Feminist Pedagogy

Volume 3 | Issue 2 Article 11

Catching Babies: Helping Students Understand Reproductive Justice Through Black Maternal Health

Jillian A. Tullis
University of San Diego, jtullis@sandiego.edu

Follow this and additional works at: https://digitalcommons.calpoly.edu/feministpedagogy

 Part of the Africana Studies Commons, Gender, Race, Sexuality, and Ethnicity in Communication Commons, Health Communication Commons, and the History of Science, Technology, and Medicine Commons

Recommended Citation

Tullis, Jillian A. () "Catching Babies: Helping Students Understand Reproductive Justice Through Black Maternal Health," *Feminist Pedagogy*: Vol. 3: Iss. 2, Article 11.
Available at: https://digitalcommons.calpoly.edu/feministpedagogy/vol3/iss2/11

This Original Teaching Activity is brought to you for free and open access by the Journals at DigitalCommons@CalPoly. It has been accepted for inclusion in Feminist Pedagogy by an authorized editor of DigitalCommons@CalPoly. For more information, please contact digitalcommons@calpoly.edu.

Catching Babies: Helping Students Understand Reproductive Justice Through Black Maternal Health

Introduction and Rationale:

Reproductive justice necessitates access to resources and safe conditions (for more see, Ross & Solinger, 2017). The ability to control when and where to have a child and the efficacy of that process and experience are essential to accomplishing reproductive justice. A glimpse at recent headlines suggest the United States is far behind in achieving these goals. Not only have recent legal rulings undermined efforts towards reproductive justice, but the existing healthcare system is failing people who can become pregnant. Childbirth is over-medicalized and expensive.

Despite its advanced medical technology and the high cost of healthcare, the United States has some of the worst maternal mortality rates in the industrialized world, which only worsened during the COVID-19 pandemic (Raman, 2020). Maternal health, which is the time period from pregnancy to 6-weeks after birth, is especially precarious for Black individuals. Black women[1] are 3-4 times more likely than their white counterparts to die in during pregnancy, childbirth, or when postpartum (Thomas, 2022). By focusing on disparities in Black maternal health in an undergraduate classroom, students become more informed about the concept of reproductive justice and health disparities, but can also better understand intersectionality as lived experience and the effects of systemic racism in medicine and healthcare.

Learning Objectives

Practice conversations about sex and reproductive health.
Define reproductive justice.
Understand the history of midwifery in the United States.
Analyze texts and **apply** concepts such as intersectionality and health disparities to texts.
Identify effective verbal and nonverbal communication skills used by lay midwifes.
Investigate and **analyze** the origins of system racism in healthcare.

[1] Similar to Ross & Solinger (2017) when discussing the historical issues, I use the term *woman* or *women*. I also use gendered language when it is consistent with the source I am quoting or paraphrasing. When discussing contemporary issues, I have elected to use more gender-neutral terms, such as *pregnant person or people*.

Explanation

Catching Babies is one class in a week-long unit focused on sex, reproductive health, and reproductive justice in an upper-level undergraduate Health Communication course. Before class, students listen to *Labor and Love*, a podcast episode from *Sexing History* (Frank & Gutterman, 2020) focused on the history of midwifery in the United States, but especially in the rural South. In this episode, they hear the voices of women who would catch babies, sometimes in exchange for goods – such as corn or pigs – instead of cash payment. Students engage a photo essay where they can see images of a contemporary homebirth and read about the revival of midwifery among Black women (Proujansky, 2021). In so doing, they discover that the use of midwives today is not motivated by a mere desire to return to simpler days. Midwifery, in fact, has a long history in the Black community, which is being rediscovered and reclaimed with the hopes of saving the lives of babies and their parents. To further orient students and ground the conversation in a reproductive justice framework, I share Ross & Solinger's (2017) definition of reproductive justice, which includes the following principles: "1.) the right to *not* have a child; 2. The right to *have* a child; 3.) the right to parent children in a safe and healthy environment" (p.9). We return to these principles at the end of the session during our debrief. Once in class, I ask students to think back to what they heard and read to consider the following questions in small groups. (In classes where group discussions are less effective, I have also used these questions as "free-write" prompts at the start of class to help facilitate class discussion.):

1. What do the texts reveal about the possible origins of disparities in Black maternal health?
2. Why do they think these disparities continue to persist, especially in a wealthy country with the information and technology to correct them?
3. What are the communication strategies used by Black lay midwives that contribute to their effectiveness and how do they compare to the practices of white male physicians?

In a health communication class, the discussion generally begins with students identifying the communication skills used by the midwives that contributed to their effectiveness. Listening is one skill the students recognize. These midwives not only listened to the individuals they cared for, they also encouraged laboring mothers to listen to their own bodies. (There are several contemporary cases of the importance of attending to the needs of a laboring person involving high profile celebrities, such as Beyoncé and Serena Williams, with which some students are familiar. I sometimes raise these examples to make the topic more salient to students.) Labor and delivery were processes that held their own kind of knowledge – the baby would come when it was ready, the mom-

to-be would "know" when to push. Midwives were guides and, with their vast experience and few resources, they knew how to minimize pain and avoid birthing injuries or complications (Frank & Gutterman, 2020). This care was empowering because it was patient- centered. These midwives were also known and trusted, which helps students understand the importance of building and maintaining rapport in a patient-practitioner context. Racial and gender concordance, which can also foster better health outcomes, was also a factor in midwives' success. The podcast reveals that midwives were also often healers and counselors with connections to families that spanned generations (Charles Smith & Holmes, 1996; Frank & Gutterman, 2020). And, in the Southern United States until the 1940s, the majority of Black babies – as much as 75% – were delivered by Southern rural midwives with excellent outcomes, despite few resources (Frank & Gutterman, 2020).

Despite their effectiveness, in the early 20th century, medical and government officials blamed midwives for high maternal and infant mortality rates and insisted licensed physicians were safer (Frank & Gutterman, 2020). Officials cited lack of "formal" education, claims of poor hygiene practices, use of antiquated techniques, and age as reasons for attempting to "professionalize" midwifery (Frank & Gutterman, 2020; Noyes, 1912). Messages that midwifery was dangerous and "backwards" further undermined the practice. The decline of Black midwives, however, also coincided with the rise in anti-immigrant sentiments and Jim Crow laws (Ausin, 2020). The campaign against midwives must also be understood as a legacy of medicine's ties to chattel slavery (for more on this history see Cooper Owens & Fett, 2019). Systems to control, surveil, and penalize Black midwives were introduced, which made it increasingly difficult to practice midwifery. Particularly in rural communities where access to hospitals was few and costly, the elimination of midwives meant pregnant women were forced to give birth in hospitals. Those labor experiences were markedly different from midwife-attended births. Now under the care of white male physicians, women were often sedated, some would be tied down to prohibit movement, and forceps could be used to hasten delivery, which can cause vaginal and perineal tearing. While we cannot know if the wide availability of midwives could have improved maternal and infant mortality, the evidence reveals that the shift to medicalized births did not benefit the Black community at the same rates as other populations. Infant death rates are worse than during antebellum slavery; and in 2013, the United States ranked the second worst in maternal mortality among 31 developed nations (Cooper Owens & Fett, 2019). What is known is that Black women report having their pain and symptoms ignored (Austin, 2020; Cooper Owens & Fett, 2019; Proujansky, 2021; Ross & Solinger, 2017) and the health effects of racism and bias are frequently linked to complications during pregnancy, labor, delivery, and post-partum (Cooper Owens & Fett, 2019).

The story of the decline of midwives is more complicated than one or two white male physicians undermining a Black community's midwife. Nor can their decline be attributed to improvements in labor and delivery science and technology. The decline of midwives is better understood through the lenses of systemic and structural racism as evidenced by the concerted effort to make the practice nearly impossible. While midwives did what they could, for as long as they could, the risk of continuing to catch babies under the threat of punishment was too much. What was once a multigenerational matrilineal practice – by Black women for Black women – was decimated. By the early 1950s, 90% of births occurred in hospital (Austin, 2020). Another, perhaps unintended, consequence of this change was how forced hospital births under the supervision of white clinicians contributed to a legacy of mistrust of the white medical establishment (for more see, Washington, 2007; Cooper Owens & Fett, 2019).

Debrief

By the end of class, students better recognize that policies and practices were not always guided by the best science, or even justice. The reasons for eliminating midwives also illustrate the intersections of racism, sexism, ageism, and classism in the context of childbirth in concrete ways for students. The unit reveals the importance of patient-centered communication to effectively practice medicine, but also to build rapport, credibility, and confidence with patients. Together, these communication behaviors can lead to better outcomes for babies and their birthing parents. Forcibly implementing changes to longstanding cultural or community practices is insufficient for ensuring their effectiveness (see, also Dutta, 2008). Students recognize how the decline of midwives played a pivotal role in disparities in Black maternal health that persists today. Fewer or no midwives forced women into hospital settings with physicians and nurses who were not responsive to their needs before, during, and after giving birth. And while a bit outside of the scope of the texts, I ask the students to expound on why these disparities persist to foster higher order thinking. Capitalism, greed, racism, oppression, ignorance, fear, and control are all offered as possible explanations.

The modern use of midwives is a reclaiming of a cultural tradition lost to systemic and structural racism. Research supports this return of midwives as a promising development with the potential to improve mortality rates (ten Hoope-Bender et al., 2014). Students understand that reproductive justice cannot be realized until Black parents can exercise their right to have a child when they want and live to raise their babies in a healthy and safe environment.

Assessment

Catching Babies can serve as a foundation for students to better interrogate society's values related to pregnancy and birth, but also question what levels of disparity and death we are willing to accept in a health context. A focus on midwifery helps students understand the complicated history of this practice and how it was and remains a strategy for empowerment and autonomy consistent with reproductive justice principles and goals.

One way I assess the effectiveness of this lesson is by observing how the concepts, especially the principles of reproductive justice, are referenced by students in other related class sessions, units, or assignments. For example, when some students complete the *SNAP Challenge* assignment (see Tullis & Ryalls, 2019), they reference access to nutrition as related to reproductive justice because of the role of nutrition maternal health and child development. Some students have a new frame for exploring issues in healthcare ethics. Many students report feeling better equipped to advocate for better reproductive health and justice for themselves and others.

Other suggested texts:

Documentaries: *Aftershock* (Eiselt & Lewis Lee, 2022) see review in this issue; *Being Serena* (Antinoro, 2018) Season 1 Episode 2

References

Antinoro, M. (2018). *Being Serena* [TV series]. Home Box Office.

Austin, K. (2020, February 2). End racial disparities in maternal health, call a midwife. *Columbia Mailman School of Public Health University*. https://www.publichealth.columbia.edu/public-health-now/news/end-racial-disparities-maternal-health-call-midwife

Charles Smith, M. & Holmes, L. J. (1996). *Listen to me good: The story of an Alabama midwife*. Ohio State Press.

Dutta, M. J. (2008). *Communicating health: A culture-centered approach*. Wiley.

Eiselt, P. & Lewis Lee, T. (2022). *Aftershock* [Film]. Impact Partners.

Frank, G. & Gutterman, L. (2020, May 21). Labor and Love (No. 1) [Audio podcast episode] In *Sexing History*. https://www.sexinghistory.com/sexinghistory/2019/11/21/season-2-bonus-episode-2-marabel-morgan-g69ap

Noyes, C. (1912). The midwifery problem. *The American Journal of Nursing*, *12*, 466-471. https://doi.org/10.2307/3404589

Proujansky, A. (2021, March 11). Why Black women are rejecting hospitals in search of better births. *The New York Times.* https://www.nytimes.com/2021/03/11/nyregion/birth-centers-new-jersey.html

Raman, S. (2020, May 14). COVID-19 amplifies racial disparities in maternal health. *Roll Call*. https://rollcall.com/2020/05/14/covid-19-amplifies-racial-disparities-in-maternal-health/

Ross, L. J. & Solinger, R. (2017). *Reproductive justice: An introduction.* University of California Press.

ten Hoope-Bender, P. de Bernis, L., Campbell, J., Downe, S., Fauveau, V., Fogstad, H., Homer, C. S. E., Powell Kennedy, H., Matthews, Z., McFadden, A., Renfrew, M. J., & Van Lerberghe, W. (2014). Improvement of maternal and newborn health through midwifery. *Lancet, 384*, 1226-1235. http://doi-org./10.1016/S0140-6736(14)60930-2

Thomas S. P. (2022). Trust Also Means Centering Black Women's Reproductive Health Narratives. *The Hastings Center Report*, *52 Suppl 1*, S18–S21. https://doi.org/10.1002/hast.1362

Tullis, J. A. & Ryalls, E. D. (2019). SNAP Challenge in the communication classroom. *Communication Teacher, 33,* 304-308. https://doi.org/10.1080/17404622.2019.1575439

Washington, H. A. (2006). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. Harlem Moon.