacy as a social order mediates the ontogenic. Instead, they tend toward collapsing the social conditions of being (Black) "poor," "non-high school graduates," who make choices between "rent and diapers," into the being of problematic people. Furthermore, as Bierra clearly argues, even amid the breakdown of plans marginalized folks make decisive choices throughout, adapting and improvising to respond to shifting circumstances, revealing in the process their agency that has always existed, but written away from them (2014). Thus, for Bierra, scholars, politicians, and organizations dedicated to the well-being of marginalized folks should ask not *if* or *whether* marginalized Black pregnant and birthing folks can be agents withing the contradiction of ongoing oppression and resistance, but *how* they can be and what kind of measures support *how* they are agents (2014).

Notably, BHS is not the only government-funded organization serving the Baltimore area that engages in producing this collapse. B'more for Healthy Babies (BHB), an organization promoted on Baltimore City Health Department website, is described in the following way: "BHB is an innovative initiative to reduce infant mortality in Baltimore City through programs emphasizing policy change, service improvements, community mobilization, and behavior change" (n.d.). Scrolling down the webpage, one finds ten specific initiatives of focus. While the introductory description of the initiative appears relatively balanced,[3] seven out of ten of the specific programs center on what may be described as "behavior change," including: B'more Fit For Healthy Babies, which is a Weight Watchers program, Preventing Substance Exposed Pregnancies, and the Teen Pregnancy Prevention Initiative. The implications expressed by the specific kinds of programs offered are that (Black) mothers/parents are the problems. Namely, they aren't at a "healthy" weight, they suffer from substance abuse and thus put their babies at risk, and/or they are teenagers. Seeking to address individual behaviors as the basis for health outcomes, without express analysis of structural oppression and its effects, can lead to stigmatization, scapegoating, heightened surveillance, and criminalization, all of which reinforce the oppression of pregnant people (Richardson et al. 2014; McLemore 2018; Scott et al. 2019). Blaming Black women for poor reproductive health outcomes obscures, and at times out right ignores, the circumstances of pregnant persons as they seek to maintain health, become pregnant, and safely give birth (Scott et al. 2019). Or, in Bierra's words, such discourses and practices overwrite the intentions of Black pregnant and birthing folks with white supremacist social authoring of Black femininity, making them the perpetuators or cause of infant and maternal mortality rather than victims of the anti-Black systemic violences (2014).

Furthermore, to disrupt the discursive and material obscuring of the experiences of Black women, the effects of explicit and implicit mother-blame on Black pregnant and birthing persons themselves must also be considered. In his ascendent work on Franz

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

Fanon, *What Fanon Said* (2015), Gordon argues that Black subjects in white supremacist, colonial worlds experience failure through investment in the seriousness of racialized categories as categories of being and meaning. Importantly, the *seriousness* of blackness on the level of the interpretive is not restricted merely to how non-Black people understand Black people. Rather, following Fanon, Gordon claims, "that the Black encounters himself or herself as the sources of failure wherever failure is manifested" (Gordon 2015, 71). Failure becomes in this instance not merely the act of failing, for example, failing an exam, or failing to win the soccer match, both which have sources that are not reduced to the pathology of the subject. Bierra makes a related point, though does not read the collapse of agency as absolute, in the way Fanon at times tends toward. Bierra, in focusing on not whether, but *how* marginalized folks express agency, argues that a heterogeneous model of agency enables one to account for agencies as they are positioned within the context of institutional power (2014). Instead of understanding dominant group members who act against marginalized folks as having successful agency, they are better understood as being able to exercise hegemonic agency. Similarly, instead of terming marginalized folks as "lacking" agency when dominant groups negatively affect them, we would be better off seeking to understand how marginalized folks deploy agency. Thus, beginning from this basic shift in framing, the two central forms of agency Bierra (2014) concentrates upon are transformative agency and insurgent agency. Transformative agency, Bierra writes, "endeavors to challenge the structural and hermeneutic conditions that facilitate the displacement of some agents and the distortion of their actions" and insurgent agency "is employed by subjects who intentionally act in unstable and precarious" to craft provisional and makeshift "practices of opposition that subvert, but still remain defined by, conditions of power" (2014, 140–41). Transformative agency enacted by marginalized folks is often met with state violence and even those actions that exist within the boundaries of codified law become vulnerable to criminalization (such as the punishing of pregnant folks who miscarry or seek abortion care) (Davis 1981; Roberts 1998). While fuller consideration of *how* the agency of Black pregnant and birthing folks, and the Black feminist organizations that seek to render them visible, is expressed exists beyond the scope of my project here, it is important to note that the intentions and actions of marginalized actors are heterogeneous, rather than binary. Such considerations will become important in my description and analysis of my interviews with doulas working in Baltimore amid the passage of Maryland SB 163.

In the next section, I consider Jennifer Nash's argument that doulas, even women of color doulas, play a role in producing the Black maternal body as a symbol—arguably *the* symbol—for the deathly work found in the intersections of anti-Blackness and misogyny (Collins 1995; Roberts 1998; Morgan 2018; Story 2018; Nash 2019). By yoking Black motherhood itself to trauma, injury, and precarity a further ontological collapse is encouraged between Black motherhood and the being of a crisis.

Obscuring the activism and community work of Black radical birth workers

Black doula and midwifery care is not new and is linked to the Black practice of "othermothering"—where Black women assist blood mothers or bio-mothers by sharing mothering responsibilities (Collins 1995). However, anti-Black racist laws and practices shifted the provisions of care available to Black pregnant and birthing persons by marginalizing Black midwives and doulas (Suarez 2020). During the colonial and antebellum periods in the United States, all women practiced various forms of "social

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

childbirthing" (Wertz and Wertz, 1977; Craven 2010; Suarez 2020). Throughout the US across racialized and class identities birthing was a community practice where friends and family, most of whom were women, supported birthing persons. And while White wealthy women often hired a midwife to assist with childbirth, it was nevertheless still a social rather than medically centered enterprise. In the Deep South, Black enslaved women supported the birthing process of other Black enslaved women, but were also required to support White plantation slaver mistresses as they birthed. In the North, White birthers were often supported by immigrant midwives and doulas who brought their own forms of knowledge and specialized care (Craven 2010). Black midwives, long known as "granny" or "grand" midwives, brought their traditions, birthing practices, and philosophies from West Africa, leading to a healing culture in the "New World" that brought respect and humanity to Black people (Ani 2015). Granny/grand midwives did far more than passively "catch babies." They acted as dietitians, psychologists, loan officers, sex therapists, prayer partners, marriage counselors, and friends to the women whose births they supported (Craven 2010). Furthermore, due to their esteemed positions as birthing experts and the fact that they moved between Black and White communities, they were able to serve abolitionist and social justice causes (Bonaparte 2016). By tracing this radical history of Black midwifery, we see the logic of contemporary feminist, critical race, queer theorists, and radical birth activists in their advocacy for greater access to doula and midwifery care for Black birthing people. That said, the intentions of said scholars and reproductive justice activists as they point to this history are often lost as legislative bodies in the US turn recommendations into policy.

For one, as Jennifer Nash (2019) argues, the birth work of Black doulas, who most closely represent the historical positionality of grand/granny midwives due to their paraprofessional status, is ambiguous. The labor of women of color doulas interrupts the "crisis" facing Black pregnant and birthing people, while simultaneously yoking the Black maternal body to suffering, recreating in effect the notion of Black maternal bodies as the source of the "crisis" (Nash 2019). Nash writes, "Doulas make 'Black mother' into a political category that stands in for woundedness, much as the state presumes 'Black mothers' (and Black women more generally) are injured subjects, with the wound becoming the only way that Black women, and Black mothers specifically, come into political view" (2019, 46). This production of the political signification of the Black mother is notably not new. Rayna Rapp and Faye Ginsburg in their collaborative projects have shown how the categories of "problematic reproduction" and "problematic reproducers" have played increasingly important roles in choreographing normality and abnormality within a system of reproductive stratification (Ginsburg and Rapp 1991, 1995; Rapp 2019; Rapp and Ginsburg 2011). The labor of women of color doulas, then, serves at least two functions: to aid in birthing and to make visible Black mothers' suffering—a suffering which then further makes necessary the work of WOC doulas by signifying Black pregnant and birthing folks as abnormal/problematic reproducers. Nash continues:

> Put differently, WOC doulas make the case that Black mothers need bodyguards in the space of the hospital as a tool of crisis mitigation. WOC doulas' important care work, then can secure the idea of Black women's bodies as in need of reform, rather than radically rejecting the myriad ways Black women's bodies are called upon to symbolize and meaning-make, including in this moment where Black maternal bodies are rhetorically gestured to as evidence of the unmattering of Black life. (2019, 46)

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

Nash's self-defined purpose is not criticize the labor of doulas, but rather to reveal the paradoxes present as the state intervenes to utilize and define the labor of doulas. And her point here is an important one, for even if women of color doulas replace White medical professionals and White folks generally as those "saving" Black women/pregnant and birthing persons, the fact of the "neediness" and "lack" of Blackness remains or, in Rapp and Ginsburg's language, Black pregnant and birthing folks are reproduced as abnormal or undesirable birthers who have to be saved by others (Ginsburg and Rapp 1991, 1995; Rapp 2019; Rapp and Ginsburg 2011). Reproducing Blackness as a site of abnormal birthing and Black folks as undesirable as birthers happens despite the intentions of individual WOC doulas who often come to doula work because of their own negative experiences with "birthing while Black" and see their work as a means through which to serve Black women in community (Nash 2019; Suarez 2020). Furthermore, the positive actions that WOC doulas and organizations like Sistersong and Black Mamas Matter Alliance (BMMA), among others, take can still function to render the Black maternal body as problematic even as they use language that differs from the state organizations and initiatives mentioned in the previous section.[4] This, of course, does not result from the individual actions of doulas or from reproductive justice organizations, but rather from the ideological framing of Blackness as lack and Black motherhood as undesirable within an anti-Black society. The question remains, then, how can academics, activists, and state actors best offer solutions to the problems Black pregnant and birthing persons face, without rendering them as problematic and without limiting the concentration of care, for Black women especially, to the space of pregnancy and the shortly defined postpartum period?

A second point that will become salient as we move to the final section of my analysis concerns the practical, rather than symbolic, paradoxes that arise as WOC doulas are called to perform "life-saving work." As individual states implement funding, often through pilot programs that enable reimbursements for doula care by Medicaid, doulas are required to undergo a process of professionalization (Nash 2019). Yet, it is professionalization itself and state laws that have required it that are responsible for the demonization and elimination of the tradition of Black grand midwives within a system of stratified reproduction (Rothman 1986; Craven 2010; Ehrenreich and English 2010; Bonaparte 2015). For example, with the specialization of obstetrics in the nineteenth century and the growing power of the American Medical Association, White men seeking to control birth began to push out midwives (Craven 2010; Bonaparte 2016; Suarez 2020). In 1921, with the passage of the Sheppard-Towner Maternity and Infancy Protection Act, which required midwives to be licensed and trained by (White) nurses, grand midwives were further disenfranchised (Craven 2010). There were other factors that contributed to the marginalization and elimination of the tradition of Black grand/granny midwives, including the fact that the NAACP and prominent Black intellectuals, like W. E. B. Du Bois, did not defend the traditions of Black midwifery and instead supported practices of hospital birthing (Suarez 2020). Additionally, midwives were criticized during this time as "criminals" who performed abortions (Craven 2010). And while it was true that some midwives performed abortions, this highlighting of the "criminality" of midwives allowed for the downplaying of the fact that physicians also provided abortion as medical care and in order to discredit midwives and encourage women to move from their care to that of obstetrics (Craven 2010). The Sheppard-Towner Act had two additional effects that are important to my analysis here. First, the Sheppard-Towner Act had the effect of opening up the homes of low-

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

income, low-wealth families to increased government scrutiny and intervention in childbirth and care which, in conjunction with the growing development of IQ tests, functioned to reinforce dominant discourses within a stratified system of reproduction about desirable birthers and undesirable birthers (Craven 2010). Second, it undermined local, community respect for elderly "granny/grand" midwives—who used insurgent practices to sabotage the medical management of the bodies of pregnant and birthing folks—by favoring and certifying younger midwives who in Craven's words "were perceived by government and medical officials as being more compliant with federal and local mandates" (2010, 37).

Thus, when the return to midwifery reemerged in the 1970s it was effectively whitened (Suarez 2020). As White women were becoming disillusioned with medicalized birthing practice and the Women's Liberation Movement was emphasizing the need for women to reclaim their bodies from men and patriarchal systems of power, the return of midwifery and doula support materialized (Craven 2010). In response to the reemergence of a generally White midwifery community, states such as Arizona, Texas, and California began to licence midwives and require licensures for midwives. Other states, like North Carolina, passed outright bans on midwives attending as the primary provider in home births. In 1994, the North American Registry of Midwives was formed which led to the creation of the CPM credential. While credentialing enabled legitimacy and legislative efforts, the requirements which included education credits, formalized written tests, and attendance at a certain number of births alienated Black midwives especially (Davis 2019; Suarez 2020). Furthermore, the central certifying bodies did not offer coursework or training that focused on racial and ethnic reproductive justice, which left the emerging tradition of midwifery disconnected from the roots in African philosophy and radical Black liberation/justice pursuits. Today, over 90 percent of midwives are White, with just 6 percent self-identifying as Black (Serbin and Donnelly 2016). Thus, Nash's concerns, and the concerns of doulas she interviews which lead her to this conclusion, are rooted in a sociohistorical analysis of the professionalization of midwives in the US. In the next section, I will expand upon this concern by looking specifically at reservations the director of The Baltimore Doula Project and the owner of DC Metro Maternity expressed in my interviews with them, coupled with a consideration of the language of a recent bill (SB 163) passed by the Maryland General Assembly.

But, first, to support the ambivalence Nash notes in her analysis, I suggest we turn to Sara Ahmed's work. Ahmed (2012) analyzes the myriad ways diversity, equity, inclusion, and anti-racism work produce paradoxes and impasses for persons doing the work and those framed as the beneficiaries of said work. One such paradox is that diversity workers are brought into an institution because it is framed as needing them to become more diverse (or at the very least appear diverse). However, for Diversity, Equity, and Inclusion (DEI) and anti-racist workers to do the work they seek to do, they have to already "fit" within the institution. The language of diversity and the work of diversity workers becomes incorporated as official insofar as it is made consistent with organization's goals, and thus, Ahmed writes, "*can be* a way of maintaining rather than transforming existing organizational values" (2012, 57, emphasis original). Similarly, Ahmed considers moves of incorporation of DEI and anti-racist work/workers as functioning and/or producing slight modifications, arguing that a slight modification might be a way of protecting what goes on (i.e., racism, sexism, inequity, etc.) by obscuring what is ongoing (2012). Craven in her work makes a similar point about women's organizing around healthcare. Women's organizing efforts to change

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

healthcare, Craven argues, "can contest, but not usually fundamentally change existing power relationships between women, medicine and the state. Rather, women's resistance to dominant state and/or medical power reflects—and even at times reproduces—the uneven ways social control has been implemented among different groups of women" (2010, 38). Here one should ask what is obscured as ongoing through the incorporation, as part of the mission of the state, to improve maternal mortality, infant mortality, and birth outcome discrepancies for Black pregnant and birthing persons. Put differently, the central goals of institutions do not often include decolonization as this would radically shift the institution's being in a way that would constitute the un-making of the institution. Thus, institutions often seek to reform or to rebrand, which both are forms of slight modification that can at times be merely rhetorical, maintaining in effect the colonial and oppressive practices but with a happier façade.

Furthermore, while doula support is supported academically and in practice by activists, the notion that doula support alone will produce reproductive justice and the valuing of Black lives does not follow. It is notable, for example, that in Maryland the most radical doula support organizations offering a full-range of doula support, such as abortion doulas, birthing doulas, and doula support for incarcerated folks, have not received state funding to engage in the work of "saving (Black) women and infants" (C. Sothoron, personal interview, June 14, 2021). The recognition of the dominant politics around pregnant and birthing folks has led for-profit doulas to "hide" or "decenter" the work of abortion and loss support offered by their companies on their websites (S. Griffin, personal interview, December 29, 2021). Birthing and postpartum doula support aligns with reproductive justice pursuits only when connected to an entire spectrum of reproductive, economic, social, physical, and emotional health and well-being, but organizations that offer this, perhaps, do not offer the kind of "saving" the state desires for Black women. Furthermore, the move to link the health and well-being of Black mothers and infants to the health and well-being of Black communities more generally can be traced not only to a history of exploitation, but positively to African traditions in philosophy, traditions that are often obscured in order to reproduce Blackness as lack, absence, and as lacking positive cultural history (Ani 2015).

Finally, Ahmed's claim that "professionalization creates new bodies" connects to Nash's concerns about what is lost in professionalization. As Ahmed notes, diversity workers are encouraged and often required to use the terms and values that are already highly regarded within a given institution (2012). Thus, diversity work loses some of the radical connections and associations with liberation philosophies in order to position its goals as aligning with the words and practices already occupying the institution. In terms of birth practices, from qualitative ethnographic work, such as that performed by Nash (2019, 2021), we know Black birth workers differ from White birth workers in seeing their profession as being dual-pronged: (1) saving individual lives and (2) performing the work of social justice by addressing structural racialized/racist health disparities (Hall 2019; Suarez 2020). However, like professionalization of midwives during the twentieth century in the US, which erased the history of Black granny/grand midwives and effectively whitened the midwifery, the professionalization of doulas will likely have the same effects. In the end, the concern is to what extent will the state's intervention produce language and goals that reinforce the White Supremacist state, rather than producing policy that recognizes and support the work that Black women have performed to support one another in community in spite of and in order to subvert white supremacy.

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

Birth work in Maryland: The Baltimore Doula Project and DC Metro Maternity

In preparation for this analysis, I interviewed two doulas who perform similar work, for similar reasons, but in different circumstances. First, I interviewed the director of the non-profit organization The Baltimore Doula Project, Carling Sothoron, who is White and queer-identified, and who provides services for primarily low-income, low-wealth folks of color and queer folks of multiple racial identities. Second, I interviewed the owner of DC Metro Maternity, Samantha Griffin, a self-identified Black woman who comes to doula work with previous experience in the non-profit sector, but who over the past few years has chosen to move into for-profit doula service. Additionally, I analyzed the language of Maryland State Bill 163 which approved a doula pilot program, as well as other bills like it such as Code of the District of Columbia 3-206.72, on reimbursement for doula services, and California State Bill 65, the California Momnibus Act.[5]

Sothoron provided a history of The Baltimore Doula Project, an overview of the work they do, as well as concerns she has about the professionalization of doula care, and the underpayment of doulas as states seek to use doula care to remedy birth disparities between White and Black pregnant/birthing folks. Similarly, Griffin, provided a history of her entry into doula work and her decision to move into for-profit doula work. Griffin shared all the concerns Sothoron raised, but additionally named labor problems that are entailed within the logic of these bills. Doulas, Griffin noted, are expected to fix racism, patriarchy, and the stress that Black pregnant folks face through their individual work with clients over a period of nine to twelve months, which is unrealistic and burdensome for doulas of color (S. Griffin, personal interview, December 2021).

Briefly, the evidence for doula care in reducing medical interventions and producing "good" birth outcomes is convincing. There have been 26 randomized controlled studies showing that birthing persons using continuous labor support, like that provided by a doula, are more likely to have normal vaginal births and are less likely to have pain medication, Cesareans, and negative birthing experiences (Bohren et al. 2017). In addition, their labors are shorter, and their babies are less likely to experience complications or spend time in the Neonatal Intensive Care Unit (NICU) (Jordan 2013). Doulas also have a deep respect for the body's inherent knowledge and self-determination, which can function as affirming for pregnant and birthing people faced with discrimination, medicalization, and disrespect. Doula care can be part of a comprehensive approach to pregnancy and birthing, such as is advocated for by respected doula advocate, creator of the JJWay©, and founder of Commonsense Childbirth, Jennie Joseph. In the National Perinatal Task Force (NPTF) report, co-authored by Joseph, Haile Eshe Cole, and Paula X. Rojas (2018), the following recommendations are made to states and organizations to increase positive birth experiences and outcomes for pregnant and birthing folks:

(1) Healthcare providers must participate in anti-oppression cultural and historical training that shifts from the individualistic nature of "cultural competency" to the systemic and institutional analysis of "structural competency" or "equity competency."
(2) There must be implemented a "prenatal care plus" model to address critical social and economic concerns and incorporate "safety-net services" in every care model.
(3) There must be support for the development of community-owned and -created Perinatal Safe Spots.

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

(4) Public funding (city and state level) should be devoted to community-based programs.
(5) There must be increased efforts to remedy social inequities broadly.

Notably, the recommendations made by the NPTF are comprehensive, pointing to the systemic and extended over time effects of anti-Black racism and social inequities broadly construed. Additionally, there is a recognition in Joseph's work, both with the NPTF and her organization, that all pregnant folks who desire to maintain their pregnancies want the same thing: healthy babies and positive pregnancy and birthing experiences. Thus, what state and healthcare actors should engage according to this model are efforts to fund community practices that are empowering, anti-oppressive, based in structural/equity competency, and increase health and well-being over time. And while the doulas who work for DC Metro Maternity and who work[6] and volunteer for The Baltimore Birthing Project are all trained in care-based methods that are trauma-informed, this is not the standard, nor is it required by SB 163 (C. Sothoron, personal interview, June 2021; S. Griffin, personal interview, December 2021).

Notably, there are limitations to currently existing studies on the efficacy of doula care in terms of the population studied. Almost all of the study participants are White cisgender women birthers, who are middle/upper-middle class, married, and able-bodied. The expectation then—and what is supported by the evidence from organizations like Common Sense Childbirth, The Baltimore Birthing Project, and DC Metro Maternity—is that doulas will serve as advocates and help to prevent the escalation of outcomes (Ani 2015; Hall 2019; Nash 2019). That said, it is stretching the limits of the work that doulas can legitimately perform to imply that they can rectify the leading causes of hemorrhage deaths and homicide of pregnant people, let alone racism, intimate partner violence, and economic inequity (Nash 2019, 2021). In fact, what data from the Maryland Maternal Mortality Review make clear is that pregnancy-related deaths are complicated and not linked merely to individual decisions and behaviors of pregnant people. While the state of Maryland hasn't explicitly claimed doulas can perform this deeper societal work, the Maryland General Assembly on March 19th, 2021 passed SB 163, establishing the Maryland Medical Assistance Program Doula Pilot Program in response to and as a solution to "disproportionate rates of maternal mortality" between White and BIPOC birthers as found by the Maryland Maternal Mortality Review Committee.

During our interview, Sothoron expressed several concerns she has with recent legislation passed in other states and noted that one of the goals of The Baltimore Birth Project is "to not pass terrible legislation" around doula care. Of her concerns, the two most notable are (1) legislation can create a centralized regulatory system for doulas, making doula work less accessible for low-income, Black and non-Black people of color, and queer folks; and (2) Medicaid reimbursements are very low and do not allow doulas to make a living wage (C. Sothoron, personal interview, June 2021). Griffin additionally noted that there are never discussions of doulas as possible salaried workers (S. Griffin, personal interview, December 2021). Both Sothoron and Griffin are, by the measures of this analysis, right to be concerned. For one, Maryland SB 163 expressly requires doulas be certified by one of four major certifying bodies (DoNA, the International Childbirth Education Association, the Association of Labor Assistants and Childbirth Educators, or the Childbirth and Postpartum Professional Association) and by the Maryland Department of health to provide health care services to Medicaid recipients (2021). This means doulas trained and independently certified

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

by national and international, Black-led associations, that explicitly adhere to philosophies of reproductive justice care and birthing justice, like the National Black Doula Association and Ancient Song Doula, are not eligible to participate. As Nash writes, "Standardization undermines the field's paraprofessionalism, which for the doulas I described, constitutes the radical promise of the field, its capacity to labor in medical spaces while subverting medical logics, its insistence that physical pain can be responded to with pressure points, rebozos, and breathing together" (2019, 38).

The second issue is that the Medicaid reimbursement in Maryland is up to $600; $360 for birth attendance and $30 for each prenatal and postpartum visit (SB 163, 2021). By comparison, the average rate for doula care in the Baltimore-DC metro area is $1200–$1500 (C. Sothoron, personal interview, June 2021). This is not unique to Maryland, but other states, such as California, have responded to this discrepancy by passing legislation that reimburses doula care up to $2000 (AB-2258 Doula care: Medi-Cal program pilot, 2020). What is unique to Maryland is that the pilot program trains doulas to become both "independent contractors" committed to racial justice and key symbols of the state's investment in Black maternal health and Black communities (Nash 2021). Nevertheless, as Nash theorizes and I want to further suggest, this discrepancy can be understood as purposeful. Black and non-Black women's dual-pronged "calling" to serve individual Black pregnant and birthing persons and the cause of social justice can be and is perhaps being used to underpay Black and non-Black women of color doulas (Nash 2019). The doulas Nash interviewed were almost all working other jobs, often times in other forms of low-paid care work like childcare, or had to take on wealthy, White clients to be able to survive (Nash 2019). At The Baltimore Birthing Project, all of the doulas either had their own personal doula businesses outside of their work with the Project, worked in other fields like education full time, or were in graduate school (C. Sothoron, personal interview, June 2021). While it is not necessarily uncommon for people in a variety of industries to have side jobs, the exploitation of women of color doulas, which appears to be happening here, is different. For one, it is requiring the labor of folks who have been effectively erased from the history of (positive) birthing practices in the US and had high-esteemed positions, like that of the grand/granny midwife, eliminated. Second, in the US where Black and non-Black women of color have been demonized for not working hard enough or being "good enough" to produce thriving families and communities, it is morally repugnant to then not adequately fund the support women of color provide to one another. Finally, a real consequence of the current exploitation of women of color doulas, coupled with the move by states to professionalize doulas, may be a reduction in the numbers of women of color doulas. Such consequences function to obscure yet again the community activism and birth work of women of color, in which especially Black women engage. For these reasons, among others, Griffin, the founder of DC Metro Maternity, opted to move away from serving low-income women of color and operate, for now, at full-market rate for services (S. Griffin, personal interview, December 2021). This means she is today serving primarily BIPOC women who are upper-middle class, and some White upper-middle class queer folks. But it is a choice she has made to sustain financially and emotionally her ability to do the work of pregnancy and labor support (S. Griffin, personal interview, December 2021). Griffin in expressing this noted that her for-profit approach to pregnancy and birthing work has led others to deem her "a capitalist," thus placing her counter to the value of "community" in which doulas who volunteer or work for lower rates frame themselves as participating. However, to dismiss Griffin because she performs doula work for profit obscures the nuanced

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

negotiations she performs to "sustain" her work—and her employees—as well the intersecting racist, sexist, and classist histories and systems, for which Griffin and other women of color doulas are not responsible. Furthermore, such dismissals fail to account for the kinds of insurgent agency that Griffin and her employees perform. One such example Griffin provided was of the actions she has to take in order to keep her birthers "as mentally safe" as possible. Sometimes, Griffin noted, it isn't best for the birthing client for the doula to confront or call out racism being encountered. Redirecting or obscuring racism can be what is best for the client. Thus, Griffin is not seeking in these instances with her clients to transform a racist system, because that would be an impossible task in the moment. Yet, this does not mean that Griffin and her client lack agency, rather Griffin, and by extension the client who hires her, is engaging a form of insurgent agency by circumnavigating oppressive conditions to meet specific ends, the well-being of her client (Bierra 2014, 140).

Concluding remarks

My argument here is neither critical of the work that doulas perform, nor individual doulas who come to the work for a variety of reasons. My concerns, rather, center on what has happened and what is happening as states, counties, and cities decide to invest in doula pilot programs as the means through which they will seek to appear to care about Black pregnant and birthing folks and their children. State agencies, including schools, government health departments, and hospitals are organs within the structure of the nation's body politic and express through their various codes, standards, and programs the sustaining of that body politic (Ani 2015). Thus, without a consideration of the effects of white supremacy and patriarchy on the entire lived experience of Black pregnant and birthing persons, their children, their families, and their communities, the rhetoric of Black mother-blame and the ontological collapse it entails will remain.

The fact that states are collecting data on maternal and infant mortality and are having conversations that enable deeper considerations of reproductive justice suggests on the one hand there is space being made for the reconsiderations of the history of discourse and practices around pregnancy, abortion, birthing, and parenting. However, collecting data and having conversations about medical racism are not sufficient to decolonize birth or to create and maintain the conditions for reproductive justice for Black pregnant and birthing folks. As has been noted by scholars like Crista Craven, Dorothy Roberts, Rayna Rapp, and Faye Ginsburg (among others), state interventions and even dominant feminist and health activist movements have not produced the effect of decolonizing a stratified system of reproduction. Thus, following Bierra's lead we may be better situated if we ask: how can the multiple forms of agency of Black pregnant and birthing folks be enabled? What is necessary to enable the transformative agency of Black pregnant and birthing folks and birth workers, while maintaining the radical values of insurgent agency?

Importantly, if "terrible legislation" is passed by states and cities, then the likely results will include over-reliance on the volunteer or underpaid labor of other Black and non-Black women of color who as a result of their community ethos feel "called to this work." Thus, material and questions about whom labor serves follow. For example, as the state enters into the birth room by funding, albeit not well, the birth work of WOC doulas, we are led to ask who a doula in this case serves: is it her birthing client or the state that reimburses her for services? And what happens when the interests, which can be

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

multiple, of the birthing client and the state conflict? Many of these questions are beyond the scope of this analysis but are invariably related to my analysis in meaningful ways.

I will end with broad suggestions based on my assessment. First, if the history of the medicalization of Black pregnancy has disrupted community practices and displaced Black feminist philosophical frameworks, then de-medicalizing the pregnancy and birthing processes are good places to start. In the work of scholars, activists, and legislative bodies who have power to affect reproductive health care systems there must be consideration of the realities of paradoxical and multiple interests held by various actors and a centering of the expression of agency of marginalized birthers—queer, Black, low-income, low-wealth—to confront the discursive and material construction of desirable and undesirable reproducers. Second, if Medicaid restrictions and state restrictions/bans on midwives and doulas have limited birthing justice for Black women, then removing restrictions is necessary. Connected to this, state bills must be remove regulations that harm doulas belonging to marginalized classes such as those that require professionalization or enact low reimbursement rates. Finally, there must exist state and ultimately nation-state recognition of white supremacy and anti-blackness as the sources of medical inequities. To address the inequities that result, scholars and policymakers must consider the effects of white supremacy on the multiple facets of parenthood, while preserving the humanity and agency that has always existed despite oppression. White supremacist oppression dehumanizes and restrict options the oppressed, but the implications that Black pregnant and birthing folks must be saved because they lack positive traditions and capacities connected to pregnancy, birthing, and motherhood/parenthood is an inaccurate and dangerous representation.

Notes

1 See, e.g., the The JJ WAY®: Community-based Maternity Center Final Evaluation Report (2017) and The JJ WAY®:Reducing Perinatal Outcome Disparities: A Retrospective Matched Comparison Study on Birth Outcomes in At-Risk Populations by Day, Gordon, Dominguez, Martzen, and Josephs. Both concentrate on the positive outcomes of "at-risk" populations including, but not limited to Black women and low-income women: https://secureservercdn.net/198.71.233.33/f3b.e30.myftpupload.com/wp-content/uploads/2019/07/The-JJ-Way%C2%AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf.

2 The term medical apartheid is best explained in Washington (2007), in which she considers how diverse forms of racialized discrimination and oppression have shaped relationships between White physicians and Black patients as well as the attitudes of Black folks toward medicine generally.

3 This scholar would question the extent to which "behavior" and decisions generally are limited within an anti-Black racist, sexist, and classist world. Akin to the recommendation of financial literacy as the solution for low-income/low-wealth folks, the idea of "behavior change" solving structural issues of oppression and the negotiations that entail is at best mistaken and at worst dangerous.

4 For example, on SisterSong's website under "About Us" the organization describes itself "as an effective network of individuals and organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities" (n.d. https://www.sistersong.net/about-x2). The language here reinforces the systemic intersections of policies, dominant society, and reproductive politics that effect marginalized folks. However, on the "Birth Justice" webpage the main program offering is described as designed in response to the high maternal mortality rate for Black birthers that is especially marked during the postpartum period. The main Birth Justice programming is "designed to teach basic skills that monitor a pregnant person's health while birthing and postpartum. Highlighting the postpartum period which is when many maternal deaths occur. Understanding the simple neglect in hospitals is what's partially responsible for causing the epidemic of maternal deaths in BIPOC communities, it was clear these skills trainings could literally save lives."

5 Notably, California SB 65 is the most comprehensive of the three in that it creates a shared leadership working group, focuses not just on doulas as the primary solution but an aspect of more comprehensive

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

and equitable care, and focuses on/supports midwifery training which leads to the possibilities for salaried employment (California SB 65). Yet Maryland's State Bill tends to be more representative of the kinds of bills being passed in terms of both language and intended effects.

6 Ten of the doulas at The Baltimore Birth Project are paid for the work they perform as birth doulas. Abortion doulas and doulas that provide support to incarcerated folks during pregnancy and birth are volunteers. The Baltimore Birth Project, as it is committed to accessibility and justice, uses a sliding scale for payment for the work of birth doulas. Birth doulas are paid a flat rate of $1200 by The Baltimore Birth Project, some of which is funded by donations. If a family or pregnant/birthing person can afford to pay more than $1200, then the extra monies are placed into a fund to help pay doula support for families or pregnant and birthing folks who based on the sliding scale pay less. The leadership council, of which Sothoron is a part of, are all doulas and are all volunteers.

References

Ahmed, Sara. 2012. *On being included: Racism and diversity in institutional life*. Durham, NC: Duke University Press.

Ani, Amanishakate. 2015. C-Sections and racism: Cutting to the heart of the issue for black women and families. *Journal of African American Studies* 19: 343–61.

Berlant, Lauren. 2007. *Cruel optimism*. Durham, NC: Duke University Press.

Bierra, Alisia. 2014. Missing in action: Violence, power, and discerning agency. *Hypatia* 29 (1): 129–45.

Bohren, Meghan A., *et al*. 2017. Continuous support for women during childbirth. *Cochrane Database of Systemic Reviews* 2017, issue 7, art. no. CD0003766.

Bonaparte, Alicia. 2015. Physician's discourse for establishing authoritative knowledge in birthing work and reducing the presence of the granny midwife. *Journal of Historical Sociology* 28 (2): 168–94.

Bonaparte, Alicia. 2016. Regulating childbirth: Physicians and granny midwives in South Carolina. In *Birthing justice: Black women, pregnancy and childbirth*, ed. A. D. Bonaparte and J. C. Oparah. Baltimore, MD: Paradigm Publishers.

Centers for Disease Control and Prevention (CDC). 2018. Social determinants of health: Know what affects health. https://www.cdc.gov/socialdeterminants/index.htm

Collins, Patricia Hill. 1995. *Black women and motherhood*. New York: Routledge.

Craddock, Karen. 2015. *Black motherhood(s): Contours, contexts and considerations*. Bradford, ON: Demeter Press.

Craven, Christa. 2010. *Pushing for midwives: Homebirth mothers and the reproductive rights Movement*. Philadelphia, PA: Temple University Press.

Davis, Angela. 1981. *Women, race, and class*. New York: Random House.

Davis, Dána-Ain. 2019. *Reproductive injustice: Racism, pregnancy, and premature birth*. New York: New York University Press.

Dubois, W. E. B. 1903. *The souls of black folk: Essays and sketches*. Chicago: A. C. McClurg & Co.

Ehrenreich, Barbara, and Deidre English. 2010. Witches, midwives, and nurses: A history of women healers. New York, NY: The Feminist Press.

Fanon, Franz. 1961. *The wretched of the earth*. New York: Grove Press.

Fanon, Franz. 2008. *Black skin, white masks*. New York: Grove Press (original work published 1952).

Fausto-Sterling, Anne. 1996. Gender, race, and nation: The comparative anatomy of "Hottentot" women in Europe. In *Deviant bodies*, ed. J. Terry and J. Urla. Indianapolis: Indiana University Press.

Ginsburg, Faye, and Rayna Rapp. 1991. The politics of reproduction. *Annual Review of Anthropology* 20: 311–43.

Ginsburg, Faye and Rayna Rapp, eds. 1995. *Conceiving the new world order: The global politics of reproduction*. Berkeley: University of California Press.

Gordon, Lewis. 1999. *Bad faith and antiblack racism*. Atlantic Highlands, NJ: Humanities Press.

Gordon, Lewis. 2000. Dubois' humanistic philosophy of the human sciences. *Annals of the American Academy of Political and Social Science* 568: 265–80.

Gordon. Lewis. 2015. *What Fanon said: A philosophical introduction to his life and thought*. New York: Fordham University Press.

Hall, Lauren K. 2019. *The medicalization of birth and death*. Baltimore, MD: Johns Hopkins University Press.

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

Hill, Shirley A. 2016. *Inequality and African-American health: How racial disparities create sickness*. Chicago: University of Chicago Press.

Hoberman, John. 2012. *Black and blue: The origins and consequences of medical racism*. Berkeley: University of California Press.

Jacobs, Elizabeth A., Italia Rolle, Carol Ferras, Eric Whitaken, and Richard Warnecke. 2006. Understanding African-Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine* 21 (6): 642–47.

Jordan, Robin. 2013. Therapeutic presence and continuous labor support. In *Best practices in midwifery*, ed. B. A. Anderson and Sjourna E. Stone. New York, NY: Springer Publishing Company.

Joseph, Jennie, Haile Eshe Cole, and Paula X Rojas. 2018. *National Perinatal Health Task Force: Building a movement to birth a more just and loving world*. https://perinataltaskforce.com/wpcontent/uploads/2021/06/Groundswell_Report_final_online.pdf

Krieger, Nancy, and Mary Bassett. 1986. The health of Black folk. *Monthly Review* 28 (3): 161–69.

Krieger, Nancy, David Repkof, Jarvis Chen, Pamela Waterman, Enrico Marcelli, and Malinda Kennedy. 2008. The fall and rise of US inequities in premature mortality: 1960–2002. *PLoS Medicine* 5 (2): 227–41.

Lorde, Audre. 1980. Age, race, class and sex: Women redefining difference. Reproduced in *Sister outsider*. Trumansburg, NY: Crossing Press.

Maryland General Assembly. 2021. SB 163: Maryland Medical Assistance Program-Doula Pilot Program. https://mgaleg.maryland.gov/2021RS/fnotes/bil_0003/sb0163.pdf

McLemore, Monica. 2018. What blame the mother stories get wrong about birth outcomes among black moms. https://www.centerforhealthjounalism.org/2018/02/18/what-blame-mother-stories-get-wrong-about-birth-outcomes-among-black-moms

Morgan, Danielle Fuentes. 2018. Visible black motherhood is a revolution. *Biography* 41 (4): 856–75.

Nash, Jennifer C. 2019. Birthing black mothers: Birth work and the making of black maternal political subjects. *Women's Studies Quarterly* 47 (3–4): 29–50.

Nash, Jennifer C. 2021. *Birthing black mothers*. Durham, NC: Duke University Press.

National Center for Health Statistics (US) Report. 2016. *Health, United States, 2015: With special feature on racial and health disparities* (Report No. 2016-1232). Hyattsville, MD.

National Institute on Minority Health and Health Disparities. 2012. *Important events in NIMHD history*. Retrieved from www.nih.gov

Olafsdottir, Sigrun. 2007. Fundamental causes of health disparities: Stratification, the welfare state, and health in the United States and Iceland. *Journal of Health and Social Behavio,* 48 (3): 239–53.

Prather, Cynthia, Taleria Fuller, Khiya Marshall, and William Jeffries. 2016. The impact of racism on the sexual and reproductive health of African American women. *Journal of Women's Health* 25 (7): 664–71.

Rapp, Rayna. 2019. Race and reproduction: An enduring conversation. *Medical Anthropology* 38 (8): 725–32. DOI: 10.1080/01459740.2019.1671838

Rapp, Rayna, and Faye Ginsburg. 2011. Reverberations: Disability and the Kinship Imaginary. *Anthropological Quarterly* 84 (2): 379–410.

Reissman, C. K. 1983. Women and medicalization: A new perspective. *Social Policy* 14 (1): 3–18.

Richardson, Sarah, Cynthia Daniels, Matthew Gillman, Janet Golden, Rebecca Kukla, and Janet Rich-Edwards. 2014. Society: Don't blame the mothers. *Nature* 512 (7513): 131–32.

Roberts, Dorothy. 1998. *Killing the black body*. New York: Random House.

Roberts, Dorothy. 2009. Race, gender, and genetic technologies: A new reproductive dystopia? *Signs* 34 (4): 783–804.

Roberts, Dorothy. 2012. Debating the causes of health disparities. *Cambridge Quarterly of Healthcare Ethics* 21 (3): 1–12.

Ross, Loretta, and Rickie Solinger. 2017. *Reproductive justice: A new vision for the 21st century*. Berkeley: University of California Press.

Rothman, Barbara Katz. 1986. *The tentative pregnancy, prenatal diagnosis and the future of motherhood*. New York: Norton.

Scott, Karen, Laura Britton, and Monica McLemore. 2019. The ethics of perinatal care for black women: Dismantling the structural racism in "mother blame" narratives. *Journal of Perinatal Neonatal Nursing* 33 (2): 106–15.

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press

Serbin, J. W., and Elizabeth Donnelly. 2016. The impact of racism and midwifery's lack of racial diversity: A literature review. *Journal of Midwifery and Women's Health* 61 (6): 694–706. https://pubmed.ncbi.nlm.nih.gov/27926804/

Sharma, Malika, and Ayelet Kuper. 2016. The elephant in the room: Talking race in medical education. *Advances in Health Science Education: Theory and Practice* 22 (3): 761–64.

Story, Kaila Adia. 2018. Mama's gon' buy you a mocking bird: Why #blackmothersstillmatter a short genealogy of black mothers' maternal activism and politicized care. *Biography* 41 (4): 876–94.

Suarez, Alicia. 2020. Black midwifery in the United States: Past, present and future. *Sociology Compass* 1–12.

US Department of Health and Human Services. 2020. *Healthy people* 2030*: Social determinants of health*. https://health.gov/healthypeople/priority-areas/social-determinants-health

Villarosa, Linda. 2018. Why America's black mothers and babies are in a life-or-death crisis. *New York Times Magazine*, April 11. https://www.nytimes.com/2018/04/11/magazine/blackmothers-babiesdeath-maternal-mortality.html

Washington, Harriet. 2007. *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. New York, NY: Vintage Books.

Wertz, Richard, and Dorothy Wertz. 1977. *Lying-in: A history of childbirth in America*. New Haven, CT: Yale University Press.

Williams, Patricia J. 2017. Race, the new black: On fashioning genetic brand. *American Journal of Law and Medicine* 43: 183–91.

Wilson, Andrea E. (2009). Fundamental causes of health disparities: A comparative analysis of Canada and the United States. *International Sociology* 24: 93–113.

World Health Organization. 2021. Health inequities. https://www.who.int/social_determinants/thecommision/finalreport/key_concepts/en/

Dr. Jina Fast is an Assistant Professor of Philosophy at Notre Dame of Maryland University. She is currently at work on a book on Black Caribbean and American existentialism and phenomenology and has been published in the *Journal of Critical Race Inquiry* and *Atlantis: Critical Studies in Gender, Culture, & Social Justice*. As a feminist epistemologist and philosopher of race, her work centers theories produced by and through the experiences and work of marginalized folks across disciplines.

Cite this article: Fast J (2024). The Politics of Doulas: Black Feminist Collective Action in Response to "Birthing While Black". *Hypatia* **39**, 343–362. https://doi.org/10.1017/hyp.2023.112

https://doi.org/10.1017/hyp.2023.112 Published online by Cambridge University Press