10 Black Birth Matters: A Conversation with Andrea Chung and D'Yuanna Allen-Robb

PART THREE

"YOU ARE YOUR BEST THING"*: SELF-CARE AS A SITE OF RESISTANCE

* Morrison, T. (2004). *Beloved: A Novel*.15th ed. Ch.27.

10 BLACK BIRTH MATTERS

A Conversation with Andrea Chung and D'Yuanna Allen-Robb

Nicole J. Caruth

In 1951, the Georgia State Department of Public Health and the Association of American Medical Colleges commissioned filmmaker George C. Stoney to create a documentary about childbirth, specifically, the practices of Black lay midwives in the Deep South. Also known as "granny" midwives, these women trained through apprenticeship and were respected healers in their communities. With the help of community liaisons, Stoney met Mrs. Mary Francis Hill Coley (1900–1966), a midwife who is said to have delivered 3,000 babies in roughly 30 years.[1] For four months, Stoney followed "Miss Mary" to her patients' homes, observing her practice and deriving inspiration for his script. Miss Mary would become the star of his film, *All My Babies: A Midwife's Own Story*, a bizarre period piece that merges reenactments by a mostly Black cast with midwifery instruction, a live birth, and a hymnal soundtrack.

All My Babies was intended to educate lay midwives in the Deep South, and Stoney was given a list of 118 teaching points to incorporate.[2] But the film found a broader audience. Advertised early on as one of the "outstanding humanist works of American cinema," *All My Babies* holds a place in the pantheons of film history: Stoney donated his outtakes to the Museum of Modern Art's Film Department, which was at one time a distributor of the film. And in 2002, the Library of Congress placed *All My Babies* on the United States National Film Registry, deeming it "culturally, historically, or aesthetically significant."[3]

In *All My Babies*, Stoney paints a familiar picture of Black subjects under the tutelage of a white "expert" doctor and nurse. What his film doesn't show is how much the American medical establishment loathed—but learned from—granny midwives, drawing from their deep well of knowledge as community birth attendants before outlawing their practices. Women have always served as birth attendants, and it stands to reason that skilled birth workers in Black communities date back to ancient societies, though the literature focuses on

slavery and segregation. In the antebellum years, Black midwives served their enslaved sistren and masters' wives. Post-emancipation, they typically provided birth services to women in rural communities who lacked access to hospitals, or women who feared medical establishments due to entrenched racism and, ostensibly, the decades of nonconsensual experiments on Black bodies. As Lynne Jackson writes, doctors and nurses generally looked down on lay midwives in the Deep South, recognizing them as a "temporary and unfortunate necessity."[4] Such attitudes can be traced back to chattel slavery, when older enslaved women who served as midwives on plantations were at once needed for their health and healing knowledge and devalued because of not only race but age—older enslaved women were considered less valuable at auction.[5]

In the decade that *All My Babies* was released, the maternal mortality rate for Black women was 3.6 times greater than that for white women.[6] One could speculate that Jim Crow segregation and lacking medical technologies underlie this disparity. But now, nearly 70 years later, the statistics are not much better. According to a report from the Centers for Disease Control and Prevention (CDC) in 2020, Black women in the United States die from pregnancy-related causes at a rate 2.5 times higher than their white counterparts[7] (reports in previous years showed a rate of 3.3 to 4 times higher)[8]. Black newborns face similarly horrible odds with a mortality rate more than twice that of white newborns.[9] Why does this gap exist and persist?

Everyday "pull yourself up by your bootstraps" anti-Black rhetoric would have us believe that poor lifestyle choices by individual mothers is the reason for the disproportionate statistics. But multiple studies point to structural inequities, including differential access to healthcare, healthy foods, clean drinking water, reliable transportation, and safe neighborhoods. Researchers also recognize that the chronic toxic stress of racial discrimination takes a toll on the body, increasing the risk of physical and mental health issues. And then there is the centuries-old myth that Black people are impervious to pain, a racial bias that crosses class and influences medical care—or lack thereof—in doctor's offices and maternity wards across the country. Women's stories of neglect include rushed cesarean sections, too little anesthesia, and failure to listen when a mother senses that she or her baby may be in danger, such as the life-threatening experience recounted by the champion tennis player Serena Williams.

Despite how much time has passed since *All My Babies* was created, the film continues to be germane, especially now amid a resurging demand for Black birth workers. Recent journalism has turned the spotlight on midwives and doulas of color, noting how their involvement fosters better health outcomes

for Black families[10] (as an aside, a midwife or doula wasn't even mentioned as an option when I was my sister's Lamaze partner 28 years ago). Birth workers serve as advocates for the mother but occupy different roles. Nowadays, midwives are clinically trained, licensed practitioners who deliver babies in homes and have access to hospitals if needed; whereas doulas are trained, unlicensed practitioners who provide emotional, physical, and educational support from pregnancy and labor to the postpartum period, including, for full spectrum doulas, miscarriage, planned abortion or medical termination, and stillbirth. In the past, a midwife might have done it all and in some countries or situations they still do.

George Stoney wrote two birth scenes for *All My Babies* based on what he had experienced in the homes of Miss Mary's patients. One scene was shot in a moderately well-off nuclear family home where everything was tidy and prepared. The other was shot in a shanty with the expecting couple depicted as emotionally traumatized and unprepared to welcome their child, believing it would be stillborn like their last. Swarming flies in this couple's home suggest unsanitary conditions. "A main emphasis of the film is cleanliness and hygiene practices for the midwives," writes Miriam Zoila Pérez. "But this emphasis foreshadows the eventual decline of the granny midwives and the messaging used to discredit them."[11] A combination of legislation and regulation eventually prohibited the services of granny midwives, but that was after they endured smear campaigns that portrayed them as dirty.

In contrast, Stoney made efforts to exclude anything that might imply poor Black-white race relations in the American South or that might be seen as a northerner's attempt to "exploit Southern poverty."[12] Despite—or maybe because of—what Stoney left out, *All My Babies* was lauded for its uniqueness, particularly for the way Stoney positioned granny midwives as respectable members of society. In later interviews, Stoney recalled comments that he had "heightened these people." His editor said to him, "You have shown them so that I don't think of them as Negroes, but just people."[13]

Contemporary Dialogues

Documentary film and photography have played a critical role in recent efforts to humanize Black maternal and infant mortality statistics. Take, for example, the 2021 documentary film *Bearing the Burden: Black Mothers in America*, released in collaboration with *The New Yorker*; the online photo exhibition,

Catching Light: Celebrating Black Midwives & Birth Workers, curated by Artists United for Reproductive Justice, an affiliate of the SisterSong Women of Color Reproductive Justice Collective; and the ongoing documentary film series *Giving Birth in America* from the nonprofit Every Mother Counts. These storytelling efforts, along with an influx of journalism on Black maternal health, have no doubt influenced contemporary artists. Among the most visible, perhaps, are the Chicago-based photographer LaToya Ruby Frazier and the San Diego-based multimedia artist Andrea Chung. Although their practices are vastly different, their work intersects at *how* they practice. That is, in relatively close proximity to doulaing and midwifery (rather than commentating from afar), serving as witnesses and champions not unlike Stoney.

In 2018, Frazier's photography accompanied Linda Villarosa's widely-circulated *New York Times Magazine* article, "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis."[14] Frazier chronicled the pregnancy of Villarosa's main subject, Simone Landrum, a New Orleans-based mother preparing to welcome her third child after the loss of her previous child. Two photographs in particular spotlight the relationship between Landrum and her doula, Latona Giwa, co-founder of Birthmark Doula Collective, a grassroots organization in New Orleans. Working in the lineage of granny midwives, Giwa represents a life-affirming bridge in the mother-child-doctor relationship. Frazier's images suggest a kinship as the two women sitting together stare directly at the camera, with Giwa appearing to literally have Landrum's back. Frazier's images echo something that Stoney wanted to portray: a celebration of childbirth and family as opposed to a depiction of trauma.

In 2017, the year before Frazier's images were published by the *Times*, the artist Andrea Chung turned her attention to midwifery too, focusing on granny midwives of the American South and the Caribbean. Her *Midwives* series pays homage to Black birth workers of the past by combining found photographs of older women (and sometimes children) from the African diaspora with renderings of medicinal herbs used in traditional midwifery practices. The women in her collages were often made to look like queens and deities. In one image, the female reproductive system is fashioned into a golden crown. Here, Black women are not victims of discriminatory health institutions but powerful care providers who bolster their community and protect its children. *Midwives* was inspired by Chung's grandmother, a market woman and midwife in Jamaica, and the birth of her own child, a son named Kingston. Although Chung says she had a relatively non-traumatic birth experience in terms of the care she received, the challenges she faced being both an artist

Andrea Chung, *Midwives II*, 2017. Collage, vellum, string and watercolor pencils, 15 x 11 in (38.1 x 27.9 cm). Courtesy of the artist

and new mother prompted her to creatively explore Black motherhood today.

In 2018, Chung revisited her *Midwives* photo collages, weaving them into her multimedia project *Eeny, meeny, miny, moe*. Mounted in collaboration with the public art and public health departments of Nashville, Tennessee, this three-part experience included a cookbook that paired low-cost recipes with images from *Midwives*; free cooking workshops for new and expectant mothers; and a baby-crib sculpture, all at the Lentz Public Health Center, the primary site for receiving Women, Infants, and Children (WIC) benefits. The workshops were taught by Nashville-based practitioners Taneesha Reynolds, a certified nurse-midwife, and Ashley Couse, a doula and childbirth educator, and each participant received a copy of the artist's cookbook with a free box of fresh produce. Chung's project calls our attention to an oft forgotten tenet of a healthy pregnancy: equitable access to healthy foods and health resources.

A catalyst for my research on Black maternal health, *Eeny, meeny, miny, moe* eventually lead me to Stoney's film, and, subsequently, this essay and transcribed conversation with Chung and D'Yuanna Allen-Robb, the director of Maternal Child and Adolescent Health at the Nashville Metro Public Health Department (as a guest curator for the City of Nashville, I commissioned Chung's project as part of a city-wide public art exhibition). As much as Chung was influenced by her earlier *Midwives* research, she was also motivated by Allen-Robb, who, with her vast knowledge of place, illuminated how maternal and infant mortality rates in North Nashville, a historically African American community, intersect with the displacement of young mothers today due to Nashville's real estate boom and gentrification. While Chung and Allen-Robb operate in dissimilar sectors, they intersect in their belief that art,

Andrea Chung, *Crowning I*, 2014. Collage, ink and color pencil, 14 x 11 inches (35.6 x 27.9 cm). Courtesy of the artist

particularly photographs, can help shift consciousness, bringing audiences closer to truthful narratives on Black life and motherhood.

Chung's project serves as a rare example of the role that positive images of Black women can play not only in addressing racial health inequities, but the potential for integrating artistic practice in health systems and spaces to affect change. This begs the question: What is the role of photography (and artists in general) in contemporary movements for maternal justice? In this conversation, Chung and Allen-Robb discuss this question, as well as Black maternal and infant mortality, and the healing presence of birth workers, from their perspectives as an artist and public health leader.

A Conversation on Black Maternal Health, January 22, 2020

Nicole J. Caruth: Andrea, let's start with what motivated you to embark on research about Black granny midwives in the American South and Caribbean?

Andrea Chung: I met Dr. Alicia Bonaparte when I was giving a lecture at the Claremont Colleges in Pomona, CA. She teaches at Pitzer College, and I was interested in her research on Black midwives in the American South. This fell in line with some interests I had around Yoruba traditions and my grandmother in Trinidad, Beryl LeCadre, who was a midwife for over thirty years. I wanted to figure out how Alicia and I could partner. After my son was born, I started thinking about birthing, the roles of mothers, and what it meant to be a mother.

I decided that to work with Alicia the most logical thing to do was a comparative study between midwifery in the Caribbean and her research on Black midwives in the American South. We wanted to compare birthing practices to see if there were any similarities or differences. We both had a lot of African retentions in midwifery that we thought were interesting. For example, using certain medicinal herbs or putting things under the bed, like axes or boots, which was supposed to reduce labor pains. I decided to start making work based on the findings of the research.

Caruth: Andrea, how did you go about finding and selecting historical photographs for your *Midwives* series?

Chung: I've always worked with archives and I've always been interested in how those images have been used, specifically images from the Caribbean. When I first started using archival images, I collected them from the Schomburg Center in New York. I was really concerned about copyright and my usage of the images. However, now I source them from the Internet, often from ethnographic postcards that had circulated or posed images of the so-called "native." I've thrown caution to the wind when it comes to copyright because, as the artist Carrie Mae Weems has discussed, who has the right to own images of another culture's history?

Caruth: D'Yuanna, before we talk about how art and photography intersect with your work, it might be helpful if you outline what you do at the Metro Public Health Department.

D'Yuanna Allen-Robb: In Nashville, I serve as the director of maternal child and adolescent health at the Metro Public Health Department. We look at healthcare systems and work with partner organizations to take a public health approach to eliminating inequities. We understand that when we look at our data around the burden and distribution of disease and disability and early mortality, it is concentrated among African Americans and African American neighborhoods and communities, not necessarily through the fault of or due to the bad habits of individuals or whole communities, but rather because of systems and structures of inequity. I'm not unique in my role because I have counterparts all over the country, but I will underscore our particular focus here on eliminating those inequities by changing systems. This includes calling out the history and structure of racism, the current practices

within institutions, and limiting beliefs about groups of people based on socialized identities, and then finding creative ways to help people see and understand that and start to move toward the action of dismantling it.

Caruth: Talk more about finding "creative ways" to help people understand inequities.

Allen-Robb: As an example, in 2010, Nashville's Public Health Department was selected as one of two communities nationally to be part of a W.K. Kellogg-funded initiative called Racial Healing. The idea was to collect oral histories from communities that have been suffering from inequities and present those stories either using photo archives or photography of the living individuals who shared their stories with us about what the community looked like 50 or 60 years ago versus what it looks like today, to help people, particularly in public health, understand what has changed.

We have grown in our work but there definitely have been times when we concentrated our messaging about hypertension, for example, around individual behavior. "You're eating too much salt. Or "You're eating too much sugar." Or "You're not eating healthy foods." But if you don't ever take a step back and ask, *What is the structure of the neighborhood? What is the structure of the community?* then you don't see what people actually have access to and how resources are distributed.

We recognize that the historic African American community in North Nashville, in the 37208 zip code, was once a very prosperous, well connected, and structurally resource-dense community before the historical insult of Interstate 40 being constructed through it. If you're just looking at data on a piece of paper from 2010, then all you see are negative statistics and all of these "bad behaviors" of the people who live there. That narrative has a tendency to create a story that these are individual decisions and individual behaviors as opposed to the creative way of embarking on this journey of racial healing: to look at the archival history and collect the oral histories of residents who lived in the 37208 zip code area who could talk about, from their memory, what that community was like.

For example, that sidewalks connected every house; that the majority of African American individuals who lived in that neighborhood owned their homes; that there were Black working professionals who had net worth at that time, concentrating the economic dollar within the Black community; that there was a Black grocery store, and three historically Black colleges and

universities. Then Interstate 40 got constructed and it decimated and dispersed that concentration of wealth and community.

Once that narrative got to be told, it forced us as a public health department, and all of the entities we work with, to use different language and tell a different story that the health outcomes we see today and saw at that time in 2010—hypertension, high rates of cancer, high infant mortality—is not necessarily a function of individual behavior. It absolutely is a function of a living legacy of racism and structural inequity that was created. And if it was created then it can be undone.

Caruth: Did the Nashville Public Health Department use photographs from the Tennessee state archives to support the Racial Healing project research?

Allen-Robb: Yes, we used state and local archives. The Nashville Public Library archive has a Civil Rights section and the Metro Records archive has old planning maps that we pulled to see what neighborhoods looked like before Interstate 40 and afterwards. Being able to digitize one of the Metro planning maps and then do an overlay of a Google aerial view of the 37208 zip code area now was pretty powerful because we could see where there had been blocks of homes and that those areas are now flattened and no longer recognized as property or residents.

Chung: What can photography do to support movements for maternal justice now?

Allen-Robb: Photography can play a significant role in a movement around maternal justice. Or, as I would say, Black women's justice. So much imagery of Black women propagated in popular culture and media is very negative. These images reinforce stereotypes and, what's extremely important, at least in this conversation, is when those same kinds of images and ideas are subconsciously used in a healthcare setting. To give an example, when a woman goes to a doctor's office for prenatal care, there might be an image on the wall of two "families." One image is of a white woman who is pregnant and there is a white man beside her. She's smiling and he's smiling, and their hands have rings on them, so the assumption is that they are married. Then there is another image right beside it, or somewhere else in the waiting room, of an African American woman who is visibly pregnant and smiling but there ain't nobody else in the picture with her. This subconsciously reinforces the

idea that we don't get married; that we don't have husbands, we somehow get pregnant by ourselves, and there's not another human being involved.

We have healthcare providers who are not checking that subconscious bias and being critical about how the brochures, pamphlets, or other materials they use make people feel welcome in a space. When you go to a provider's website to figure out where to get care and you don't see images of people who look like you, that is a critical opportunity for photography in a system, to help break down subconscious bias related to skin color and race.

Photography also has a critical role in telling stories about social cohesion and family to help offset feelings of internalized oppression and racism. There are ways to say, through photographs, "We are strong. We are supporting one another. We raise healthy children. We have this expectation for our families, and not only for our families, we have this expectation of the system around us." When we expect more, we demand more, and we hold people accountable for delivering on the more that we expect and demand. I think that photography, and images of Black women specifically, can be extremely powerful in not only systems shift, but also in helping us as a collective of individuals shift our own internalized thinking.

Caruth: Andrea, talk about your work with photographs of Black women, specifically around midwifery and motherhood.

Chung: Becoming a mother changed a lot within my practice. It's made me more vocal and direct—I don't feel like I have the time to be passive—because of my experiences, including one that I had at a residency program where a white curator questioned my ability to be successful as an artist because I'm a mother. She basically called my child a distraction (my son was just three months old at the time). That made me more aware of how much harder it was going to be. It's hard enough to be a Black artist but to be a parent too… That experience made me consider what it meant to be a mother, especially a Black mother.

My use of archival images started from thinking about labor, specifically what it looks like in the Caribbean, and re-examining photos that we don't necessarily look at carefully. A lot of images of slavery in the Caribbean were not actually taken during slavery but later. People were forced to pose to project certain ideas, to make it seem like they were docile. Many stereotypes that come from the Caribbean are of exoticized women, or market women, who are often pictured in subservient positions—laying down or bending over or

sitting with another figure, usually a white person, standing above them. I wanted to change the way we read these images and question who took those images and why.

My grandmother on my father's side was a market woman who had nine kids that she raised all on her own. There's power and strength in raising nine children. If you were to look at her from far away, you would judge her like, "Oh wow, a single mom with nine kids…" But she was way more than that. She was also very politically active and a Garveyite. As D'Yuanna was saying earlier, with these stereotypes of Black women, I often feel that people don't take a close look at why these women are where they are. I focus on giving the women in the [historical] photographs some power and agency. I've done things like transform them into Orishas, particularly Yemeya who protects all mothers and children.

Caruth: Recently, there have been notable articles in *ProPublica* and the *New York Times*, for instance, about what is being called a crisis of Black maternal and infant mortality in the U.S. How do statistics in Nashville compare to national rates?

Allen-Robb: I will segment out infant mortality because it continues to be our leading indicator and then I will talk about maternal mortality and maternal morbidity.

Infant mortality, or the death of an infant before their first birthday, continues to be an issue. In Tennessee, our infant mortality rate is around 6.5 per 1,000 live births, so that's about 6.5 infants that are dying for every 1,000 infants that are born. In Nashville, the rate has declined a little bit in the last year and is down to 7 infant deaths per 1,000 live births. That is still higher than the national rate and certainly higher than the Healthy People 2020 Goal. We should be nationally closer to an infant mortality rate of 5 or less. When we start to segment out infant deaths by race, that rate is about 1.5 times higher for African American families than it is for Caucasian families (Latinx families are also experiencing higher rates of infant death than Caucasian families). If you compare Tennessee to other states in terms of infant mortality rates, we're consistently around 45, so you have a better chance of surviving in 45 other states then than if you're born here. We're obviously not proud of that fact and continue doing work to drive that number down. We're seeing some success.

When it comes to maternal mortality, it's a bit more difficult, especially since maternity mortality reviews are relatively recent in Tennessee. We didn't

start reviewing the deaths of women (when a death is associated and related to a pregnancy or birth and up to a year after the birth) until about two years ago and we had to pass legislation in order to do that. Some of the early information we have is that there's about 78 pregnancy associated deaths annually and about 28% of those were determined to be pregnancy-related, meaning women dying as a direct result of them being pregnant. About 63% of those deaths were not classified as being pregnancy-related, so they could have been related to a homicide. The likelihood of a lethal event when there's domestic violence increases dramatically when a woman becomes pregnant. So, it may not have been directly related to her being pregnant or how she was treated by a hospital, but she still died, and she was pregnant at the same time.

In terms of how Tennessee compares to the rest of the country, we have relatively low numbers when you think about the number of actual maternal deaths nationally. About 700 women in the United States die from a pregnancy or pregnancy-related complication every year and certainly, when we look at the racial disparities, African American women are three to four times more likely to die from a pregnancy-related or pregnancy-associated death. But in Tennessee our numbers are averaging around 73 annually. We are lower than the national average, and the disparity between African American women and Caucasian women isn't as stark, primarily because of Caucasian women who are suffering from a substance abuse disorder. We are being hit pretty hard in this state around substance use and we're helping people get into treatment. In a lot of pregnancy-related deaths among Caucasian women, a suspected overdose was the leading cause.

Caruth: This is depressing! It makes me think of the first time that Andrea and I met you at Lentz Public Health Center. Andrea, I remember you talking that night about how hard it was to hear about women and children dying "just because they're Black." I'm wondering if and how this knowledge is affecting you?

Chung: I did not realize things were this bad until I met D'Yuanna. My OBGYN took really good care of me and my pregnancy went relatively smoothly until she opened me up for my C-section. I had blood vessels everywhere and it was kind of a difficult birth. I thought that was as bad as it could be. But then a friend of mine in Brooklyn had a horrible birthing experience and could have died. She's a doula now because of what she went through. And then I thought back to the fact that my mom lost a son before me primarily because the

doctors waited too long to give her a C-section. Her baby couldn't live without being on a machine, so they had to make the decision at 22 months to let him die. This idea that Black women can withstand more pain and that we're not given the right to have a child like anyone else is unbelievable. How could we not be affected by reading or hearing stories like this? Everybody has the right to have a kid. Everybody has the right to proper treatment in a hospital and Black women are dying for no reason—or for lack of care.

Caruth: Andrea, you've talked about revisiting your Nashville project, particularly the cooking workshops. What do you want this project to do going forward?

Chung: Sometimes books like *What to Expect When You're Expecting* aren't all that helpful; they don't give practical information about what your body's going through at certain stages and what it feels like to be a mother. There are things about being a mother that I had no idea about because no one ever told me. You just deal with it and it's very isolating when you don't have someone to talk to. I feel that when mothers come together there's possibility for sharing information; meal and clothing swaps (which is something I see happening in an Artist Mommy group I'm a part of on Facebook); and the support of knowing that you're not the only one dealing with something like postpartum depression, which I had. I would like to continue creating community among mothers so they can organize and rely on each other. I would love to continue working with women so they know how to buy food on a budget, and properly care for their bodies, not just prenatal but also postnatal to make sure the kids and family are eating healthy.

Caruth: D'Yuanna, from a public health perspective, what are some of the benefits when a Black mother has a community of folks to talk to, seek advice from, etc.?

Allen-Robb: Human beings are designed to belong and be in community. There are psychological benefits to having people that you can depend on, a support structure, which doesn't have to be a biological family. As we continue to learn more about the health impacts of living in an isolating society, the Centers for Disease Control and Prevention has released information about loneliness being a public health threat. Living in isolation increases symptoms of depression and physical ailments.

From a cultural standpoint, the African American experience and part of our DNA is rooted in the fact that we've always existed in villages and in community with the sense that I will do for you and you will do for me. And your child is my child and we will care for each other and our children collectively. We should embrace the fact that we desire a sense of belonging. There are benefits to social cohesion for us mentally and physically. When women are well, children are well. Give women the support they need. One of the best ways to do that is women taking care of women and showing up for each other as a part of a community.

Chung: Going back to the artist residency I mentioned, I was really lucky to have a supportive cohort and staff members who offered to babysit. You definitely need a group to lift you up and make you feel that you can do this because mothering is hard, even if you're not working a 9 to 5 job. Raising a child is the hardest thing you will ever do in your life. I would not be getting through this if I did not have people to lean on, and people who supported that parenting was something I wanted to do alongside this other dream I had of being an artist.

Caruth: I was listening to a webinar from Black Mamas Matter Alliance the other day and one of the speakers said, "Midwifery was more than catching babies; midwives were psychologists, dieticians, loan officers, sex therapists, partners, marriage counselors, etc." I think this speaks to the various needs of mothers and also to the importance of the midwife as a community leader. My next question is for you, D'Yuanna: What are some of the documented benefits when Black mothers have a Black doula or midwife?

Allen-Robb: I'm going to frame this a bit more broadly around birth support because it could be the midwife or doula or the circle of women who are your friends who form your support system. And I'm going to tie this into the benefits of group prenatal care when women are receiving education and support together during their pregnancy. Oftentimes, this model of group care is led by a midwife or a nurse practitioner or somebody who has a birthing background. What the information shows is that Black women primarily benefit from psychosocial support (and this goes back to that sense of belonging) and having a person or people who understand the unique experience of being Black.

A mother might say: "I'm being treated differently and there is another voice or set of voices in a hospital setting who are going to advocate for me. If this is the birth plan I have put together and this is what I want to experience, as long as it is safe for me and my baby, I don't have to explain myself. And there's this group of people, or my midwife or my doula, who are going to make sure my wishes are carried out within this system."

When pregnant women have a support system, they have lower incidences of experiencing hypertension. Our blood pressure naturally goes up during labor and if you have lingering high blood pressure after you deliver a baby, that's a post-pregnancy complication that can impact your next pregnancy. Women are also more likely to say they feel a sense of satisfaction in their birthing experiences because their wishes were honored, meaning they got to do things the way they wanted to do them and received more patient-centered care. The medical research will show that the impact of implementing patient-centered care includes patients reporting lower complaints of pain post-surgery, for example, and that patients are more likely to be "medically compliant," meaning they come back for their follow-up appointment.

All of these things are impacted by having a relationship with a midwife or a doula or a support system as a part of the birthing experience. And these relationships need to continue well past the postpartum period. It's a major adjustment bringing a human being home; it's an adjustment for everybody in the household or everyone who knows you. Your whole life has to change and everybody else's life changes within the family structure, whatever that is, because this new human being has arrived. Having a support system helps take some of the load off the mom or dad or immediate biological caregivers. To take it back to the African village, the child is then the collective responsibility of us all.

Caruth: D'Yuanna, what kind of policy change is necessary to reduce or eliminate the disparities in Black maternal and infant health?

Allen Robb: I sometimes struggle with this question because one policy initiative that was put in place by the American College of Gynecologists (ACOG), which is the national governing body of licensed obstetrics, is what we call "safety bundles." These are protocols that hospitals are required to follow when they are providing care to women who are in labor. For example, one complication of labor can be a postpartum hemorrhage and when we look at maternal mortality quite a few women have died from this.

A story people might be familiar with is that of Charles Johnson and his wife Kira who died at Mount Sinai hospital in Los Angeles in 2016. Charles has been traveling the country talking about the changes that are needed. He testified before a Senate committee and helped to get legislation passed that authorized the Maternal Mortality Act, which sends millions of dollars flooding into states to help address maternal mortality. But here's the issue: You can have policies all day long and at the end of the day you still have biased human beings providing care. If you have a policy and the policy is not followed, the degree of reprimand could be some type of after-action review in the hospital to try to understand what happened. A physician may lose his license or a hospital may lose accreditation but this is rare. Policies in and of themselves are not enough.

The Alliance for Innovation on Maternal Health safety bundles as supported by ACOG and other national organizations are critical because they get hospitals to actually think and have protocols in place. But you have human beings who don't follow them because when they see me or you or Andrea, they don't think we deserve the best care. When Charles's wife complained of shivering and feeling like something was wrong, and even when Charles saw the blood in his wife's catheter (I'm paraphrasing his story), it didn't matter because she was Black.

Chung: I mean, if Serena Williams is dealing with it then…

Allen-Robb: Exactly. What I think we need are three things: Policies, yes, because there has to be some type of administrative structure that sets the standard for what an entity will and will not do in terms of care.

Two, there is a need for all kinds of training and for people to call out inequity when they see it. Every human being has biases and we've been socialized to have them. Many biases are subconscious and the fact that we have them isn't a reflection on an individual's moral character. It is simply a known fact of growing up in the Western hemisphere that you're going to have biases, so it's not something to be afraid of. But when those biases literally come down to life and death decisions, you have a practice responsibility as a licensed professional to be aware of your biases and there has to be a process in place for institutions to be able to address implicit bias.

Number three, we as consumers have to start demanding more. The internalized oppression that I think we carry sometimes as African American women may make us think, "I'm not really sure if this is what I deserve?"

Sometimes we don't know what quality looks like because if you're not white maybe you've never seen it. But we do know that something is wrong, and we have to start moving with our economic power.

Maternal mortality and infant mortality have been an issue since the first pregnancy and there's obviously been advances because of modern medicine. But in my non-researched opinion, village women have been delivering babies in sterile conditions and they have been just fine. Mom didn't die and her baby didn't die. Somebody cared about the mother, knew her name, knew her story, and was *excited* to welcome this child into the world. That is the difference. We need to be seen as human beings. Period.

Chung: How do you train someone to respect another person as a full human being?

Allen Robb: More of us have to be willing to do the hard work of becoming aware of our biases and those of the people around us. And institutions have to be willing to create spaces where those kinds of challenges can happen. The brilliant people at Harvard recognize that there are 138 different implicit biases (and those are just the ones we know of) and this is backed up by brain science. We can reprogram our brains; we can route new pathways. The brain is plastic and it can still learn. A doctor can reroute their brain from assuming that every Black woman is aggressive and a single mother and stop to read her chart, ask her questions, and act, not based on assumption, but what she actually says. For some people it's just a matter of asking them, "If this was your wife, if this was your daughter, what would you do for her?"

Chung: My gynecologist is a Black woman and I told her that I'd never had a Black gynecologist before—they're like unicorns. She said most gynecologists are white males, and there's a shortage of gynecologists in general. She also mentioned that biases aren't just coming from white doctors but from Black doctors too because of their training. It's like everybody needs to be reprogrammed because they've all been trained to think that Black women can bear more pain than other patients, or they've been trained not to listen to us. It's sad and even more frustrating when the biases are coming from a doctor who looks like you.

Allen-Robb: There are only two historically African American medical schools in the entire United States. One is at Howard in Washington, DC and

the other one is here at Meharry Medical College in Nashville. There's not a whole lot of opportunity for Black professionals who want to pursue medicine and have an unbiased experience, and there's only so many spaces for enrollment. The threat of racism intersects with everything. If you pull one thread in this tapestry, you're going to connect to many other threads. To map it back to photography, images can help open up a conversation about how all of these things are connected. There's an opportunity for every person to see themselves as being a part of the solution.

Caruth: Is there anything either of you want to say that feels relevant to this discussion that I haven't addressed?

Allen-Robb: I would love to see more local health departments embracing creativity and using photography to tell stories, understand root cause issues, and change the narrative. The narrative that we tell in public health is that people are sick and they don't live as long because of individual decisions. The narrative we should be telling is that people are sick and don't live as long because we did this to them, because of our racist inequities that have to change. It's not solely on the individual; it is on the system and the institution that is getting rich off of the fact that people are sick and dying early. I do believe that part of the role of public health, and those of us living in this society, is to push social justice forward because we all have a functional understanding of the disparities and there's no excuse. If we aren't telling these stories, if we aren't presenting pictures and our understanding to people, then things won't change.

There is evidence that change is happening because I can see it in the data. I can see that we have more babies being born today that are celebrating their first birthday than we did last year, and that's a very promising sign. It tells me not to take my foot off the gas. I'm going to continue moving forward and building this movement. We are saving ourselves and we just need more communities to do it so that no matter where you are, you and your family have the best chance that you can have.

Notes

1 "Mary Francis Hill Coley," Georgia Women of Achievement, https://www.georgiawomen.org/mary-francis-hill-coley.
2 Jackson, L. (1987) "The Production of George Stone's Film 'All My Babies: A Midwife's Own Story' (1952)," *Film History* 1, no. 4 (1987): 372, http://www.jstor.org/stable/3814989.
3 "About this collection," Library of Congress: Selections from the National Film Registry, https://www.loc.gov/collections/selections-from-the-national-film-registry/about-this-collection/.
4 Jackson, "The Production of George Stoney's Film," 387.
5 Fett, S. M. (2002) *Working Cures: Health, Healing, and Power on Southern Slave Plantations*. Chapel Hill: University of North Carolina Press, 55.
6 Centers for Disease Control (1990) "Differences in Maternal Mortality Among Black and White Women: United States," *Morbidity and Mortality Weekly Report*, no. 44 (January 13, 1995): 6–7,13–14, https://www.cdc.gov/mmwr/preview/mmwrhtml/00035538.htm.
7 Hoyert, D. L. S. F. G. Uddin, and A. M. Miniño (2020) "Evaluation of the Pregnancy Status Checkbox on the Identification of Maternal Deaths," *National Vital Statistics Reports* (January 30) https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69_01-508.pdf. And Dina Fine Maron, "Has Maternal Mortality Really Doubled in the U.S.?," *Scientific American* (June 8, 2015), http://www.scientificamerican.com/article/has-maternal-mortality-really-doubled-in-the-u-s/.
8 Petersen, E. E., N. L. Davis, D. Goodman, S. Cox, N. Mayes, E. Johnston, C. Syverson, K. Seed, C. K. Shapiro-Mendoza, W. M. Callaghan, and W. Barfield (2019) "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017," *Morbidity and Mortality Weekly Report*, no. 68 (May 10, 2019): 423–429, http://dx.doi.org/10.15585/mmwr.mm6818e1.
9 Greenwood, B. N., R. R. Hardeman, L. Huang, and A. Sojourner. (2020) "Physician–patient racial concordance and disparities in birthing mortality for newborns," *Proceedings of the National Academy of Sciences of the United States of America* 117, no. 35 (September 1): 21194–21200, https://www.pnas.org/content/pnas/117/35/21194.full.pdf.
10 Bahadur, N. (2020) "What It's Like to Be a Midwife or Doula Fighting Black Maternal Mortality," *Self* (January 13, 2020), https://www.self.com/story/midwives-doulas-black-maternal-mortality; and Janel Martinez, "What Black Doulas Are Doing to Keep Women and Children Alive," *Well + Good* (February 27, 2020), https://www.wellandgood.com/good-advice/black-doulas/.
11 Pérez, M. Z. (2015) "Granny Midwives' of the South," *Colorlines* (March 19), https://www.colorlines.com/articles/tbt-granny-midwives-south.
12 Jackson, "The Production of George Stoney's Film," 376.
13 Jackson, "The Production of George Stoney's Film," 386.
14 Villarosa, L. (2018) "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis," *The New York Times Magazine*, (April 11), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.