2021

Doulas, Community, and Care: Analyses of Doula Work Among Black Women in New York

Smelanda Jean-Baptiste

Doulas, Community, and Care: Analyses of Doula Work Among Black Women in New York

Smelanda Jean-Baptiste

Department of Anthropology and Sociology

Denison University

Advisor: Dr. Jane Saffitz

April 5th, 2021

Abstract

This research explores the work that Black, diasporic doulas do to support their birthing clients. Motivated by the disproportionate rates of maternal morbidity and mortality among Black women in the U.S., this paper seeks to characterize the core themes, values, and practices that are central to the work that my participants do. It also contextualizes doula work amidst the legacies of the medicalization of Black bodies, the delegitimization of African-descended midwifery and the persistence of obstetric violence since colonial times. As doulas are constantly circulating through various roles such as being educators, community resource networks, emotional supports, and more, we see that their job is not isolated within the nine months of pregnancy nor the months postpartum—the efficiency of their work depends on the continual practice of community-connectedness through forms of intimacy and care that span across space, place, time, institutions, and entities. I argue that the doulas I interviewed hold knowledge forms that are reflective of the community-centered values they hold through their identities as Black, diasporic doulas.

Table of Contents

Acknowledgements

I want to express my deepest gratitude to the doulas who trusted me in their space and shared their experiences with me. Thank you, Ms. Lesane, for your continued support and guidance throughout this project and for my future endeavors on maternal health. Thank you, Dr. Saffitz, for taking me in as an advisee and allowing me to delve deeper into a field I have been excited about for a long time. Thank you, Dr. King, for your guidance, presence, and mentorship, and for encouraging me to embrace creativity in my work. Thank you, Dr. Griffith, Dr. Sears, Dr. Davis, Nancy, and the ANSO department for a great four years of learning, fellowship, and community which, albeit cut short, filled me in ways which I will always be grateful. Thank you, Ebony, Jackie, Sandra, and my Schomburg cohort for making the past year bearable and allowing me to find joy and laughter in finishing my senior year.

Preface

The idea for this project arose in the Summer of 2020. To say the times were disheartening would be an understatement—videos of Black death pervaded news outlets to the point of near desensitization. People mobilized over the deaths of Breonna Taylor, George Floyd, and a continuing prevalence of white supremacy, systemic racism, and overall violence since the country's inception. In the mentally and physically constraining time of quarantine amidst a pandemic, I found community in a fellowship with the Schomburg Center as I was enriched by Black scholars and professors, my personal research on Haitian nurses and medical imperialism, and my fellow peers. I was indecisive about continuing my research on medical imperialism in Haiti from a historical anthropological lens, or staying contemporary with my recent interests in maternal health and doula work. I was introduced into the field of maternal health while an anxious junior searching for an internship in 2019. Having done various research assistant work around the health of marginalized women in different communities, I knew I wanted to apply my scholarship to practical experience working with nonprofits. While I ended up finding an internship in a writing field, I was able to contact the director of the Caribbean Women's Health Association and volunteer at their workshop targeting Haitian women and childbirth experiences. It was through this experience where the director informed me of doulas, which I had not heard much of before. Specifically, it was the existence of Haitian Creole-speaking doulas that the organization had in their network that caught my attention. Thinking about my mother and her own experiences navigating healthcare settings, I wondered what the significance was for Haitian women to have fellow Haitian doulas who spoke Creole.

I was very interested in the ties between language, race, and migration in the medical context. Though, I soon realized that I was less interested in linguistics, but rather I had questions of how intimacy, care, and community are cultivated and translated through the shared

experiences and social worlds enabled through racial and ethnic connections. Throughout the course of my fellowship this past summer I encountered many works on Blackness, intimacy, and history that truly contextualized the present-day angst I had around the protection, health, security, and wellbeing of Black women in the United States. Christina Sharpe, Saidiya Hartman, and Régine Michelle Jean-Charles were some of the scholars that helped me think through the importance of understanding generational constructions of raced and gendered bodies in the exploration of present realities. At the same time, while the archives hold very important philosophical and theoretical discourses that shape our understanding of the present, I was still passionate about hearing voices from the present. I decided to focus my research on Black doulas—the work they do, how they see that work, how they support their pregnant clients, and their impact on the birthing process.

Introduction

A few years ago, the car-packed streets of Brooklyn lit the gray October evening sky; an unexpected snow storm held everyone up. Amidst people trying to go home or to some other commitment, one small sedan held three people, four if you count the soon-arriving newborn. Martha, already in active labor, was sprawled on the backseat on all-fours, winter coat still on, practicing breathing techniques while Astrid, her doula, was wedged in the side with what little room available pressing her hands against Martha's hips under the coat fringes. While her husband drove them to the hospital, Astrid would guide Martha through breathing and alternating between hip-squeezes and shoulder blade counter-pressures, reassuring her that everything would be fine. It wasn't easy to convince Martha that it was time to go to the birthing center. While it is ideal to stay home as long as possible during labor before going to your place of birth, this wasn't Martha's first pregnancy, so her labor times were comparatively shorter than the first time around. Martha's original doula had an emergency and would not be available, so Astrid, the back-up doula who had been acquainted with Martha, met up at the house instead. It was typical: the contractions were slowly getting shorter apart, Astrid reminded Martha to breathe, the husband prepared a bag with all the essentials. "Okay, we have to go to the birthing center," Astrid would say. Martha was not having it. As she reminisced with me back in February of this year, "trying to convince a pregnant person that's actually in labor to do anything, let alone move?" She laughed. But Astrid was able to coach her through it and they were eventually able to make it to the birthing center.

Everything seemed to flow, Astrid reminisced. It was as if Martha, her body, and her soon-coming baby knew exactly what to do and when. By the time they all got to the birthing center, the transition phase of labor had started and Martha's contractions were getting more frequent and painful. Astrid helped Martha into the tub where she would have her water birth,

and from there it was smooth sailing. In the small bathroom with five people, including the husband, birthing assistant, and midwife, Astrid, again found herself wedged in between the toilet and tub, comforting Martha as she could. She poured water over her with a washcloth, letting Martha rest her head on her, and reminded her things would be alright and that despite all the pain, she will birth her baby−she was the only one who could. And Martha did. No guidance was necessary, Martha pushed when she felt she needed to, listening to the flow of her contractions and her intuition, and the newborn slid out and rose to the top of the tub peacefully.

'It was so like, relaxing," Astrid remembered. "You know, you get to see like, okay, this is what birthing was like before hospitals were introduced—and not to say there's anything wrong with giving birth at a hospital, but I think people—if more people got to see, like that, they would be like "wow, I want to do this too."'

Theoretical Frameworks and Insights

This project highlights the significance of doula work among Black, African-diasporic doulas and the communities they have worked with. Birth doulas are professionals trained to provide support throughout the span of their client's pregnancy so that they can achieve their birth goals. The service they provide is holistic in the sense that it typically ranges throughout the pregnancy process and into postpartum, including both material support (e.g. education, physical techniques, resource, and advocacy) and immaterial support (e.g. the fostering of emotional, spiritual, cultural and community connections). Motivated by the disproportionate rates of maternal morbidity and mortality in the U.S. and particularly in New York, my goal is to understand the work doulas do to support their clients. Located at the intersection of Black studies and medical anthropology, this project attends to nuanced understandings of marginalized bodies as they influence experiences of pregnancy and birth.

Black feminisms engage Black people and women specifically as experts in their experiential knowledge as a foundation for theorizing and understanding global oppressions of marginalized folks. Patricia Hill Collins's foundational work on Black feminist thought centers the unique experiential knowledge that Black women have through their very identity due to the ways in which they navigate the world as Black and female (Collins 1989). Specifically, "Black feminist thought articulates the taken-for-granted knowledge of African-American women, it also encourages all Black women to create new self-definitions that validate a Black woman's standpoint" (1989: 750). Furthermore, African American female literacies, seen as "cultural productions that are created to carve out free spaces in oppressive locations," inform my understandings of the type of knowledge production that the doulas in this study engage in, including the epistemologies they produce through the ways they talk about and describe their work (Richardson 2002: 678). This semi-ethnographic work prioritizes the ways in which my participants themselves see and define their work as doulas; it uplifts their diverse beliefs, values, and expertise as birth workers amidst the historical delegitimization of African and diasporic practices that that are not fully aligned with biomedical society.

Doulas are trained to view the totality of their client and center the individual in their unique situation (Gallicchio 2015). And yet, individual bodies are never divorced from their larger social, political, and historical context. The subjugation of Black reproductive bodies was imperative to the economic survival of slavery in the U.S., leading radical doula scholars to emphasize the importance of the Black body as an extension of its community for the sake of healing (Abegunde 2015). Likewise, anthropologists share in viewing the body as more than material, and embrace the social, political constructions that affect the way we understand and experience wellbeing, healing and illness in our society (Scheper-Hughes and Lock 1987). This project expands upon these theories by exploring how doulas' perceptions of themselves and

their work go beyond the just "doula work," but can reveal characteristics of care and support that are unique to the communities they come from.

Likewise, many pioneers of the reproductive justice movement were interested in creating a unique theoretical framework that undergirded their work against white supremacy's impact on Black mothers, families, and communities. Reproductive Justice (RJ) was coined by Loretta Ross, now the founder of the pioneering national justice organization SisterSong, along with twelve fellow Black women activists in 1994 at a national Chicago pro-choice conference. It is a "radical theory" that "opposes white supremacy as an ideology used to promote unequal laws, practices, and social outcomes" (Ross 2017; 13). RJ is focused on three core rights: the right to not have children, the right to have children under conditions chosen by the individual, and the right to parent children in safe and healthy environments. Heavily influenced by the legacies of colonialism, eugenics, genocide, forced sterilization, and the overall domination of Black bodies as reproductive subjects, RJ clearly identifies white supremacy—defined as "a totalizing system comprised of racism, sexism, homophobia, Christian nationalism, transphobia, ableism, and classism that differentiates who has access to institutionalized power"—as both a materially and theoretically violent entity that must be tackled in efforts towards the liberation of Black people and oppressed people globally (13). Not all doulas are nor aim to be radical doulas, however the fact remains that doulas of marginalized identities are constantly navigating a white supremacist society as well as biomedical institutions and spaces that continue to reproduce such ideologies. Therefore, doulas experiences should be looked at through the lens of the powers they often combat in both subtle and explicit ways.

Doulas are birth workers, but the roles and forms of support that the doulas featured in this paper embody are all in varying degrees concerned about the wellbeing of Black women, which highlights the need for a Black feminist health science perspective. A new field created by

Black feminist and disability scholar Moya Bailey, Black Feminist Health Science Studies (BFHSS) is "an emergent lens and praxis, built on existing and growing research that demands a multi-pronged approach to ameliorating the health disparities of Black women" (Bailey, 2017; 4). As an inherently interdisciplinary field, BFHSS is necessarily incorporated into this medical anthropological work in how it critically analyzes taken-for-granted assumptions legitimized through Western science, one example being "how the biomedical knowledge produced by physicians constructs certain bodies as normal and others as pathological" (2017: 3). This concept will be further elaborated in Part One.

Doulas are often navigating hospital spaces which are prime sites where biomedical ideologies around bodies, health, and healing appear in tangible ways. This paper is concerned about how doulas navigate such spaces that often contribute to adverse experiences of pregnancy and birth for marginalized women. Feminist geography perspectives allow me to frame how doulas and their clients navigate spaces and places that have been and continue to produce violent experiences (Pain and Staeheli 2014). At the same time, I am focused on how the doulas I interviewed build their own forms of space and place-making through their crucial roles of "holding space" and being a "witness" during pregnancy and in birth. I aim to display how doulas provide their own care practices and engender spaces of power and intimacy in birthing spaces.

This project was largely inspired by the work of Angela Castañeda and Julie Searcy, whose edited volume *Doulas and Intimate Labor* greatly informed my thinking of birth work and intimacy. Through their "physical, psychological, and emotional closeness to the labouring woman, doulas gain intimate knowledge" of their clients and their bodies (2015: xxi). As I will show in this paper, doula work deepens understandings of bodily care through the inherent relationality of the work they do. Their clients are not only birthing individuals, but have multi-dimensional needs beyond the aspects of their pregnancy. Intimate labor serves as a way of

understanding the "relational, fluid, and processual" work that doulas do: "as doulas move between worlds and learn to live in liminal spaces, they occupy space that allows them to generate new cultural narratives about birthing bodies" (2015: 130, 8).

Since the intimate labor doulas perform are tied to the support they offer, it is important to contrast their work from the ways in which larger governmental and biomedical institutions perform "care" on their populations. Medical anthropology can inform the unique ways in which doula work and biomedical institutions impose different forms of care onto individuals. Carolyn Suffrin explores the government's treatment of pregnant, carceral bodies and how care operates through multiple dimensions: "as concern, as relationship, and as practice," not only between everyday exchanges with people but also between carceral, biomedical and government structures (2017: 21). Similarly, Lisa Stevenson, influenced by Foucault's concept of biopower, illustrates how care can be seen on multiple levels, both everyday forms of care and "bureaucratic care" which desires to regulate vulnerable population's bodies to keep them alive or healthy according to a certain standard, which is not always in the best interests of the people (2014; 3). Defining care as "the way someone comes to matter and the corresponding ethics of attending to the other who matters," Stevenson shows the ways in which institutional entities have inherited often-dehumanizing care practices from colonialism (5). Likewise, I stress the importance of a historical and transnational Black feminist perspective that extends concepts of care to showing how Black reproductive bodies come to be regulated by biomedical institutions across the Black diaspora. This includes histories of medical imperialism, the violence against indigenous women and midwifery/herbalist practice in the Caribbean, and the ways in which, as Christina Sharpe contends, Black people continue to live "in the wake," in the legacy, of transatlantic slavery (2016). I hope to illustrate how doulas, while still interacting with and working with biomedical entities, can offer a counter-narrative to biomedicine which treats and

regulates bodies through homogenized and standardized forms of care, which, as BHFSS scrutinizes, "idealize[s] white bodies as exemplars, leaving other bodies working to meet these standards" (Bailey and Peoples 2017:20). While my scope of analysis for this project is broad, my theoretical perspective is pinpointed around the various ways in which doula work responds to the regulation and medicalization of Black bodies.

Methodology and Ethics

Pregnancy, childbirth, and parenthood are experiences that often leave a long-lasting mark on individuals, generating intense emotions and vulnerabilities that as a researcher I cannot take lightly. Any person who commits to being a doula must be prepared for the vulnerable situations their clients face during birth. This holds implications for how I conduct my research methods, and how I approach receiving stories that may evoke intense emotion. I am grateful to the doulas who have trusted me to share their life stories, fondest birth memories, traumatic birth experiences, and more. I view them as more than research subjects, but as people whose rich lives I cannot possibly encapsulate within the confines of this paper. At the same time, I seek to honor the unique experiences of each interview and not commensurate them, while still acknowledging the shared values and experiences they have that tie them together as African-descended women.

I collected data through dual means: semi-structured one-on-one interviews with doulas and social media and discourse analysis through social media, blogs, and doula websites. The goals of these methods were to capture both ways in which doula work operated both intimately and publicly within the doula's life as well as their target communities. These diverse stories were thematically analyzed and used to both supplement and diverge from existing (and dominant) epistemologies concerning doula work, biomedicine, cultural knowledge, and care.

I interviewed 11 doulas who identified as Black, African, or part of the African diaspora and were working in or around the New York area.[1] The goal of this method was to gather a scope of unique stories, knowledges, and beliefs around the realities and significance of doula work for various individuals, and tie these experiences around central themes. Two of the doulas were based in Connecticut, but have had clients based in New York. Doula working experience ranged from one year to over 20 years. Recruitment was conducted mostly through my work relationship with the Director of the Caribbean Women's Health Association in Brooklyn, which connected me to doulas who were part of the organization's community-based doula program. The interviews were hosted over Zoom and lasted approximately one hour and sometimes longer. The interview format was based on a set of IRB-approved questions, and the informal setting allowed interviewees to not be restricted in the topics, stories, or issues brought up. Informed consent was retrieved prior to interviews, and interviewees were informed that the Zoom sessions would be recorded and that they did not have to feel obligated to answer all questions or provide specific information about clients or locations.

Due to the constraints of the COVID-19 pandemic, I waived ethnographic research as is traditionally done in the field of anthropology and is defined, methodologically speaking, by participant observation and embeddedness within a community. While the sample of doulas interviewed does not compare to traditional ethnographies this paper instead focuses on the strengths of qualitative interpretations and attempts a "thick description" of the women

[1] The use of “diaspora” has many sociohistorical and geopolitical connotations and has been used in many movements to construct perceptions of pan-African unity. I am using diaspora as way to embrace the unique and different perspectives of individuals of the sociocultural construction of Blackness globally, and I am aware of how sociohistorical articulations of race allow for a constant need to critique the language we use concerning shared identities. Stuart Hall characterizes diaspora as “articulated, as a structured combination of elements ‘related as much through their differences as through their similarities.’” (Edwards 2001:66). While I use diaspora to highlight shared experiences of Blackness, I am cognizant that such experiences are by no means monolithic, and that more attention needs to be paid to the ways in which Blackness is experienced and (re)produced differently in various contexts.

interviewed as I explore the historical and contemporary social worlds that the doulas are immersed in through their identities, values, and the work that they do. Originating in anthropology, thick description attempts to contextualize human behavior in the social worlds, or the "multiplicity of complex social structures," of the people we study (Geertz 1973:10). Furthermore, feminist methodology contends that ethnography is not only meant to document the lives of the people we study, but to "to understand the experience of women from their own point of view," and to "conceptualize women's behavior as an expression of social contexts" (Reinharz 1992:51). The purpose of this ethnography is not only to document the work that Black doulas do, but to situate and interpret their point of view and behaviors as expressive of larger socio-historical contexts.

Out of a desire to immerse myself into the specific doula community that most of my interviewees reside in, I participated in a seven-week long doula training by Ancient Song Doula Services (ASDS), a Brooklyn-based, internationally-certifying organization and reproductive justice proponent that is focused on addressing the different experiences and needs surrounding birth among marginalized people. This training provided me with firsthand, up-to-date, and culturally-specific knowledge of the pedagogy, bodily techniques, and immaterial forms of care that doula work entails. ASDS is a "full spectrum labor and postpartum training," meaning that doulas are equipped to work with institutions and organizations to "provide care at no cost to individuals across the spectrum of pregnancy choices, including during abortions, miscarriages, stillbirth inductions, adoption planning, and births for low-income women" (Robinson and Mitchell 2015). An experiential understanding of doula pedagogies and skill sets was imperative to set the stage for my interviews and allow me to understand the nuances, references, and significance of the topics my doulas discussed. It was thus central to a project that promises to elucidate the intimate labor and forms of care that doulas provide to marginalized women.

Part One: Contextualizing Birth Work and Biomedicine in the United States

This section aims to contextualize the geographical and sociocultural histories that continue to impact the present-day realities of childbirth and birth support in the U.S., particularly among Black populations. Chapter One focuses on the practices of Black midwifery in the U.S. and the threat of biomedical and governmental institutions in delegitimizing its prevalence throughout the 19th and 20th centuries. Chapter Two narrows into the ways in which Black reproductive bodies were integral in the professionalization of biomedical fields, specifically gynecology. I then turn to the present-day context of medicalization in New York, where most my doulas work in, and highlight the continuation of centuries-old attempts to medicalize Black bodies.

While this study focuses on doula work in the U.S. context, nearly half of my doulas are from or descended from Caribbean and Central American countries, namely Haiti, the Dominican Republic, Guatemala, Jamaica, St. Thomas, and more. New York is a diverse state with a high immigrant population, so doulas have worked with clients from a range of countries including those from Africa and Asian countries. While this paper will not be going into the rich histories of indigenous and diasporic birthing, healing, and spiritual practices, I find it important to stress their importance in the context of birthing in the U.S. My desire to contextualize these backgrounds arises due to how they influence many of my doulas and their work, whether through their knowledge about birth, herbs and healing, foods, and more. Additionally, I find it important to note the expansive influence of U.S. empire, which has had pervasive effects on restructuring health systems and marginalizing native health practices in many countries. This study is partially focused on how doulas navigate a U.S. biomedical society, however it must be

noted that we cannot separate such discussions from the ways in which globalization, colonialism, and imperialism also contributed to biomedical dominance in other countries.

Chapter One: Black Midwifery and Biomedicine

> *I'm learning these skills of birth from other women who know how to do the work. And we're passing this down within our community and enabling the success of each other's birth experience. Either through knowledge or bearing witness….that's how midwifery originated. These kinds of communal birth skills. Only recently did some white man take birth outside of people's homes, from the granny midwives who were teaching the white nurses and the white doctors and then the white doctors said 'I know you taught me this, but I know how to do it better with my machines and my shit in this hospital.' That shit is new. So, you think I'm gonna sit here and believe, that for some reason he's going to do it better than how it's been done for ages, for centuries, for life-time? Nah. That's not how this works. So what I'm doing is unlearning, reteaching, and continuing very ancient practices.*
>
> —*Fabiola, Doula*

Before the medicalization of pregnancy, birth attendants held esteemed roles in their communities. African diaspora scholars have discussed how Africans enslaved in the U.S. continued the practices that had been commonplace in their homeland, including practices around healing and birth. South Carolinian Black birthing practices and midwifery—which had a strong presence during the antebellum period and holds continued influences today—was strongly influenced by the ideologies and practices surrounding healing and the importance of

nature for the therapeutic use of herbs (Hudson 1994; Brown 2001). Hudson notes that these practices were "a crucial source of empowerment and resistance to dominant cultural practices," and enslaved African midwives contributed largely to the passing down of these practices by practicing it throughout their communities (215-16).

With the colonial founding of new fields in modern medicine (see chapter 2), white male doctors have attempted to override midwifery through legislation since the 1800s, even though their deliveries resulted in more infant and maternal mortality (Wertz and Wertz 1989; Simonds 2007). It was not until the increasing standardization of medical practices and increase in hospitals in the mid-20th century that more women started using physicians rather than midwives for pregnancy support, the percentage of midwife-attended births decreasing from almost 50% to 12.5% (Yoder 2018). However, this mostly applied to white women; Black midwives were still a strong presence in many poor and rural communities, and the need was compounded by the continuation of post-emancipation economic and geographic discrimination through Jim Crow legislation, leaving largely-Black communities with few medical resources (Robinson 1984).

Perceptions of African-descended people, both locally and institutionally, contributed to the struggles Black midwives and their communities had in their birthing practices. Historically, medical discourse has sought to put Black midwifery and practices in juxtaposition with contemporary medicine, often stereotyping by conflating Blackness with uncleanliness, ignorance, and adverse birth outcomes (Muigai 2019; McMillen 1991; Craven and Glatzel 2010). On a legislative level, scholars note the importance of the 1921 Sheppard-Towner Act as one of many contributors to the delegitimization of traditional Black midwifery practices and the further medicalization of pregnancy and birth. The legislation had various aims: it provided monetary incentive for states to train midwives through the guidance of nurses, to implement health programs and clinics to reach those who could not receive obstetric care, and to integrate

immigrants into the U.S. birthing system (Anderson et al. 2020; Menzel 2020; Suarez 2020; Craven and Glatzel 2010; Ladd 1988). While some argue that the licensing restrictions on midwifery care were positive to Black midwives, (Anderson et al. 2020) others contend that in fact, the act only boosted the political power of white women who were advocating for reproductive rights alongside the right to vote, and further allowed white nurses who travelled down South to train Black midwives to reproduce perceptions of Black uncleanliness and ignorance as contributors to infant mortality, as opposed to poverty and racial violence (Cancelmo 2021; Menzel 2020; Suarez 2020). The increase in state requirements for midwifery licensing only contributed to the further distancing of Black Southern midwives from generationally-passed and efficacious methods of healing and birthing practice.

Amidst the struggle that Black birth workers had in opposition to oppressive biomedical systems, it is important to acknowledge the forms of resistance that are constantly being exerted and how this applies to doula care today (Foucault 1978). Following the Sheppard-Towner Act, head midwives and health authorities were able to inspect a midwife's bag at random (during midwife meetings, home-visits, etc.) to make sure they were using the proper tools as designated by biomedical standards and that they were not doing any practices outside of their jurisdiction (Menzel 2020). Unsurprisingly, this act of surveillance mostly targeted Black midwives disproportionately in an attempt to discourage the use of traditional practices and tools such as herbs, teas, gloves for vaginal checks during labor, burning tools for postpartum rituals, vernacular and physician-provided medicines, and more (Ladd-Taylor 1988; Menzel 2020). However, various historical accounts show that they circumvented these practices, whether it be through carrying two bags—one for inspection and one for use—or simply refusing to practice (Menzel 2020). Fundamental to note, midwives were not refusing "the official tools and tasks of

hygiene," but rather they were affirming their "capabilities, the forms of expertise that they had learned through apprenticeship and their own experiences as practitioners" (Menzel 2020; 301).

With the rise of reproductive justice pioneered towards the health and safety of Black mothers and babies, doulas of marginalized communities are also standing firm in their generationally-rooted epistemologies, and many are determined to serve the communities they are a part of. The Birthing Project, founded by Kathryn Hill-Truijillo, is one example of continued birth activism for Black communities. The organization supplies young pregnant women with mentors, "Sister Friends," throughout pregnancy and in the first year postpartum in order to support them, whether it be community resources, emotional support, or helping families through doctors' visits and pre/postnatal care. Anthropologist Dana-Ain Davis highlights Hill-Trujillo's motivations in starting the Project, being her personal understanding that "their [family's] lives were entwined with the lives of others in their community (2019; 8). Furthermore, it "creates a sense of belonging and connection among Black women," and "reestablishes a collective witness to Black births in order to legitimate children's existence" (9). Among many Black birth activists, it is evident that presence, mentorship, guidance, and community are seen as inextricably linked values in the struggle to ensure the survival of Black families in the reproductive context.

Another example of an organization doing ancestrally-rooted and community-focused work is Ancient Song Doula Services (ASDS), founded by Chanel Porchia-Albert. Most of my participants were trained through ASDS at some point in the beginning or throughout their practice (doulas can receive multiple trainings and certifications through various organizations). ASDS is a reproductive justice, activist, and doula training organization that also provides doula services to women of color and low-income families. It emphasizes using "ancient principles of birthing" alongside "modern modalities" as foundational to eliminating health inequities in

marginalized communities (Davis 2019: 4; Ancient Song Doula Services n.d.). Valuing the integration of passed-down indigenous and diasporic practices into a biomedically-dominated society, the organization strives to perpetuate the demedicalization and decolonization birth in the U.S. (which is best seen through their annual Decolonize Birth Conference). Whether explicitly or more personally, my participants all hold varying degrees of cultural, familial, and/or generational values that influence how they do their work as doulas. Among the doulas there are various values that showcase this which are by no means monolithic: the value of spirituality and prayer among doulas, the reliance on ancestral guidance, the relating to clients through lens of kinship, the awareness of diasporic roots of indigenous midwifery, and more. In Part Two, I show how these doulas, through their ideologies and practice around the work they do, are centered in relation to others as extensions of community.

Chapter Two: U.S. Colonial Medicine, Obstetric Violence, and Contextualizing New York Health Care

> *Black women are dying...and not because we can't birth, and because stuff is messed up, it's because of racism. [Medical] Students think that because you're Black you don't feel pain and if you're asking for an epidural a medication to assist you in that process then 'oh you don't need it,' or 'you're not hurt.'*
>
> *-Indira, Doula*

Conversation around maternal health in the U.S. cannot be separated from the founding modern medical fields which were furthered by the exploitation of Black bodies as subjects for scientific gains. In this section I overview a selective history of colonial medicine as it relates to

the founding of gynecology, the increasing biomedicalization of reproductive life, and its continuing impact in the U.S., specifically in the New York health care system.

Colonial Medicine and the Medicalization of Birth

During the trans-Atlantic slave trade, the "health" (which can be synonymized with "survival") of enslaved Africans only mattered due to the fact that they were seen and treated as commodities for profit and nation-building. Sowande' Mustakeem details how since slave ships were sites of perpetual ailment for all, physicians aboard the ship "generated both economic and professional benefits often unattainable in their homelands (2016: 132). Physicians' access to Black bodies were often used for the advancement of knowledge that, of course, did not benefit the enslaved. Physicians, in their ability to experiment on techniques and treatments to maladies and then continue their knowledge-searching through autopsy, were "acting upon the privilege, right, and power granted to him as both a professional and slave trade worker over an ailing and dead slave" (145). Slavery was an inherent biopolitical apparatus, one that assumed control over Black bodies even after death. Women, and particularly pregnant women, faced strengthened "efforts" from physicians to preserve their lives due to their reproductive "investment" to furthering the slave population (147). Physicians were integral to the slave market through their inspections of Black bodies and assuring that they were "sound" for sale (Owens and Fett 2019). To be a southern physician in the 19th century United States, there was an expectation that "to accurately determine the market value of Black bodies was one of the key professional competencies" (Owens and Fett 2019; 1342).

Black bodies were both indispensable and disposable, highlighting a contradictory reality that perpetuated gender-based racial violence throughout the centuries. In 1662, the state of Virginia passed a law, partus sequitur ventrem —"offspring follows belly"— which designated

that any child born from a Black woman would have the same legal status as the mother (Morgan 2018). This accounted for the ambiguities over whether mixed-raced infants born from African-descended enslaved women should be in bondage or have status as free citizens, but it also operated on a grander scale. After the U.S. banned the trans-Atlantic slave trade in 1807, partus sequitur ventrem helped to secure a means to continue slavery. Black women were reproductive and political subjects as established through governmental law—the issue of their reproduction was fundamental to the nation whose economic and sociocultural survival depended on the labor of its enslaved population. This provided an optimal venue for medical exploitation which contributed to the professionalization of biomedicine in the U.S.

Medicine was deeply tied to the sustenance of slave economy, and consequently the building of nations not only through the need of forced labor, but through the immaterial knowledges around bodies and science that were gained through making Black bodies into specimens. Owens and Fett note that "medical journals and planter records in the British West Indies and the United States reveal growing attention paid by White physicians to enslaved women's reproductive lives" (2019: 1343). Similarly, Black bodies were used to further the education of medical students through the use of their bodies in medical museums and schools in the South (Kenny 2013). Additionally, just as physicians during the Middle Passage were able to use their experiences on ships to further their medical careers, "white physicians in 18th- and 19th- century slave societies built their reputations by 'medicalizing Blackness' in their professional writings" (Owens and Fett 2019: 1342). The reproductive life of enslaved women was fundamental to Marion Sims' eventual title as the "father of modern gynecology." Deidre Cooper Owens details how Sim's biomedical advancements, notably the founding of the speculum and the surgical repair of vaginal fistulas, were dependent on his continual experimentation of over a dozen enslaved women and girls in the slave hospital he founded and

worked in between 1844 to 1849 (2017). Owens notes that "the increasing ability of Dr. Sims and other men to heal and repair women's bodies encouraged the growth of gynecology as a profession and elevated it to a respected medical specialty" (39). The medicalization of Black bodies operated transnationally and institutionally. François-Marie Prevost was titled "Father of the Cesarean Section" after he had perfected the procedure on enslaved women in Louisiana, after escaping Haiti shortly after the Haitian Revolution (Owens 2017: 25, 26). As noted in chapter 1, the increasing dominance of white male physicians over midwives contributed to the further marginalization of the practice of midwifery for both Black and white midwives. The establishment of the American Medical Association in 1847, who Sims was at one point the president of, only aided in further increasing the legitimization of American medicine.

The use of Black reproductive bodies continues into the 20th century as the notions of Black in/dispensability continue to evolve. The use of Henrietta Lacks' DNA to study the growth of cancerous cells and the purposeful non-treatment of Black men in the government-funded Tuskegee Syphilis experiments are only two of many examples of the persistence of medical racism throughout the 20th century. Disenfranchisement and social control of Black bodies continued post-slavery through various means such as the segregation of hospitals, the coerced sterilization of Black women, and the persistence of racial discourse around family planning and contraceptive use (Prather et. al 2018). Medical racism and inequalities are reproduced today as centuries-old racial (il)logic inform medical education. Dana-Ain Davis notes how perceptions of Black "endurance and durability, as well as expendability" continue in material forms such as in lower prescription of pain medication to Black patients and beliefs of inherent biological difference (2019:100; Singhal et. al. 2016; Hoffman et. al. 2016). In the context of New York, where most my doulas work, there are hyper-visible disparities in how Black reproductive bodies navigate health care, medical interventions, and pregnancy access.

Contextualizing New York Health Care

Medicalization, most generally, is the process in which human experiences, phenomena, and behaviors are medically defined and seen as "mandating or licensing the medical profession to provide some type of treatment for it (Conrad 1975:12). In an overview of the history of discourses around medicalization, Conrad (1992) records that one of the levels through which the process occurs is institutional. In New York, the evidence of institutional overmedicalization is apparent in the fact of the state's 34% average cesarean section rate, with most individual hospitals rating over 20% and stretching into the 40s and 50s rate (New York City Profiles 2017). The World Health Organization has stated there is "no justification for a rate above 15%, (World Health Organization 2015) and while cesareans and other obstetric procedures can be seen as a medically necessary approach for certain situations, when done unnecessarily (i.e. to low-risk women) they can increase the chance of morbidity and mortality, infection, injury of other organs, and lessen the chances of breastfeeding (Gotbaum 2006).

The racial and ethnic disparities in birth—the often-highlighted statistic of Black women in NY being twelve times as likely as their white counterparts to die from pregnancy-related causes—are directly connected to medicalization (New York City Department of Health and Mental Hygiene 2016; Strauss 2018). While c-section rates have increased for all birthing people in the U.S. in past decades, there have been a multitude of studies and reports that have underscored the heightened performance of c-sections based on race and immigration status (Janevic et al. 2014; Huesch and Doctor 2015; Getahun and al. 2009). Further reports have highlighted structural and systemic racism as a contributing factor, seen in physician-patient interactions and more largely, the physical manifestations (such as hypertension) of living in a racist society (Taylor 2019; Owens and Fett 2019).

In biomedically-dominated society, births outside of the hospital are seen as unreliable, which is a growing factor to fears many pregnant individuals have around birthing at home or in a birthing center, which are facilities usually staffed with midwives that allow for more home-like, private, and hands-off birth experiences. As of 2017 and 2018, there were only three birthing centers and less than 1% of people deciding to birth at home or at a center (Satow 2018; MacDorman et al. 2018). Furthermore, almost half of New York City hospitals providing maternity services have no midwives available (Strauss 2018). This contributes to the lack of knowledge and access about birthing alternatives and reflects the continuing ideological dominance of physician-provided care.

Doulas have been shown to contribute to positive outcomes in birth, their presence linked with reduced rates of preterm births, cesarean sections, labor times, and dissatisfaction towards birth experiences and increased breastfeeding rates (Hodnett et. al., 2013; Thurston et al. 2019). It has also been shown that Black and low-income women are the most likely to want but least likely to have access to doula care (Kozhimannil et al., 2014). In the beginning of the COVID-19 pandemic, New York had initially banned doulas from being able to physically assist clients in hospitals. On April 29th, 2020, Governor Andrew Cuomo signed an Executive Order which allowed doulas to be able to enter hospitals and support their clients throughout the duration of their pregnancy (New York State 2020). Doulas note continuing struggles in supporting clients due to the pandemic and also due to navigating dynamics in medical spaces. This legal backing has been generally characterized by doulas I have spoken with as a move forward in terms of the integration of doulas into the health care system. Some doulas, however, remain hesitant about the order, and question the implications for the future of doula work as they increasingly become seen as essential workers tied to state systems.

Past and Present Realities

Christina Sharpe uses the metaphor of the slave ship to build the concept of the wake, the ways in which Black individual lives are "produced and determined, though not absolutely, by the afterlives of slavery" (2016: 8). This can be seen through the continuing perpetuation of generational trauma and medical dehumanization in the communities that the doulas I interviewed do their work in. At the same time, due to the histories they've inherited and the realities they face, Black doulas are experts in understanding the various power dynamics and factors that shape how they need to show up as supporters for their clients. Jennifer L. Morgan argued that even through partum ventrum sequitur formed African women into "early theorists of power" who through first-hand experience knew how "the alienation of their children placed them at the crux of unprecedented individual and systemic violence" (2018:16). Just as Black feminists emphasize Black women's experiential knowledge as expertise, I hope to highlight my doulas' intentional awareness around the acts of support and care they provide for others, and honor the multiple realities that they have shared with me.

Part Two: Doula Epistemologies

In this section I attempt to characterize the core themes, values, and practices that are central to the work that my participants do. The epistemologies and cultural literacies—the ways of knowing and the(re)producing of specific forms of knowledge—of doula care manifest in tangible forms of support practices. The work that my doulas do are not only outward-facing or surface level, but they are also representative of individual, community-based, and generationally passed down forms of knowledge that are immaterial, spiritual, and relational. Values that span throughout past, present, and future relationships reflect doulas' desires to humanize birth, and consequently humanize their communities. This counters an intentional awareness of the biomedical standardization of birth that dehumanizes individuals' unique needs and wants and

homogenizes groups into populations (Bridges 2011). Contrary to this homogenization, Marie E. Hamilton Abegunde—a doula, Egungun (ancestral) priest, and Yoruba devotee—says that "from a Yoruba-based perspective, and maybe even an African-based one, becoming human is a multi-dimensional community venture steeped in the creation of worlds within worlds" (2015: 99). Similarly, I hope to highlight the multidimensional worlds that my doulas and their clients navigate, all of which illuminate various practices and knowledges that constitute doula care.

The structure of Part Two contains overlapping themes due to the ways in which the various dimensions of doula work are connected. Doula work is not easily separated into prepartum, birth, and postpartum: doulas are constantly circulating through various roles such as being educators, community resource networks, emotional supports, and more. The liminality of doula work is furthered by the fact that doulas are never navigating the same spatial and intimate relationships, because as is commonly stated, no two births are alike. For birth doulas, their job is not isolated within the nine months of pregnancy nor the months postpartum; the efficiency of their work depends on the continual practice of social and community-connectedness across space and place, time, institutions, and entities. I argue that the doulas I interviewed hold knowledge forms that are reflective of the community-centered values they hold through their identities as Black, diasporic doulas.

Chapter Three: Prepartum Support

Most doulas were doulas the whole time, it's just that they kind of gave this more concrete education in order to certify as a doula. But typically most doulas already have that love and empathy and desire to help people…

-Jade, Doula

Barbara, a doula from Connecticut, found out what doulas were through her job working at a maternity home—housing for pregnant individuals—in the Bronx. As a guidance counselor in the home, her job was to help women make plans in other areas of their life (school, employment, etc.) and to help them in their transition into parenthood. One day the home received a new tenant, Ada, who was fleeing a domestic violence situation from down south; having been referred from another shelter, she had arrived 9 months pregnant and due that same week. While it wasn't in Barbara's job to attend births, she decided to stop by the hospital when Ada was laboring to hand her a coloring book, which she recalled Ada saying she loved. When she got to the hospital, she realized that all her conceptions of birth were misconceived—Ada was in active labor, not the "fluffy" early stages, and she definitely was not in the headspace to color. On the spot Barbara's co-worker, who was supporting Ada, asked to switch places so she could head home, wash up and eat. Labor had been going on for 13 hours, and Ada couldn't have an epidural due to pre-existing issues with her back. Promising she'd be back in 30 minutes, the co-worker left Barbara; just as she left the hospital, Ada had progressed into the pushing stage of labor. Inexperienced, Barbara was briefly taught by the nurse how to coach the pregnant woman through pushing along with the contractions. With no family in the country, Barbara's presence was her biggest support at the moment. Holding onto Ada's hand just as the nurse taught her, Barbara recalls feeling overwhelmed to tears when the woman gave birth, even being the one to cut the baby's umbilical cord. It was then that the nurse noticed her again and said, "you would make a really great doula." After looking up the term after the birth, Barbara knew she had to pursue doula work. "From that day forward I was like, I have to serve women in this capacity.

—

A doula's role revolves around the needs of their client. From the first introductory meeting to figure out whether the doula and client are a good fit for each other, to the crucial moments of birth, to the following up after, a doula is constantly thinking, planning, and showing up for their clients on multiple levels. Typically, a doula's relationship with their client starts at the beginning of the client's pregnancy or first few months. It is around this time where the client will talk about their birthing goals, concerns, relevant pregnancy or medical histories, and what they want in a doula. If a doula decides to take on that client, they will meet occasionally throughout the course of the pregnancy and the doula will be available through phone, text, or any other form of communication to answer any questions or concerns of the client, even in the middle of the night.

A fundamental part of doula care is education and sharing information and resources—the range of this education is endless and varies based on the desires and needs of the clients. Some may already come in knowing all the biological processes of birth, or may have questions for their doula about balancing hormones or what types of foods are best for pregnancy. Some clients may not care at all about the intricacies of birth, but may have fears about their baby's health or questions about where to birth. For Astrid, a Haitian woman who has been a doula for over 4 years, a lot of her prenatal visits can be spent encouraging her clients to get familiar with the location of their birth.

> Not even encourage, if they're my client we have to find out where you're giving birth. It's like when you're going into a restaurant, you don't just eat, you don't just pick a random restaurant. You do research on it. So it's the same thing for me giving birth. You know, look up things online, see what their statistics are for their c-section rates. Or take a hospital tour, be familiar with the environment, speak to a provider about things before you have them catch your baby, because you don't want to be asking any question, your doctor questions, when they're catching the baby. You want to know what their thoughts are on x, y, z, before you go in there. Like, what

> are their thoughts on eating food? What are their thoughts on you being able to labor outside of the hospital bed? So, those are the things that are so simple, but very important.

The act of gathering information about a birthing location is approached as a baseline prerequisite in the pregnancy process for Astrid. It is an attempt to familiarize clients with an often-unfamiliar environment as well as a way to know what to expect when in labor, and whether a location can accommodate the individual's desires for the type of environment they want to birth in. Similar to choosing a restaurant, this preparatory step is important so that the client can know the space they are entering and the biomedical culture. This is also important in addressing surprises when it is time to labor, which Astrid discusses among her Haitian immigrant clients:

> I will say one thing about helping Haitian clients is that, they don't realize how difficult or different the U.S. medical system can be. So I remember I had another client where during a prenatal I'm just telling her like, I said something about the goal is to labor at home for as long as possible then head to the hospital, because when you get to the hospital, all you're gonna have is ice chips. She was like "wait, I can't eat when I get there?" and I'm like no...so it's certain things like that, certain things that are normal to them in Haiti is not like that [here]...

Astrid holds a dual knowledge of the Haitian and New York birthing contexts which she yields to prepare her client in navigating new spaces, which, in the case of eating, may bring along disappointment. While being able to understand client expectations comes through conversation, relating to client's experiences also impacts the efficacy of the support they can offer. Karry is a doula coordinator for a community-based doula program in New York that provides free doula care to people in the community. She talks about the larger importance of why her organization seeks to match clients with doulas of similar cultural backgrounds:

> Most of the doulas that we do work with come from the same communities of the clientele that they're serving. So they have an experience that themselves, they probably know someone who

> has experienced that kind of discrimination, or that negativity that comes with being a Black and brown person when you go to try and get access to health care. So being that I work here, I see that, I lived it, and working in that community, the community where we serve, we get to see the difference that we're making.

The ability for doulas to have shared experience and lived realities as their clients is tied to their ability to better support their clients. Of course, race or ethnicity is not a tell-all: a few of my doulas note that they or their clients have had negative experiences with medical staff that were Black, highlighting a broader issue with hospital culture and education. At the same time, Karry suggests that being able to relate to a doula can open pathways of vulnerability and trust for a client:

> It's a more [feeling of] comfortability, you feel more—you discuss things with them, especially if they're exactly from where you're from, you feel a little bit more comfortable, and then you can be more receptive of what the information that they can offer to you as well. So I think it's better because then you have a better understanding of that person. The person feels more prone to opening up to you.

Doulas help perpetuate placemaking and belonging for their clients, which can impact them beyond their birth. Karry finds that many, though not all, of their clients do not have additional support systems, mostly because they recently migrated and have family back home. For all of my doulas, their racial and/or ethnic identity factored in varying degrees in their decisions to become doulas. A study in Minneapolis reported similarly, that doulas of color largely had a desire to serve their racial, ethnic, and/or cultural community (Hardeman and Kozhimannil 2016). In terms of how that translates to work, Astrid's awareness that her communities face "more challenges" in the medical sphere contributes to the heightened importance of informational and educational support, which all doulas typically provide:

> I think it plays into it tremendously, like, there's never a day where...I'm not thinking about my work as a Black woman. It plays into it heavily. I make sure that when clients are looking for me in my bios, I state the obvious—that I'm a Black woman, and that I was born in Haiti, and that my role, my job is to support people who look like me, but of course I'm open to supporting other ethnicities, but overall, I love supporting people that look like me because often times we're the ones that are faced with more challenges when it comes to the medical system, so, yeah.

Doulas' interactions with clients are not only focused on the health of the baby: doulas are concerned with aspects such as their client's mental wellbeing, building rapport with family and supports, lowering fears over birth and motherhood, facilitating biomedical encounters (when necessary) and more. For Cassandra, she notes her doula approach as light-hearted:

> I think I am approachable, a little ratchet, fun, just like—the way I approach it, if you're pregnant, what my clients tend to want is community, someone with whom they can discuss life issues, that is really like an advocate in support of the way that they want to experience labor. So I am "your way is my way"...For me it is a dynamic and a relationship that I don't take lightly with the person that is pregnant. We definitely go in with like a really, fun, looking at this like a life experience type of thing, and moderately relax as much as possible.

The ability for Cassandra to build community with her clients, most of whom are Black, through her approachability is seen as translating into the support she offers in advocacy for her client's goals, whatever they may be. Cassandra performs an embodied care that is 'relational, fluid and processual,'" or as doulas have described it, a "doula spirit" (Castañeda and Searcy 2015:130; Jaye 2004: 41). Cassandra highlights her profession beyond the conventions of professionalism where the doula and client are strictly operating on transactional and static terms. Instead, doulas are centered around the "hopes, fears, plans and goals of their clients," which immediately open up pathways to pluralistic experiences of birth, as opposed to seeing their clients as a "homogenized institutional birthing body" that takes a "one size fits all"

approach (Castañeda and Searcy 2015: 135). This practice is most evidently seen in the birth plan.

The Birth Plan and Facilitating Client Desires

Building a birth plan is a foundational step in the doula-client prepartum relationship, as it sets the stage for how the doula will prepare to support the client through education and planning, and then at the critical moment of birth. A birth plan more generally is the intent someone has for their birth. In the doula context, it is often written down in a document which outlines the client's ideal conditions for birth. It is a flexible document that can be short and straightforward or include a multitude of information: what type of birth the client intends to have—vaginal, planned induction or cesarean, hydrobirth, with or without pain medication, etc.; the location of birth; home, birthing center, hospital, etc.; contact information of doctors, support systems, and other necessary resources. A birth plan can also include information about the client's relevant medical histories and how that informs their birth, for example if a client wants a vbac (vaginal birth after having had a previous caesarean section).

The birth plan assumes that the pregnant individual has a right to choose the type of birth they want, which is a core tenant of reproductive justice advocacy. However, in a state with few midwifery-model hospitals and even fewer birthing centers, the idea of the birth plan as a technology of "choice" can be challenged (Mol 2009). Regardless, doulas often attempt to highlight the alternative options that a client has to hospital births, such as birthing center or home births. Many of the doulas I spoke with noted the lack of awareness their clients have about other birthing options until they discuss them together. Barbara, notes:

> One thing I see is that as soon as a Black woman gets pregnant, it's like, "okay what hospital?" It's even the language, or the programming. "Okay I gotta go to a hospital" no you don't. You don't have to go to a hospital, you can have your baby in your home. You can have your baby at a

> birthing center. If you fit the bill for what that can be, then you can—if you want natural birth, then there's other options, you know.

Some doulas state that factors of proximity and prominence of a hospital can contribute to initial decisions around where they birth. For example, an individual knows of family members or friends who have birthed at a certain hospital or has had positive experiences there. On the other hand, lack of knowledge is also a large factor, with most of my doulas mentioning that they believe their clients would choose home or birthing center births if they knew more about it or if it was more easily accessible through insurance. Astrid says that as a doula she offers birthing options that a client may not have considered based on their own birth goals.

> Well I think the goal is really what they want, so like do you want a natural birth, do you want to birth at the hospital? And then I customize my role to what they want...So if there's a client that's telling me like "hey I wanna have a natural birth and I'm low-risk" and so on and so on, I'm like, "okay have you considered giving birth outside of the hospital? Have you considered giving birth at home?" So, it just depends on what they want and then I'm like okay, let me hear what they want first. Because essentially it is to support them, so I have to figure out which path we're going down, and then see how to best support them.

Doulas often help facilitate the communication of the birth plan by aiding in preparing for prenatal check-up appointments. If the client would like, doulas can go to the client's prenatal appointments with them. A doula can also have a set of questions that the clients can ask to their doctor, which Astrid elaborates on:

> I have a sheet that kind of has all those questions already for them to kind of ask. But in the beginning when I first became a doula, I would go to like prenatal visits with clients. Not a lot but I would go, but more so now, I really just prep them before they go, and then I'm always available for them to just text me and say "hey, this is what's going on," or so on and so on. So, I make sure that they're prepared before they go.

Gisele, who has been a practicing doula for four years, is more likely to go to prenatal appointments if her client's doctor is part of a small practice, or if a midwife is giving birth, since the likelihood of that doctor delivering the baby is higher. The purpose of these types of prenatal preparations is to make sure that the client's desires and birth plan is communicated with the medical parties who are expected to be involved during birth. Gisele finds prenatal appointments a great time for the client to bring and discuss their birth plan and ensure that the doctor and the hospital's policies can work with their plan. Examples include the ability to use objects such as a squat ball during birth, knowing whether intermittent monitoring by staff is standard practice, whether food is allowed, and more.

In the prepartum stage, doulas are not only preparing for birth, but they are concerned about the present-day, multi-dimensional needs that pertain to the client's life. For these doulas, this can vary depending on who they are serving. Fabiola, a doula in Yonkers, notes that her role as a doula functions on multiple relational levels:

> I am everything to my client—their sister, their mother, their best friend, their provider...everything. I'm their one-stop shop. And if they need, and it's beyond my scope, then it's up to me to help connect them to what they need. Whether that's a place to live, how to apply to food stamps, a dv [domestic violence] counselor, just everything, I'm everything. I will deliver their baby too, that's my scope.

Fabiola's intimate connection to her clients prompts her to care for her client by connecting her with community resources that will ensure her day-to-day needs. Fabiola is also trained in birth trauma-informed care, midwifery assistance, herbalism, prenatal yoga, indigenous postpartum care practices, and more. She sees doula work as a profession of constant learning, which is necessary for the communities she is passionate about serving:

> It just doesn't end. Literally...My son's dad I remember he was like, 'you're always in a training.' But there is so much to learn, and—very different from white doulas that are like 'this is my

> scope,' and 'this isn't my scope' and that's bullshit. As a woman of color, the need is so high in our community that we're literally everything. Sometimes we are their provider, sometimes I am their doctor, their herbalist, am I their mental health practitioner.

Fabiola's work is attuned to the diverse needs that her communities may need and not have access to, and is willing to embody the various roles that her clients may require. However, not all doulas may feel comfortable performing certain roles and some stress their need to establish boundaries in the initial meeting with their clients, such as not attending home births that do not have a midwife or not doing overnight postpartum work.

Gisele, who has her own private practice while also working as a community doula, echoes a similar view to Fabiola about the diverse needs of her clients. Most of the doulas in my study are both community doulas and have their own private practice: they are paid by organizations or programs to provide free doula care to clients who otherwise would not be able to afford it. Gisele notes:

> The community clients I feel like need to, occasionally, they need to address their social challenges and the challenges within the home life—maybe their relationship, the resources that they have, a lot of health concerns that they've had even prior to pregnancy. Then once we can address those, sometimes we're able to move on and explore other things and other options [around birth plans].

While having an optimal birth experience is one of the main goals for doulas, other present needs can often take precedence during the prepartum months. For Gisele, doing community doula work was important for her since in her private practice she is often serving wealthier white clients. For context: most of my doulas balance their profession with another full-time job; some, like Gisele, are full-time doulas with their own private practice, and some are in transition to doing doula work full time. Occupations of my doulas ranged from working in supply chain management, corporate, managerial settings to being social workers or working

in community programs. For doulas working in both private and community work, there are often racial or income disparities between their clients which can impact (but not always) the type of prepartum support they give. Gisele recalls:

> It was tricky, because in my private practice, I'm getting $2500 a birth and then add-ons for postpartum hours, and placenta encapsulation, but I'm supporting wealthy white women. Or I'm in spaces where the doula work is really different, as opposed to the community clients....[where] there was a lot more work that I would put into those clients finding resources, education, lactation, going to doctor's appointments with them, making sure that there was communication and understanding. So I felt like I was sort of dishonoring the reasons that I got into birth work. So that's why I still have my private practice but I'm still very involved in the community work. And I like to still take on those jobs.

The racial and classed dynamics of doula support expand throughout the various stages of pregnancy. This is one point of contestation for doulas who provide embodied care: the dual understanding of knowing that their labor is a profession and a commodity alongside knowing wanting to be of service to their community. Doula care often "competes with a neoliberal market model in which individuals see themselves as sets of skills that need careful marketing" (Castañeda and Searcy 2015:130). Doulas often must balance this tie between doula work as a business and doula work as a community practice.

Chapter Four: Birth Support

I'm the one that specializes in her. So, from wiping her hair away from her head, from giving her water and coaching her through those moments. So yeah, giving that emotional support, helping also parents, or the person that's birthing and their birth partner, to help in making critical decisions. We don't make

them for them, we just are like, alright, so let's go over all your options. Let's—what would you feel most comfortable with, most guided with.

-Barbara, Doula

Gisele's favorite birth occurred on Christmas day; it was one of those births where "everything that could have gone wrong went wrong." She met her client, Jasmine, through a community organization. She was paired with her earlier than typical for community cases—Jasmine was 25 weeks pregnant, giving them much time to work together and get to know each other. At an ordinary doctor's appointment Jasmine was told that she was 6cm dilated, meaning she was approaching active labor, much to her shock. Initially believing she would be alone besides her doula's presence, Jasmine was fortunately able to have her mom, aunt, and sister present. Things proceed smoothly: Gisele rubbed her client's feet, gospel music played aloud, and it seemed as if everything was fine. At least until Jasmine's father arrived, which changed the dynamics as the family started to bicker more and the tension in the room started to build. By the time the staff checked the labor status, it's revealed that she was not progressing much, even though her contractions were getting worse. The tension only increased as discussions of medical interventions arose; Jasmine was given Pitocin, a synthetic hormone identical to oxytocin to promote labor. After laboring for over 24 hours with increasingly strong contractions, Jasmine eventually decided to get an epidural. Gisele decided to quickly go home to shower, take a nap, and eat some food when Jasmine called her saying that it was time to push. Arriving back around 6am, it was apparent that none of Jasmine's family members wanted to be in the room while she pushed to see the details up close. To make matters worse, the father of Jasmine's child was not yet here and when Gisele called, the baby father's wife picked up, much to her surprise. They decided to proceed with the pushing anyway, but then Jasmine's mom fainted, needing to be

taken to another location since they were birthing at a children's hospital. Jasmine continued to push and eventually it was just her and Gisele, who looked in her tearful eyes and reassured her that regardless of everything going on, they were just going to stay focused together. She rested her leg on Gisele's shoulder for some movement, and after an hour of pushing she birthed her baby. The two cried together afterwards, and Gisele recalled, "there's always this amazing euphoric awakening that I see in moms, and it's so transformative and it's just this moment of clarity and abundance and gratitude that I've never seen anywhere else in my lifetime."

—

Doulas provide various material and immaterial forms of support when attending birth. Labor times can range from half a day to over 24 hours, which call for the need of comfort measures—practices performed during birth with the goal of reducing tension, pain, and fear for the birthing client, and ultimately to facilitate labor. The importance of touch is one example, as doulas perform massages of various body parts and pressure points, which allow for pain alleviation but also the release of chemicals such as oxytocin (aka the "love hormone"), which are crucial in the physiological progression of labor. Additionally types of comfort measures include talking and eye-contact to ground clients in the present, music, aromatherapy, visualization techniques, and more. These practices all strengthen the doula's relational connection with the client, which allow the client to not feel isolated or disembodied during the birthing process.

Importantly, doulas see their role in advocacy as a main distinction of their role from that of others in the birth team like the birth partner, nurse, or doctor. Advocacy comes in a variety of forms and levels, and is not only limited to birth. For example educating clients about their rights as pregnant individuals is a simple form of advocacy. One doula, Jade, notes the prevalence of people not knowing their rights, such as patient and pregnant patients bill of rights which include

components such as the right to health care information, choice over providers and health care plans, respectful care, informed consent over the administration of treatments or drugs, to be accompanied by a support, and more.

During birth, advocacy can often require a deep understanding of hospital cultures and expectations. Cassandra echoes sentiments that many other doulas discuss about the constant questioning (which to some is considered harassment) by medical staff about medical interventions such as taking epidural and other pain medications, particularly for pregnant individuals who come in knowing that they want an unmedicated birth.

> Labor can be uncomfortable for some, there's high levels of discomfort for many. And so, there are going to be like "ugn" like sounds or whatever people are going to use to manage their process, and so to have someone kind of, "oh, you want epidural? You look like you're in pain, you want an epidural?" without giving that person an opportunity to really manage or figure out strategies that they can use to manage the discomfort. Or to honor the fact that they may have said, "we don't want this."

Because many of my doulas see birth as an event that the body is capable of doing on its own without medical interventions, they are often aware of the unwillingness of hospital staff to allow their clients to have control over their own birthing experience. In Fabiola's words:

> getting an IV, getting strapped to a bed, being told you can't labor without an epidural, being harassed to get an epidural, then being told you can't get up from the bed, you gotta pee through a pan, it's just sick shit..to be in a place that tells you, forces you to believe that your body is incapable.

Cassandra recalls a recent birth where her client was committed to having an unmedicated birth, however they were not making labor progress quick enough for the staff. In New York, where hospitals are often over-crowded with the expectation of quick patient

turnaround, there is little patience for prolonged labor in many instances. The staff kept asking Cassandra's client about the option of taking an epidural, which only added to frustration.

> She was frustrated with their line of questioning, and so I really had to be like, "look girl," they're about to come in here and ask you this. You don't want to hear it, then you gotta move….I was like you can't not do anything, because that's not going to be good for you or the baby. Show some effort so that they can stop asking you these questions and so that you can make the progress that you want.

Part of Cassandra's advocacy involved a combination of reminding her client of her goal and promoting light physical activity, which eventually allowed her client to have the birth she wanted. Another advocacy technique that resonates throughout my doulas is the way that doulas facilitate communication between patients and providers. Astrid, who often works with immigrant clients or those who are not used to the U.S. biomedical system, notes that part of her work often puts her as a medium between the client and medical staff.

> So one of the techniques I use the most is advocacy, making sure that my clients voices are heard in the birthing room, helping be the translator in a sense between medical jargon and you know, being that person in the medium where I'm like "okay doc, can you repeat that again?" or asking those questions where it helps them to dig a little bit deeper.

Having a desire to not cause conflict among medical staff while also promoting optimal care and outcomes for their clients, doulas who work in hospitals are constantly navigating a liminal space due to their status as intermediaries. Nicole C. Gallicchio discusses doulas' "liminal status as institutional outsiders, their emotional connection with their clients, their authoritative knowledge, and their ability to read the emotional temperature of the birth room, all of which enabled doulas to enact strategies in service of their clients" (2015: 108). Liminality can illustrate how, as Everson and Cheyney argue, "doula care can constitute a vital common ground in the context of birth and maternity care (Everson and Cheyney 2015: 204).

Harriet, who has been doing doula work for over 20 years, is keen on subtler forms of advocacy similar to asking questions like Astrid mentioned. While she's had overall positive experiences with medical staff, she balances her role as a doula in the hospital by not dominating the space and leaving most of the communication to her client, and she rarely ever needs to talk to her client's doctors besides introducing herself to them. However, there are times where Harriet's feels the need to advocate more directly, especially when it comes to her Black clients. She discusses the racial biases in medicine contribute to differences in medical treatment:

> One of my clients, a woman of color, was attempting a vbac, which is really hard for women of color. There's a vbac calculator, and the only race on there is Hispanic or Black. White people aren't on there. So if you don't check any of those, then you're considered to be white, or white passing. And then your chances of having a successful vbac, which is a vaginal birth after a cesarean, is about 80%. But if you put the same criteria in the categories—you know, your bmi, your age, your height, your weight—and then you put Black, your chances have now gone from 80% to 18%, so it's much lower.

Fueled by her perspective as a Black doula serving a Black client, she is aware of how medical technologies are racialized and can often disadvantage marginalized patients. Davidson writes that "doulas are experts in birth and have an expertise that is largely unique to their training and practices" (28). This is seen through how Harriet's knowledge of hospital cultures and technologies inform her advocacy. The chances of having a successful vbac are not lower for Black or Hispanic women due to biological difference, but due to how medical technologies can reinforce misinterpretations, as has been shown with vbac studies (Dresang and Hampton 2015; Thornton 2018; Thornton et. al 2020; Faulkner et. al. 2021). Harriet was aware of how perceptions over race and labor capabilities influenced the chief physician's behavior to repeatedly come into the birth room to stare at the baby monitor:

> We were under a fine microscope, and we were just waiting for something to change. So he comes in, and he walks over to the monitor and he folds his arms and he stands there and he

> looks…. I said, 'is there a problem, I see you looking at the monitor. Is there a problem?' 'Oh no, I was just checking.' I said 'oh, because I know that you could see it [the monitor] from outside, I thought you coming in meant that maybe you saw something that we weren't aware of. So a little playing dumb a little bit...in those cases I'm advocating for them. Because at this point, they're not paying attention to the doctor walking in at the monitor, but I know his presence means something, and I know that most of the time, it's just to intimidate. because if you instill fear in the birthing person, then you can stall labor. And if you stall labor, especially in attempting a vbac, then they can say, 'oh, your labor has stalled, you failed to progress, we have to do a c-section now.'

Without being explicit or offensive, Harriet uses her own cultural literacies around advocacy to navigate the various racial and gendered power dynamics in the birth room that she notes, a non-Black doula may not have been able to do for this client. The client ended up having a successful labor, and the client's original doctor had even confirmed with the couple that the staff had initially been discussing a c-section, which further validates Harriet's actions. Astrid details a similar awareness and intentionality behind her behavior in hospitals:

> [I'm] friendly with the staff because I understand that they have a job to do, but just also always making sure that my focus is on the client. You know, reading them, body language, being able to see what kind of energy they're giving me and certain things because, when you think about the power dynamics, just as far as body language goes, here's a person most likely in a hospital bed looking up at everybody. So that's already a power dynamic, so I really try to sit next to my client and be able to see what they're seeing, and just—I'm in the back in a sense watching, but then I'm also where I have to be, it just depends on the situation.

The spatial awareness that my doulas possess operate in a variety of ways. "Holding space," as I will explain, is another way in which doulas conceive of advocacy.

Holding Space

Part of doula's advocacy and liminality involves what is commonly called "holding space." The term generally has to do with the doula's physical proximity to their client, but it operates on multiple levels. For Astrid, holding space can signify the ability to exchange energies, love, and strength with another person so that they feel safe in their most vulnerable moments.

> Wow, you are literally in it with the person, like every step of the way holding space and just being in that space and exchanging energy and love, sitting in that vibration, that exchange to them, knowing that they feel safe and comforted, you know, building that space and holding that space for them. It is an intimate exchange, and an intimate moment to be a part of.

The doula's ability to "build" space coincides with the cultivation of intimacy. Pain and Staeheli view intimacy through three relations that simultaneously operate: intimacy as a "set of spatial relations," intimacy as a "mode of interaction," and intimacy as "a set of practices" (2014: 345).[2] In this sense, doulas are architects of intimate space: they cultivate intimacy through the creation of new spatial relations and dynamics, forms of interactions, and practices. Holding space often operates with the goals of allowing the client to feel supported, safe, and vulnerable without exploitation. Harriet sometimes feels the need to create space for her client and their support system (partner, family, etc.) to deliberate any decisions. She can do this by asking the staff to clear the room for a moment to pray, allowing for privacy between the client and their support. The ability to subtly diffuse tension or create moments for deliberation is another example of doula's being birth experts as Davidson mentioned. In such moments, Harriet notes the importance of being able to distinguish between emergency and non-emergency situations. If

[2] Here is the full quote for a clearer explanation: "First, intimacy is a set of spatial relations, stretching from proximate to distant; in this regard, much feminist research has emphasised the house hold or the body. Secondly, intimacy is a mode of interaction that may also stretch from personal to distant/global; for example, recent work on emotions highlights how subjects reflect, resist or shape wider power relations. And thirdly, intimacy may involve a set of practices, again applying to but also connecting the body and that which is distant; for instance, relations of care frequently traverse the interpersonal, institutional and national realms" (Pain and Staeheli 2014: 345).

a situation is not pressing, then the client should have time to discuss and think through their options. This connects to her view of empowerment:

> If we have time to ask to pray or to have a moment to discuss what you guys [medical staff] just said, then gives me time to say "okay these are the pros, these are the cons, what do you think, what's your opinion." And so well, it's really your decision, I'm just telling you the facts—I'm giving you evidence-based information to make these informed decisions. And then they go in, because now they feel empowered. So empowering is a huge part of my advocacy.

Notions of holding space that connect to empowerment can be contextualized further in the ways in which the biomedical system can be disempowering, often having patient's dissociated or out of touch with their bodies (which will be further elaborated on in Chapter Six). Nearly all of my participants note that their desire for coming into birth work was influenced from positive or negative birth experiences, whether their own experience or a friend or family member. Eleanor, who now has three children, decided to become a doula after having her last child eight years ago. During a check-up, her doctor "sweeped" her without her permission, which is an act of stripping the cervical membranes using fingers to induce labor. Furthermore, she was incessantly asked about taking medication (e.g. epidurals, Colace) to the point where she took them just to be left alone. Eleanor talks about how the desire to hold space motivated her doula journey:

> That was how much I knew I wanted to be a doula, to be able to hold space for other moms. That they don't have to be concerned about—-they're holding their own space while trying to give birth. Having a doula there allows them to focus on birthing the baby the way they wish to birth the baby. And someone else is there holding space for them.

Doula epistemologies understand the multiplicity of spatial relationships. A doula's job is not to take up the client's space, but rather build a space of their own that supports the client's ability to focus solely on their birth, "their own space". As Bastien notes, "entering doula work

[to heal from one's own negative birth experiences or to right a social wrong] becomes problematic when they cast the doula as the central figure in the journey of birth" (35). However, the doulas in my study who were called to the work from personal experience note the centrality of doula work being around the client's wants, and not the doula's.

Doulas are not meant to dominate the birth space—whether it be in a delivery room, a hydrobirth in a bathroom, at a birthing center, etc.— rather their efforts are prioritized towards making sure that the client can focus on themselves and their birth, instead of other factors that may arise. Doulas are not even always in the room with their client, for example in instances where the client may want personal time with their loved ones. Astrid shares a story in which she subtly advocated for her client by holding space:

> A doctor says to my client "okay we wanna break your water" right, your bag of waters. And I'm like "okay..." One, the question wasn't even phrased as a question. So it [my role] is more like "okay, do you want that to happen?" You know, I'll kind of like ask my client "did you hear what they said? They want to break your waters. Do you want that to happen?" Or I'll say like "hey, do you want to think about that before you do it?" So giving my client that time to be able to make that informed decision, because sometimes even for me as a doula, going into the hospital—again they're there for a reason I'm not knocking them—but sometimes, you can feel like you're not presented with the choice. So I'm there to kind of be like that, that refresher, that breath of fresh air in that space and be like "hey, we need like five minutes to think about this," so yeah.

Astrid's behavior is part of a well-known practice of advocacy among doulas, referred to by the acronym B.R.A.I.N, which is meant to promote informed consent when faced with a decision to make. This is often promoted when a doctor is suggesting a medical intervention such as c-section or in Astrid's case, a prelabor rupture of membranes ("breaking her water"). The B.R.A.I.N method is meant to have clients think about the (b)enefits, (r)isks, and (a)lternatives to making a certain decision, while also considering their (i)ntuition and what would happen if they

did (n)othing or if they choose a decision, then figuring out what the (n)ext steps are. While doulas can help clients think through these aspects, doulas are highly aware that the decision-making and deliberation process belongs to the client and their support systems (partner, family, etc.). In this case, holding space for a doula means offering a means for deliberation that would ordinarily not exist due to the paternalistic, gendered, and racialized nature of biomedicine, which assumes knowledge over its patient. Cassandra notes how her client's identities mixed with hospital culture can influence her need to advocate through holding space:

> And their identities being like...poor people, whether they're read as being uneducated, whether they're experienced as being young, if they have several children, if they're Black, depending on specific spaces. I think that all of these identities impact the way that they are received at times...There's kind of a paternalistic "we know better than you" type of situation. Or from another angle, the assumption that people don't experience pain equally.

Cassandra talks about an experience where, since one of her client's was birthing her sixth child, the doctor figured that there was no need to explain anything to her about her labor. Another example, which is mentioned through a few of my doulas, is expecting clients to sign papers—whether it be about delivering the baby, giving the baby a vaccine, accepting pain medication, etc.— without reading them or having the doctor at least summarize them. To Cassandra, there is "no engagement" with the client in terms of such communication, and that is why as a doula she facilitates that engagement by encouraging clients to read contracts if they would like to, and taking their time in reading and asking questions.

Holding space has material consequences since doulas see the body on multiple levels throughout space and time. For Eleanor, the body's relationship to its environment and past experiences can manifest in various ways. Eleanor sees her upbringing in the countryside of Jamaica playing into her birth work. Feeling a sense of freedom through her connection to nature

and all forms of life, she emphasizes that womanhood is associated with energetic, spirituality, and intuitiveness:

> I always say that pregnancy and birth begin way before you even think about it, because we are all potentials. So that's the space I enter when I enter the birthing world. When I'm working with a mom, I know they have that potential. And it's up to me, I find at times, to just remind them of that. You can do this. And if they have fear, I honor that too, because everyone journey is different.

Furthermore, Eleanor's perception echoes a prominent theme among my doulas that the body goes beyond the physical. Having a doula is not just supporting a client through birth, because the experiences of the body cannot be confined by boundaries of time and place.

> So by doing this work I'm not coming to this mom just "okay I'm just gonna be your doula for the birth aspect of it," I'm very keenly feeling what you're saying. So most times, it seems like I'm listening with my ear, but I'm more feeling with my ear, feeling what they're saying. So these are the work I'm doing allows me to actually tap into other area within that mom. I have experience where I'm speaking with a mom and they're always very tense in the lower part of their body. Most likely—and not always happen—but most likely if I work a little bit longer with them, I realize they were traumatic experiences. Then the body is not allowing—the pelvis area is very tight. So those are areas, doing this work, that allows me to work with them to kind of release certain energies that are trapped in their body, for them to then have that birth.

Eleanor uses modalities of connecting to her client that rely on what I see as an embodiment of feeling. When Eleanor "listens with her ear," she is attempting to connect to her client on a level that goes beyond the physical. It is a psychic connection that is premised on the idea that Eleanor and her client are intimately connected as humans—she notes in another instance, "As soon as we start to work with each other, the only thing I see is that we're women. Our humanity, that's what I see." Patricia Hill Collins notes that an "ethic of caring" is integral to

Afrocentric feminist epistemology, in which "personal expressiveness, emotions, and empathy are central to the knowledge-validation process" (1989: 766). Trauma, whether through a previous birth, physical injury, sexual abuse, domestic violence, or other issue, are seen as experiences that may manifest in various ways during birth. For Eleanor and other doulas, a tight pelvic floor can signify issues that the client is dealing with in other areas in their life. On the other hand, a traditional biomedical doctor may see a tight pelvic area as a reason why a pregnant person should not have a vaginal birth, and suggest they have a c-section instead without suggesting other means of addressing the issue. This is what makes doula epistemologies significant in a biomedical society, and especially for Black and brown mothers: the multi-faceted view of the individual and the connection to them on levels beyond the physical contributes to seeing broader pathways to addressing concerns without over-medicalizing them. To Eleanor and other doulas, the ability to relate to their client on a deep, "inner" level directly translates to their ability to aid them through physical aspects of their pregnancy as well. It is an expert, valued knowledge that is often discredited by biomedical science.

Chapter Five: Birth Trauma and Postpartum Support

When Fabiola was pregnant five years ago, she felt like she was prepared to the best of her ability. Her birth plan was to have an unmedicated, vaginal birth without any vaginal tearing. However, she was 7cm dilated (the cervix is supposed to be 10 cm dilated and fully effaced to start pushing) and according to her obstetrician, she was experiencing labor dystocia, stalling of labor. The next course of action was to give her Pitocin. Fabiola recalls feeling dissociated from her body throughout the remainder of her labor, she pushed "fairly dramatically" when it was time to deliver the baby, leading her to tear. She still has pelvic pain since that experience, believing she broke her tailbone (she says "believes" since no one checked her afterwards and she did not go back to the hospital) as well as having diastasis (the separation) of her pubic bone

and abdomen. At the same time, she felt that the presence of her doula allowed her to feel supported. Her doula allowed her to feel like she had the time to think through her decisions, even if she still ended up receiving medication. Her doula hanged her rebozo (a long, indigenous scarf) from a rail to allow Fabiola to swing her body for a while and move. Her doula allowed her to keep the momentum to get through her birth. She recalled: "I felt a lot of things in my labor, but I didn't feel alone, or not supported by my doula...her just witnessing me made all the difference. Fabiola's birth experience directly influenced her desire to become a doula: "If this was me being thoroughly prepared and educated and supported with an ideal scenario, environment—at the time I thought it was—how can, you know, Jane Doe, who's working full time, doesn't know what I know, stand a chance in having an empowered birth?"

—

For doulas, there is a simultaneous awareness: birth can be a joyous experience, and at the same time, when you are birthing in a hospital, you are operating under a system of limited choice and agency. Within that understanding, there are various directions one can go with their work: most doulas I interviewed still worked in hospitals to some capacity for varying reasons, but Fabiola was the only doula who does not attend hospital births. While Fabiola has been a doula for five years, she only recently decided to stop taking clients who want hospital births. She notes:

> I'm doing it as an act of defiance, as an act of demanding that women get treated better than how they're getting treated in the hospital—they see birth as a medical event. Birth is not a medical event; birth is a natural event. Women don't need intervention. 95% of women are low-risk, and they're going to the hospital for what? Birth just happens...I do it, because they [birthing institutions such as hospitals] haven't proven that they can be respectful towards a woman's laboring body or child...Why would I take a woman, somewhere that I know, she's going to walk out with something that she does not want...C-sections are what's killing us, as Black women.

Fabiola's decision is not only as an act of resistance against the violence of the biomedical system, but she also sees herself as implicated in the violence. She notes that being a Black woman impacts her birth work in biomedical spaces:

> If I was a white doula, they would not take the things I say as threats, I know it. The white woman is not, her presence doesn't seem...as a threatening thing. I feel like we're treated a lot more hostile, I feel. We're put in places where we have to defend ourselves. Because we don't feel heard. So if my client doesn't feel heard, imma feel a certain way about it. Yes I'm gonna get defensive, or she's gonna get defensive. But it's not that we're defensive, it's like, you're not giving us a standard of care.

While Fabiola is the only doula to not do hospital births, other doulas also navigate their moral feelings around biomedical spaces. Harriet is keen on advising clients against hospitals that are known to mistreat Black and brown bodies. Similarly, Gisele recalls stories from other doulas about staff overreactions to pregnant individuals: one client had a social worker assigned to her since she adamantly refused to have a scheduled c-section, since due to her frustration they felt "concerned" over her mental health. Or cases of clients being put on mental hold over concerns of depression and anxiety, even though the issue had been discussed with the doula beforehand.

My doulas have had mixed experiences navigating birth spaces. Although Eleanor became a doula due to her own birth experience, she notes how as a doula she has relatively positive interactions with medical staff. This is partly due to her awareness of how her identity as a doula can be seen as threatening:

> I always make sure when I enter the hospital that I'm entering somebody else's space...once those you're working with realize that you're not walking inside there to kind of just clear the room out and say "I'm here," once they realize that it's a shared space and our goal is really to help that mom, their guard is down... I can feel the guard can go up if you enter that space and feeling like

> you're coming to take over during the duration of the time you're there. And if you're going to do that, chances are it's gonna be friction. And the goal is to not have friction if you're working with a mom. So I'm always aware that the goal is for the mom to have the best possible outcome, so it's not about me.

Eleanor continues, comparing her navigation through hospital spaces like "water":

> So I always feel like it's good to be like water, like I mentioned before. Whatever situation you're placed in, whatever hospital you're placed in. So there's certain hospitals you walk inside and realize, okay maybe it's best to be much more quieter in certain regards, because at the end of the day it's about the mom. So you're always gauging, you're constantly gauging, and you follow accordingly. So it's hard to say this is I will be at this hospital versus that hospital. Because you're constantly gauging based on the group or the team you're working with.

Eleanor's liminal way of navigating biomedical spaces is an example of the wisdom that doulas draw from as a source of knowledge. Eleanor, whose countryside upbringing ties to her values of humans' spiritual connection to nature, metaphorizes herself as water as a means to best provide for her clients, which is partially based on conflict-avoidance with medical staff. Patricia Hill Collins writes that Black women tend to embody two types of knowing: knowledge and wisdom, the latter which is based on experiential knowledge and "has been key to Black women's survival" (1989: 759). Gallicchio's fieldwork on Pacific City doulas and self-exploration led her to see that "expertise of the self" was important to being an effective doula; this constituted the doula's "spiritual, corporeal, emotional, and psychological selves, including divergent ever-changing ideas about their own personhood" (2015: 109). This is supported by Eleanor and other doulas who emphasize the importance of self-care and postpartum rituals as ways to cope with the intenseness of birth. Indira remembers sleeping for an entire day after attending her first birth. Now she manages by centering herself before births, and afterwards she

has a ritual of taking a bath, using salts, herbs, and "cleansing" herself of all the energies she has taken in.

> That birth force energy that comes out, you can absorb it in some ways. So I guess maybe I must have absorbed the energy but also just the on-call alertness that I had. I was just exhausted, and that was a different exhaustion I have ever experienced. I had never been that tired before...It is an intimate exchange, and an intimate moment to be a part of.

Birth trauma is only one aspect of the overall experiences of vulnerability that doulas face in the biomedical field. Doulas experience vulnerability in a multitude of ways, one predominant way being through the emotional, intimate investments they provide in client relationships. In *Doulas and Intimate Labor,* one definition of intimate labor is "bodily or emotional closeness, close observations of another and personal knowledge or information" that translate into "intimate knowledge of a birthing body" (Casteñeda and Searcy 2015:125). This very work requires emotional vulnerability, and it is the ability to do that in authenticity that brings doulas to embody this role. Eleanor underscores this:

> You feel such a depth of connectivity [when we work with each other], because when a person becomes vulnerable, the only thing you're feeling and seeing is that vulnerability. You're not seeing the outside....This is someone who is at their most vulnerable place, and they need to know that you're there for them. You're there to support them, to care for them. And to allow them to be. So that's another thing that I personally took from growing up the way I was brought up in my part of the island in Jamaica.

The act of doula support is an exchanging of vulnerabilities, an exchanging of emotional investments. Gisele resonates to the term "emotional investment" to describe the deep connection she can feel when caring for a client, especially such as in the earlier mentioned story of her longest birth:

> I just cried with the mom. When the baby was born, we just sobbed...It was like I was a part of the moment. And I felt genuinely connected to my clients, not in a, like a friendly or familial way, but as a person I love you sort of way. And as a person I believe in you. And I'm here to support you, because I know you can do this. And I think that's why you can't take every client. Because when they're throwing up, or when they're pushing their baby out and you see everything, and you smell everything...and you're rubbing their feet or rubbing their back or their butt. Like I can't do that to everyone. I say I have a heart-centered approach; I have heart centered care. It really does come from me and it comes from the investment that I like to make in my clients.

Gisele's words harken to Viviana Zelizer' notion of "relational work," which connects economic transactions with their crafting of social relationships**.** Going back to the notion of doulas as architects of intimate space, I see how such cultivations aid clients through birth by allowing the client to focus inwards on themselves. This work continues into postpartum work, where there is heightened vulnerability for the mother which the doula helps to ameliorate.

Postpartum Support

As a postpartum doula, Dorothy helps the client and their family or support systems adjust to having a newborn. Dorothy describes her work as a doula as "mothering the parents," which for her looks like a combination of educational, practical, and emotional support. This includes teaching how to latch the baby for breastfeeding, how to bath and calm the baby, how to develop attachment-style parenting, encouraging parents to rest, (especially if they've had surgery such as a cesarean section) and more. Some postpartum doulas are mostly educational, while others work in the home for hours at a time or even overnight to alleviate other stressors in their client's life. Importantly, Dorothy is especially concerned about the wellbeing of the client, who, institutionally, is often forgotten after birth. For her Black clients, she is even more aware of this:

> I do feel with Black families, I'm more alert to any symptoms that they talk about. So their feet are still swollen by the second or third visit, or they're complaining of a headache...there's things that can lead to postpartum complications—high blood pressure, that just leads to death with us, because people don't listen when we go back to the hospital and say there's something wrong. "Well yeah, you should have a headache, you're tired," and you go home and die. Like there's no, there's no sense of urgency. So I will, I don't want to say exaggerate, but I will be like, "call your doctor, keep calling your doctor, go to the hospital. Do you need me to go with you to the hospital?" So if there's anything that I'm even slightly concerned about, I would rather them be like, "we ran all the tests and nothing was wrong". Great. Fantastic. That's what my insurance was for. As opposed to you being like, "oh, I don't really want—" No. Now's not the time to be like "I don't want to bother anybody." So I will push that really hard. Probably more with Black clients just because I know their concerns are not as heard.

Similarly, Barbara is aware of the sociopolitics of postpartum for her clients.

> It's not as evident as when people hear the statistics, they're like "oh, how can people—how can Black women die more often, isn't it obvious?" and it's like, no, it's not obvious, because it's more of a domino effect than this one specific event. And a lot of death does happen in the postpartum as well. So I really am an advocate for it, I really wanna fight for Black women—again, to have a healthy birth that she can brag about, you know.

As a Black doula attentive to the sociopolitics of care for her Black clients, postpartum care has to operate on multiple levels. Dorothy and Barbara are cognizant of how the mixing of how both the clients race and their physical vulnerability puts them at higher risk for postpartum complications. The doula's liminal position in the life of their client allows them to facilitate relationship-building on multiple levels. As seen with holding space and advocacy, doulas facilitate interactions between clients and medical staff, but they also do so between a client and their partner, prior children, and other family members. This is a part of what makes doula care

for my clients a community-oriented work, even though the prioritization is on the client. As a postpartum doula, Dorothy operates in a liminal space of taking up a necessary role in her client's present life while also working to stabilize her client so that they will not need her in the future. In her words, "I'm working myself out of a job. So, by 8 weeks, they really shouldn't need me anymore." For Dorothy, this looks like integrating partners into parenting life and teaching them how to best support their partner in recovery. Dorothy notes that her role is needed due to the displacement many men feel in the pregnancy process:

> They don't have space for that [postpartum depression]. We barely acknowledge men's mental health to begin with, but postpartum depression in a man, when you're struggling, I mean...There's a lot of new expectation shifts, a lot of men kind of get focused on money at that time. Like this is their way to provide, so they're gonna work more hours, they're gonna be out more, they're gonna hustle. They wanna do. Some men are the exact opposite, they're nurturing, they wanna bring the baby to you when it's crying. It really just depends on the person and the support you have. Some people are just not set up to listen well. They were also in the room being traumatized by your birth experience. So when do they get to process that? How can they provide support when they're still trying to figure out why you were bleeding for so many days? It's a lot.

Gender expectations and ambiguity, mental health stigmatization, and the lack of attention to the potential birth traumas of partners contribute to difficulties in care practices during pregnancy that span from pre- to postpartum. Consequently, for some of my doulas, integrating the client's spouse, partner, or family members into the birth plan is an important aspect of their work. This can range to encouraging them to attend doctor prenatal visits, educating on the preparation bag needed for birth, offering support in how they can help their birthing partner, teaching how the partner can help the client with breastfeeding, and more. On the client-perspective, Dorothy talked about how she comforts those who feel unable to express their feelings and traumas around birth:

> Everyone is trying to one-up each other...it's almost like when you complain about being tired as a new mother. Everyone's like right, that is exactly what you signed up for. "You cannot complain about this," but you can complain about it with me. You can absolutely complain. You will have empathy...Like everybody is out of sorts, so I can come in as a very calming, kind of, all of this is natural, all of this is normal, you're not alone, here's how other people have dealt with this before, here's what has worked with other people, here are some specialists that I think would benefit you [e.g. couples counseling, babysitters, etc.]...So I'm trying to kind of ride the wave of the intensity, sit with them. What you call it, puddle sitting. So you're crying about something, and I'm just gonna sit with you, in your puddle...you should cry, all of this is a lot. So [I provide] a lot of empathy.

Resisting discourses around birth, trauma, and motherhood, doulas are often dealing with the socialized silence due to stigmas and assumptions around childbirth. Dorothy's insistence on empathy is necessary to address the needs of the postpartum client, which is largely centered around rest, healing, and adjustment. Similar to holding space, empathy or "puddle sitting" is a form of intimate space cultivation that serves the client in ways beyond the physical. Multiple doulas discuss the need for awareness in how non-birth related traumas that highly affect Black communities can impact birth. Fabiola sees many factors as contributing to birth experiences and sees the connections between various realities; the lack of midwifery hospitals; the high c-section, maternal mortality and morbidity rates; the low vbac rates; the fact that a third of women perceive their birth experience as traumatic; and the fact that at least a third of women are survivors of sexual trauma. Similarly, Dorothy notes that historical and continual sexual trauma of Black women can affect choices around breastfeeding. Trauma-informed awareness is linked to the importance of client-centered care and a trust in the client's own "expertise of the self." Eleanor mentions:

> Most people know what they want. So there's some that tell me straight up, "I want an epidural," "I don't want to have the baby by my vagina, I just want a c-section." And you don't question that because as I mentioned before, there's some women who have been traumatized and just having a baby coming through it's just not—they're just not able to handle it. So they already know in their psyche that they're not going to do it.

While Fabiola takes a stance against hospital births, she acknowledges the need for doulas to still "bear witness" to marginalized clients in hospitals:

> These are crimes against humanity. So yes, there's a doula for every doula, and yeah, most doulas should be going to hospitals because it's better to have somebody bear witness than to go through it alone. But it's also not right for us as women to not warn each other, and educate each other that things can be different. Even if it means that we ourselves are gaining the skills to take ourselves out of the system.

Even in disempowering situations, Fabiola believes that the presence of a doula still holds power:

> Even if it goes down...I can still bear witness to my client that's being mis-led, lied to, abused, neglected, enduring birth trauma and still bear witness, and my presence be of support to her. Nothing about that is empowering, nothing. But she's not alone, I'm bearing witness.

Influenced by their identities, values, and beliefs around the people and communities they serve, my doulas show how the understandings of care beyond the body are integral to the doula's role. In the next section, I show how doula's work and motivations are largely influenced through intimate connections through generation, ancestry, and culture.

Chapter Six: Generational, Ancestral, and Community Ties to Doula Work Practice

Tapping into a lot of that ancestral wisdom, we birth in community, centered with other women who need that support.

Nothing we do is solely because of us, it's always because of the people who have come before us.

-Indira, Doula

Ten years ago, when Indira was around nineteen, she met Ancient Song Doula Service (ASDS) founder Chanel Porchia-Albert. Indira was working for a leadership organization teaching female empowerment based in Brooklyn and Newark, New Jersey. Porchia-Albert came to tell the group about Ancient Song, the services they offer for Black and brown families, and their overall goal of supporting families reproductive birth rights and bringing resources to communities. Learning what doulas were for the first time, Indira was amazed by the work that ASDS did. Even more, she was shocked to learn about the state of Black maternal health in America, but at the same time felt she was too young to do any of the work that Porchia-Albert talked about. Years later while doing the Peace Corps in Eswatini, Indira found her interest in working with young women and reproductive rights, along with birth work and being in community with the women and elders involved around it. After finishing her Master in Social Work, she decided to start doula work through a program in Michigan, though felt it was very white-dominated. Indira was very adamant about serving people that looked like her, so she decided to come home and get trained through Ancient Song in 2019, and has been practicing doula work since then.

For all of my participants, doula work necessitates embodying knowledge that is rooted in cultural, ancestral, and/or generational roots in varying degrees. The very act of birth work as a deeply-rooted community practice is cognizant for many doulas. It impacts how doulas come to relate to their clients through practices and emotional/spiritual connections. In this section, I argue how such connections are core values of doula work and how they work towards the fostering of community between the doula and the client.

Epistemologies of Black doula care are rooted in community and connection throughout space, place, and time. While doulas come into the profession for a variety of reasons, the aspect that many of my doulas have in common is the desire for meaningful connection. Whether they had a traumatic birth themselves, supported a friend through birth and felt joy, wished they had a support or advocate during birth, or just felt a connection to pregnant people and their communities like Indira, many wanted to become doulas due to the desire of being with others in such an intimate way. Feelings of kinship are pervasive through many doulas I spoke with. Astrid, who was trained by ASDS and has had majority Black clients, sees the relational aspect of doula work as something that is easy to enter when you are in your own community.

> So I'm able to relate to them on a cultural level. And just provide a listening ear and then also connect them to resources in the community, so I wear different hats as a doula. It's not, you know, in a sense where it's like in a clinic setting where things are more formal...But I really more-so feel like it's a sisterhood...because I feel like "mothering the mother" sounds a little preachy, but sisterhood is like, you know, you go and you go speak to your tribe, your circle, and people just get it. And they just fill in the blanks wherever it may need to be.

"Mothering the mother" is a common phrase in the U.S. doula community that harkens to a pivotal book in the field about the impact of doulas on birth outcomes (Klaus 1993). The phrase refers to the "physical, spiritual, and emotional connection" formed by virtue of the doula's role as catering completely to their client (Castañeda and Searcy 2015: 125). Astrid acknowledges this phrase but distinguishes herself slightly away from it, seeing her connection as a sisterhood. This form of describing herself in terms of "sisterhood," "tribe," and "circle" can be seen as positioning herself in a horizontal power dynamic to her client rather than a vertical dynamic. Unlike feelings of paternalism which can sometimes arise from exchanges with

medical staff, Astrid's positionality suggests a different sort of dynamic, one that is more of a support by one's side while affirming the client's decisions, whatever they may be.

Working with Black women not only fosters an instant connection for Astrid, but it allows her to better perform the other roles she has as a doula (such as providing community resources) through the trust they are able to cultivate. Patricia Hill Collins notes that "African-influenced understandings of family have been continually reworked to help African-Americans as a collectivity cope with and resist oppression. Moreover, these understandings of woman-centered kin networks become critical in understanding broader African-American understandings of community" (2000: 183). For my doulas, connection and community are prerequisites for feeling safety, comfort, and belonging. Cassandra goes into this idea in-depth:

> I really just feel like there's something...organic about the way that people engage one another when they feel safe and comfortable. And so I want that for my clients too...I don't want them to feel like they have to perform for me...And that piece of kinship is needed and I think particularly for Black people. That you need to feel seen in that process. And often that being able to be seen or feel seen comes from somebody who you feel you can see as well.

Feeling "seen" arises among doulas who are aware of how their society hyper focuses on the growing fetus and not the birthing person, but furthermore how Black mothers are susceptible to societal invisibility. The "invisibility" many Black women face come from their vulnerability to systemic and structural violence held unaccountable, most notably through slavery, but also pervasive through rhetoric around Black motherhood, Black family dynamics, and the navigations of Black reproductive bodies in health care systems. To be "seen" comes more naturally, or "organic" in Cassandra's words, from someone else who experiences a similar sociopolitical reality.

The present-day connections that doulas cultivate with their Black clients are not separate from generation ties. As a postpartum doula, Dorothy is often cognizant of how her advocacy for getting more Black clients to breastfeed is tied to a history of community and mourning:

> And I think we have a long history of trauma around breastfeeding, so we don't want to breastfeed because we don't know how long this baby is going to be with us. They might be taken from us. That really should have been the opposite reason, we need to give them as much as possible for as long as possible before they go, because they're gonna need it for the rest of their lives. So this is foundational food.

Dorothy's comments draw from the histories of family separation through enslavement, the forced nursing of slaver's children, and racial/classed dimensions of infant formula in the 20th century that continue to impact Black women's relationship to breastfeeding today (Green et. al 2021). While understanding the history of trauma and mourning around birth that continues into the present, Dorothy instead focuses on strengthening future Black children, giving them "as much as possible," so that they can thrive. LaKisha Michelle Simmons uses the concepts of generation and relationality as a way to "theorize Black motherhood as connected not only to intergenerational suffering but also to survival and remembrance" (2020: 312). Understanding Simmons concept of generation allows me to contend that the doulas place themselves in "a Black sense of time," where their sense of self and the work they do is connected to their past and the future they work towards for themselves and their communities (318). Similarly, Collins theorizes the significance of generational ties in her conceiving of Black motherhood, being "a series of constantly renegotiated relationships that African-American women experience with one another, with Black children, with the larger African-American community, and with self" (176). Almost half of the doulas I interviewed do not have children, and yet their realities as doulas still apply to Collin's notion of Black motherhood due to its relational and kinship

component that extends beyond biological connection. Karry notes that as a doula program coordinator, she hears stories of client's asking their doulas to be their godmothers, or asking to be supported again by a specific doula in a later birth. On the other hand, Harriet feels differently: it is the lack of kinship or emotional investment that allows the doula to better support their client, as they are in a liminal relationship between the client and biomedical entities:

> I'm not emotionally connected to you. They're not my kin; I'm caring for them as a human, not a relative….Sort of like the gatekeeper that is not emotionally connected to the family or financially provided by the hospital.

Harriet takes advantage of the liminality and the lack of investment on both sides (client and medical system) in order to fully be able to provide for her client without emotional baggage or institutional liability. At the same time, Harriet's emotional and professional boundaries in her doula work are partially connected to the fact that she works for many white clients in her private practice. Establishing boundaries with clients is fundamental to being treated with respect. She notes some of the nuances of navigating being a Black doula for white clients:

> There's a very thin line between like, hmm, am I the nanny, the slave, the cook, the cleaner, like what am I? So because we already have that in the back of our heads, being a woman of color going into a household that's not, I have to be very clear upfront. Because if I get any sense that I am being looked at like that, then this is not the place for me. I can't work there. Because I'm going to have up some built-up anger and animosity.

The ways doulas navigate domestic spaces has multiple dynamics as women of color due to the known histories of their communities, and the sense that those racial and power dynamics can manifest in various forms in the present. While it is normal for many postpartum doulas to clean, cook, and take of newborns, not all doulas take on those roles, and some primarily take on

the role of educator, especially now during the pandemic. Dorothy offers a similar sentiment as a postpartum doula, mentioning:

> There's a level of...I'm the help? But I *am* the help. They hired me and I'm supposed to be doing something. So it's not an idea, it's reality.

In thinking about the origins of the word doula—"from the Greek doule, meaning female slave, helper, or maidservant"— I draw immediate connections to enslaved African women and their status as doulas, albeit not by that title (Castañeda and Searcy 2015:4). These women, like doulas, had many roles in the lives of white women—through means of their bondage and domestic proximity they were bound to intimacy and intimate labor. Albeit involuntary and forced, they were doulas, and more. What does that mean in today's context, and what does it mean for Black women in society when their labor is never adequately compensated, valued or nurtured? In such contexts, it is fruitful to seek out the care practices that Black women have and continue to practice among each other. That care practice is evidently ever-changing and flexible, similar to Collins' definition of Black motherhood as constant negotiations. For Indira, it is the role of the doula to embody flexibility in how they relate and show up for their client:

> I feel like as a Black birth worker, you show up to a birth space and you take on a character or role for that person whether it be—you're filling the role of like a sister, or older sister, or mother, or grandma...I always feel like I'm a part of the space, and it's like a family...I think that's kind of what helps to build the trust and lead to more positive birth outcomes.

The flexibility in the connections doulas have with their clients, or as doulas call it, wearing different "hats," is rooted in community. We can akin this to Collin's notion of other-mothering—"women who assist bloodmothers by sharing mothering responsibilities...Grandmothers, sisters, aunts, or cousins act as othermothers by taking on child-care responsibilities for one another's children" (2000; 178). Othermothers are not always

biologically related, and they show the historical and continuing significance of "women-centered networks and community-based child care" in African American communities (2000:179). While doulas are not necessarily always sharing in "mothering responsibilities," part of their role involves "mothering" their client, or as Eleanor says, teaching the client how "to become a mother to themselves" through practices of self-love.

The concept of othermothering is important to Black doula epistemology as many of my doulas felt called into their work due to inspirations from others. As Indira was inspired by the work of Ancient Song, Astrid was inspired by her grandmother in Haiti. Astrid's grandmother was a babysitter in the city of Okap (Cap-Haitien) who was also an entrepreneur, running services out of her home. She always had various streams of income; in addition to her care work she was a seamstress and also travelled to neighboring islands to do various jobs. Astrid's grandmother is the prototypical madan sara—phrase for the Haitian "strong woman" who often is the predominant economic contributor in the family, usually characterized through trade and various local economies which play a large role in the national economy as well. Astrid's memory of seeing her grandmother in Haiti tie to important themes of doula work.

> “I got to see how compassionate she was about doing the work and how, you know, if a family didn't have money to pay for services one week, she'd be like "it's okay pay me next week". So, growing up around that it was something that was just normal, to see that, you know, I got to actually, literally got to see that it takes a village, it takes a village to raise a child, in person. So my grandmother was definitely someone who inspired me to do the work that I'm doing now.”

Black relationality and othermothering are important in seeing how community-rooted doulas continue the generational work of their ancestors in a capitalist-dominated U.S. society. The historical devaluation of women's labor and care work contribute to how doula navigate economic systems that do not promote community building. Fabiola is heavily influenced by her

Dominican culture, and indigenous midwifery in her doula practice. Charging around $3000 as a base rate for her services, she is aware that not everyone will be able to afford her:

> What do I look like, truly connecting with somebody, and being like, 'nah, you can't afford me,' you know what I mean?...The conversation instead will be like 'how much can you afford.'

Similarly, Indira, who recently started out as a doula in 2019, is still figuring out how to balance compensation with her desire to be accessible to the communities she wants to serve. With her Caribbean roots, she likes to barter and meet clients in the middle—"what else can you do that I might need?". Since she's starting out, most births she has done have been free, and in turn her clients often support her in other ways, such as donating into her herbalism training fund, or supplying her with material she can use for her doula services. While around half of my doulas work almost exclusively with Black and brown clients, the other half have more varied clientele in terms of race. Most of my doulas partake in both private and community doula practice—in community doula work, typically the doula is part of an organization that provides low-cost or free doula services to individuals, and in turn pays doulas a small rate (e.g. $500). Private practices allow a doula more flexibility in cost, but for most of my doulas, they are less likely (but not completely unlikely) to serve Black clients. The race and class barrier to doula care is what leads doulas to doing community work. Other means of service involve charging "market rate" prices for services for those who can afford, so that they can charge less for others who cannot—as Cassandra says, "doing a $2500 birth so that you can charge someone else $500."

When it comes to doulas and their cultural practices with similar clients, they are able to embody the knowledge that has been passed down to them while also contributing to a better pregnancy experience for their clients. Fabiola notes the importance of being able to understand Dominican and Puerto Rican dialectics and the cultural nuances of what a client or their family

wants. For example, being able to play a certain genre of music for her client or talk to her client's mother and establish rapport—"Me being able to dance with them is already a different set of belonging." Astrid also elaborates on what she feels when working with Caribbean clients:

> It's like you're able to connect a little bit more when they know that you're from the same places as them and knowing that you're also Caribbean so you can speak about certain things. You know, cultural things that parents do when babies are born, and being able to connect. Because once that happens, it's almost like—once that connection happens I feel like clients are more able to let their guards down and speak to you about certain things without feeling like they may be judged if they were to present this to somebody that's not from the Caribbean, you know what I mean? So, I think it's amazing to be able to do that and it just makes them more comfortable.

Even though individual cultural experiences can vary from country to country, the overall sense of geographic community that Astrid feels allows her to engender feelings of belonging for clients. Harkening back to embodiment, it is evident that for Fabiola and Astrid, belonging is connected through the ability to relate through shared backgrounds, even if those experiences are not identical. For Indira, who loves to cook using Okra and Black-eyed peas and share recipes with clients, she emphasizes that these "these are foods our ancestors passed down." Generational knowledge continues to thrive in the work of doulas through food, bodily practices like breastfeeding, dancing, and postpartum rituals. However, it is important to note that generational knowledge is not linear, which is why education is so important to fill the "gaps," as Dorothy notes: “There are things we lose over generations, especially if you weren't breastfed like my mother.” There are many reasons why people are disconnected from passed-down knowledge: family traumas, separation from one's family or community, institutional or government efforts, and more. Indira, who is adopted, recently started connecting with her biological family and South Carolinian and Alabama lineage. She sees her background and spiritual connections to ancestors as intimately connected to her doula practice:

> I only have that knowledge [about foods passed down] because my ancestors had that knowledge and shared it with me….I know the ancestors support the work that I do. They show me signs all the time, they communicate through me, they give me courage and strength and motivation to keep going. Because it's not an easy job. Or I don't even think about it as a job—it's not an easy path to be on. Holding space can be a lot...helping people feel seen. Not everyone has ever felt seen before…

The ways in which doulas harken to family, ancestors, and cultural practices reflect a cultivation of spiritual strength that has very material impacts for how doula work is done. As Dorothy believes, newborns are "supposed to hear the sounds of the community, and get them to stir." Many doulas I spoke with displayed a desire to maintain the communal essence of birth work, even if it is not the same as practiced years, decades, or centuries ago. Despite historical and technological changes, the essence of doula work relies on its extension to how communities should already be supporting each other. The doula's role as facilitators of the birthing process implicates them in the process of community growth and uplift.

Conclusion

This project sought to explore the characteristics and significance of doula work among Black, African-diasporic doulas and the communities they serve. The forms of knowledge, intimacy, and care that they cultivate all revolve around the needs and goals of the client. At the same time, doulas are aware that their client nor their birth experience cannot be isolated from sociocultural contexts. In going through the various types of support that doulas provide, I showcased how the doula work is reflective of the community-centered values they hold.

The education and resource support that doulas provide are examples of how they see their client's needs during childbirth through a multidimensional perspective. The ability to understand those varied needs through shared racial, ethnic, and socio-geographic connections

showed how community-centered doula work can aid marginalized communities. During birth, doulas enact various forms of material and immaterial forms of care and intimacy in the birth space that work to strengthen the client's confidence around birth. By embracing their liminal status as they move between space and time, doulas strategically facilitate biomedical encounters and advocate for their client when necessary by '"holding space." They do so while also emphasizing a desire to not dominate the birth space or the birth experience for the client.

The doulas in this project are highly knowledgeable about the state's biomedical context and how it's normalization can be disempowering. Amidst a geographic context of New York and the medicalization of Black and brown bodies, doulas navigate their own vulnerabilities with previous birth experiences and those of their clients. As architects of intimacy, doulas offer a restorative care practice dependent on relationality and connection, amidst a biomedical society where birth can often leave the patient feeling isolated, unsupported, and disembodied. As birth professionals and as Black women with various cultural backgrounds, the doulas see their work as intimately tied to the ways they see themselves in a grander context that expands space and time. The ways in which doulas harken to their grandmothers, ancestors, and communities reflects a form of spiritual strength that has very material impacts for how doula work is done.

As I conclude, I highlight some comments that inspire further discussion about the future of doula work. In our conversation, Dorothy mentions:

> I don't think I'm invaluable, I don't think I'm necessary. I think I'm needed. Because I think a lot of people survive their postpartum, 'I made it, okay! I don't know how I did it, but I made it!' And I think we could definitely have a different way of doing this, we could thrive.

"We could thrive" represents the desires that Dorothy and other doulas have for their clients and communities. For many people of marginalized backgrounds, the focus on survival can often dominate life choices and behaviors, and in Dorothy's experience, prevent a postpartum

mother from properly resting and healing in lieu of returning to home or work duties as normal. Dorothy was also keen on emphasizing that other people in the client's life should not have to be attentive to ensuring the survival of their loved one during birth, but rather should be able to thrive and rejoice with them and the newborn. As Dorothy says, "maybe grandma doesn't want to be a doula." Similarly, Cassandra ended our conversation with hopes for the future of doula work, especially for Black doulas:

> "[My goal is for everyone to] not have to feel like you are there in order to save a life. That the medical industry becomes a place…where if we want to doula, we can do 16 hours of hip squeezes because we want, and not have to stop doing that because now we're cognizant of who treated our client's poorly because they're Black. That it's like we can be doulas and not security guards...I didn't sign up to be a security guard, I signed up to give hip squeezes and give words of affirmation. So that's where I want to center my joy, that's where I want to center my service....And to create spaces where Black women can feel safe, and loved, and held.

The desire to center their work on joy was present through a few other doulas as well, and I draw connections between their desires and the work that Black feminist scholars have done on the ability for joy to be reclaimed from the "impacts, delusions, and limitations of oppression and/or supremacy" (Brown 2019: 13). Discussions of doula work, intimacy, and care continue to inform notions of biomedicine, Black bodies as reproductive/political subjects, and the larger workings of institutional apparatuses on the lives of its populations. At the same time, I hope that more room is made for important conversations of identifying and reproducing forms of joy that exist when people support each other in such vulnerable moments.

Bibliography

Ancient Song Doula Services. n.d. “About Us | Ancient Song Doula Services.” *Ancient Song Doula S*. Retrieved April 26, 2021. https://www.ancientsongdoulaservices.com/about-us.

Abegune, Hamilton Maria E. 2015. "Learning to Walk in Water: Invoking Yemanja on the Doula Path." In *Doulas and Intimate Labor: Boundaries, Bodies, and Birth*, edited by Angela Castañeda and Julie Searcy, 99-106. Ontario; Toronto: Demeter Press.

Anderson, D. Mark, Ryan Brown, Kerwin Kofi Charles, and Daniel I. Rees. 2020. “Occupational Licensing and Maternal Health: Evidence from Early Midwifery Laws.” *Journal of Political Economy* 128 (11): 4337–83. doi: 10.1086/710555.

Bailey, Moya, and Whitney Peoples. 2017. “Articulating Black Feminist Health Science Studies.” *Catalyst: Feminism, Theory, Technoscience* 3 (2): 1–27. doi: 10.28968/cftt.v3i2.28844.

Bastien, Alison. 2015. "Retrieving the Maps to Motherhood'" In *Doulas and Intimate Labor: Boundaries, Bodies, and Birth*, edited by Angela Castañeda and Julie Searcy, 32-38. Ontario; Toronto: Demeter Press.

Bridges, Khiara. 2011. *Reproducing Race : An Ethnography of Pregnancy As a Site of Racialization*. Berkeley, CA: University of California Press.

Brown, Adrienne M. 2019. *Pleasure Activism: The Politics of Feeling Good*. Chico, CA: AK Press.

Brown, R. 2001. “‘Walk in the Feenda’: West-Central Africans and the Forest in the South Carolina–Georgia Lowcountry.” In *Central Africans and Cultural Transformations in the American Diaspora*, edited by L. Heywood, 289-318. Cambridge: Cambridge University Press. doi:10.1017/CBO9780511529108.013.

Collins, Patricia Hill. 1989. "The Social Construction of Black Feminist Thought." *Signs* 14 (4): 745–73.

Collins, Patricia Hill. 2000. *Black Feminist Thought.* Taylor & Francis Ltd / Books.

Conrad, Peter. 1975. The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior. *Social Problems* 23 (1): 12-21

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18 (1): 209–32.

Conrad, Peter, Schneider, J., and Gusfleld, J. 1992. *Deviance and Medicalization: From Badness to Sickness*. Temple University Press.

Craven, Christa, and Mara Glatzel. 2010. "Downplaying Difference: Historical Accounts of African American Midwives and Contemporary Struggles for Midwifery." *Feminist Studies* 36 (2): 330–58.

Davis, Dana-Ain. 2019. *Reproductive Injustice: Racism, Pregnancy, and Premature Birth*. NYU Press.

Davis-Floyd, Robbie E. 1994. "The Technocratic Body: American Childbirth as Cultural Expression." *Social Science & Medicine* 38 (8): 1125–40. doi: 10.1016/0277-9536(94)90228-3.

Delgado, Richard, and Jean Stefancic. 2017. *Critical Race Theory: An Introduction*. Third edition. New Delhi: Dev Publishers & Distributors.

Dresang, Lee T., and Adrienne Hampton. 2015. "Vaginal Birth After Cesarean (VBAC) Calculator Risks." *Birth* 42 (4): 379–80. doi: https://doi.org/10.1111/birt.12192.

Edwards, Brent H. 2001. "The Uses of Diaspora." *Social Text* 19 (1): 45-73. *Project MUSE.* muse.jhu.edu/article/31891.

Faulkner, Shakeela, Madeline Haas, Dongyu Wang, Catherine Walker, Aviva Lee-Parritz, Rebecca Perkins, and Somphit Chinkam. 2021. "The Effects of Removing Race from the VBAC Calculator: Implications for Counseling." *American Journal of Obstetrics and Gynecology* 224 (2): S467–68. doi: 10.1016/j.ajog.2020.12.769.

Foucault, Michel. 1978. *The History of Sexuality, Volume 1: An Introduction*. Trans. Robert Hurley. NY: Pantheon Books.

Gallicchio, C. Nicole. 2015. "What Kind of Doula are You? Birth Doulas, Multiple Moralities, and the Processes and Politics of 'Ethical Becoming'" In *Doulas and Intimate Labor: Boundaries, Bodies, and Birth*, edited by Angela Castañeda and Julie Searcy, 107-123. Ontario; Toronto: Demeter Press.

Geertz, Clifford. 1973. *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.

Getahun, Darios, Daniel Strickland, Jean M. Lawrence, Michael J. Fassett, Corinna Koebnick, and Steven J. Jacobsen. 2009. "Racial and Ethnic Disparities in the Trends in Primary Cesarean Delivery Based on Indications." *American Journal of Obstetrics & Gynecology* 201 (4): 422.e1-422.e7. doi: 10.1016/j.ajog.2009.07.062.

Glenn, Evelyn Nakano. 1992. "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor." *Signs* 18 (1): 1–43.

Gotbaum, Betsy. 2006. "Giving Birth in the Dark: City Hospitals Still Failing to Provide Legally Mandated Maternity Information." *Public Advocate for the City of New York* website, Accessed April 26 2021. https://publicadvocategotbaum.com/pages/reports.html.

Green, Victoria L., Nekisha L. Killings, and Camille A. Clare. 2021. "The Historical, Psychosocial, and Cultural Context of Breastfeeding in the African American Community." *Breastfeeding Medicine* 16 (2): 116–20. doi: 10.1089/bfm.2020.0316.

Hallowell, Elizabeth. 2014. "'Between the Wall and the Sword': Reproductive Governance and the Technology of Emergency in Guatemalan Maternity Care." *Feminist Formations* 26 (3): 100–121.

Hardeman, Rachel R., and Katy B. Kozhimannil. 2016. "Motivations for Entering the Doula Profession: Perspectives From Women of Color." *Journal of Midwifery & Women's Health* 61 (6): 773–80. doi: https://doi.org/10.1111/jmwh.12497.

Hodnett, Ellen D., Simon Gates, G. Justus Hofmeyr, and Carol Sakala. 2013. "Continuous Support for Women during Childbirth." Cochrane Database of Systematic Reviews (7).

Hoffman, Kelly M., Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. 2016. "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites." *Proceedings of the National Academy of Sciences* 113(16):4296–4301. doi: 10.1073/pnas.1516047113.

hooks, bell. 2015. *Feminist Theory : From Margin to Center*. Third edition. New York: Routledge.

Hudson, Larry E., and Ohio Library and Information Network, eds. 1994. *Working toward Freedom: Slave Society and Domestic Economy in the American South*. Rochester, N.Y: University of Rochester Press.

Huesch, Marco, and Jason N. Doctor. 2015. "Factors Associated With Increased Cesarean Risk Among African American Women: Evidence From California, 2010." *American Journal of Public Health* 105 (5): 956–62. doi: 10.2105/AJPH.2014.302381.

Janevic, T., E. Loftfield, D. A. Savitz, E. Bradley, J. Illuzzi, and H. Lipkind. 2014. "Disparities in Cesarean Delivery by Ethnicity and Nativity in New York City." *Maternal and Child Health Journal* 18 (1): 250–57. doi: 10.1007/s10995-013-1261-6.

Jaye, C. 2004. “Talking around Embodiment: The Views of GPs Following Participation in Medical Anthropology Courses.” *Medical Humanities* 30 (1): 41–48. doi: 10.1136/jmh.2003.000146.

Kenny, Stephen C. 2013. “The Development of Medical Museums in the Antebellum American South: Slave Bodies in Networks of Anatomical Exchange.” *Bulletin of the History of Medicine* 87 (1): 32–62. doi: 10.1353/bhm.2013.0016.

Klaus, Marshall H. 1993. *Mothering The Mother: How A Doula Can Help You Have A Shorter, Easier, And Healthier Birth*. First edition. Reading, MA: Da Capo Lifelong Books.

Kozhimannil, Katy B., Laura B. Attanasio, Judy Jou, Lauren K. Joarnt, Pamela J. Johnson, and Dwenda K. Gjerdingen. 2014. “Potential Benefits of Increased Access to Doula Support during Childbirth.” The American Journal of Managed Care 20(8):e340–52.

Ladd-Taylor, Molly. 1988. “‘Grannies’ and ‘Spinsters’: Midwife Education under the Sheppard-Towner Act.” *Journal of Social History* 22 (2): 255–75.

MacDorman, Marian, and Eugene Declercq. 2019. “Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017.” *Birth (Berkeley, Calif.)* 46 (2): 279–88. doi: 10.1111/birt.12411.

McMillen, Sally. 1991. “‘No Uncommon Disease’: Neonatal Tetanus, Slave Infants, and the Southern Medical Profession.” *Journal of the History of Medicine and Allied Sciences* 46 (3): 291-314.

Menzel, Annie. 2020. “The Midwife’s Bag, or, the Objects of Black Infant Mortality Prevention.” *Signs: Journal of Women in Culture and Society* 46 (2): 283–309. doi: 10.1086/710806.

Mol, Annemarie. 2009. “Living with Diabetes: Care beyond Choice and Control.” *The Lancet* 373 (9677): 1756–57. doi: 10.1016/S0140-6736(09)60971-5.

Morgan, Jennifer L. 2018. “Partus Sequitur Ventrem: Law, Race, and Reproduction in Colonial Slavery.” *Small Axe* 22 (1): 1–17.

Muigai, Wangui. 2019. “‘Something Wasn’t Clean’: Black Midwifery, Birth, and Postwar Medical Education in All My Babies.” *Bulletin of the History of Medicine* 93 (1): 82–113. doi: 10.1353/bhm.2019.0003.

Mustakeem Sowande M. *Slavery at Sea: Terror, Sex, and Sickness in the Middle Passage.* Urbana, IL: University of Illinois Press; 2016.

New York City Department of Health and Mental Hygiene. 2016. *Severe Maternal Morbidity in New York City, 2008–2012.* New York. https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf.

New York City Profiles 2017. “Cesarean Births.” Retrieved April 27, 2021. https://profiles.health.ny.gov/measures/all_state/16575.

New York State. 2020. “Secretary to the Governor Melissa DeRosa Issues Report to Governor Cuomo Outlining the COVID-19 Maternity Task Force's Initial Recommendations.” *New York State* website. https://www.governor.ny.gov/news/secretary-governor-melissa-derosa-issues-report-governor-cuomo-outlining-covid-19-maternity.

Owens, Deidre C. 2017. *Medical Bondage: Race, Gender, and the Origins of American Gynecology*. Athens: University of Georgia Press. doi:10.1353/book.64082.

Owens, Deirdre C., and Sharla M. Fett. 2019. “Black Maternal and Infant Health: Historical Legacies of Slavery.” *American Journal of Public Health* 109 (10): 1342–45. doi: 10.2105/AJPH.2019.305243.

Pain, Rachel, and Lynn Staeheli. 2014. “Introduction: Intimacy-Geopolitics and Violence.” *Area* 46 (4): 344–47.

Prather, Cynthia, Taleria R. Fuller, William L. Jeffries, Khiya J. Marshall, A. Vyann Howell, Angela Belyue-Umole, and Winifred King. 2018. “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity.” *Health Equity* 2 (1): 249–59. doi: 10.1089/heq.2017.0045.

Reinharz, Shulamit. 1992. *Feminist Methods in Social Research.* New York: Oxford University Press.

Richard Delgado, and Jean Stefancic. 2017.*Critical Race Theory (Third Edition): An Introduction*. Third edition. NYU Press.

Richardson, Elaine. 2002. “‘To Protect and Serve’: African American Female Literacies.” College Composition and Communication 53(4): 675–704. doi: 10.2307/1512121.

Robinson, Sharon A. 1984. “A Historical Development of Midwifery in the Black Community: 1600–1940.” *Journal of Nurse-Midwifery* 29 (4): 247–50. doi: https://doi.org/10.1016/0091-2182(84)90128-9.

Robinson, Annie and Lauren Mitchell. 2015. "Story-Centered Care: Full-Spectrum Doula Work and Narrative Medicine." In *Doulas and Intimate Labor: Boundaries, Bodies, and Birth*, edited by Angela Castañeda and Julie Searcy, 186-202. Ontario; Toronto: Demeter Press.

Ross, Loretta, ed. 2017. *Radical Reproductive Justice: Foundation, Theory, Practice, Critique*. First Feminist Press edition. New York, NY: Feminist Press at the City University of New York.

Satow, Julie. 2018. “Why New York Lags So Far Behind on Natural Childbirth.” *The New York Times*, November 30. Accessed April 26, 2021.

https://www.nytimes.com/2018/11/30/nyregion/mount-sinai-west-birthing-center-natural-childbirth.html#:~:text=Texas%20has%2070%20free%2Dstanding,centers%3B%20New%20York%20has%20three.

Scheper-Hughes, Nancy, and Margaret M. Lock. 1987. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1 (1): 6–41.

Sharpe, Christina. 2016. *In the Wake: On Blackness and Being*. Duke University Press.

Simmons, LaKisha Michelle. 2020. "Black Feminist Theories of Motherhood and Generation: Histories of Black Infant and Child Loss in the United States." *Signs: Journal of Women in Culture and Society* 46 (2): 311–35. doi: 10.1086/710805.

Simonds, Wendy, Barbara Katz Rothman, and Bari Meltzer Norman. 2007. *Laboring on: Birth in Transition in the United States*. New York: Routledge.

Singhal, Astha, Yu-Yu Tien, and Renee Y. Hsia. 2016. "Racial-Ethnic Disparities in Opioid Prescriptions at Emergency Department Visits for Conditions Commonly Associated with Prescription Drug Abuse." *PloS One* 11 (8) :e0159224. doi: 10.1371/journal.pone.0159224.

Stevenson, Lisa. 2014. *Life beside Itself: Imagining Care in the Canadian Arctic*. Oakland, CA: University of California Press.

Strauss, Nan. 2018. "Maximizing Midwifery to Achieve High-Value Maternity Care in New York." *Choices in Childbirth + Every Mother Counts.* https://everymothercounts.org/wp-content/uploads/2018/10/MaxiMiNY_Final_5_3_18.pdf

Suarez, Alicia. 2020. "Black Midwifery in the United States: Past, Present, and Future." *Sociology Compass* 14 (11): e12829. doi: https://doi.org/10.1111/soc4.12829.

Sufrin, Carolyn. 2017. *Jailcare: Finding the Safety Net for Women behind Bars*. Oakland, CA: University of California Press.

Taylor, Jamila, Cristina Novoa, Katie Hamm, and Shilpa Phadke. 2019. "Eliminating Racial Disparities in Maternal and Infant Mortality." *Center for American Progress*. Accessed April 27, 2021. https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/.

Thornton, Patrick. 2018. "Limitations of Vaginal Birth After Cesarean Success Prediction." *Journal of Midwifery & Women's Health* 63 (1): 115–20. doi: https://doi.org/10.1111/jmwh.12724.

Thornton, Patrick D., Kylea Liese, Kirby Adlam, Katherine Erbe, and Barbara L. McFarlin. 2020. "Calculators Estimating the Likelihood of Vaginal Birth After Cesarean: Uses and Perceptions." *Journal of Midwifery & Women's Health* 65 (5): 621–26. doi: https://doi.org/10.1111/jmwh.13141.

Thurston, Lydia A. Futch, Dalia Abrams, Alexa Dreher, Stephanie R. Ostrowski, and James C. Wright. 2019. "Improving Birth and Breastfeeding Outcomes among Low Resource Women in Alabama by Including Doulas in the Interprofessional Birth Care Team." *Journal of Interprofessional Education & Practice* 17. doi: 10.1016/j.xjep.2019.100278.

Wagle, Tina, and David T. Cantaffa. 2008. "Working Our Hyphens: Exploring Identity Relations in Qualitative Research." *Qualitative Inquiry* 14 (1): 135–59. doi: 10.1177/1077800407309328.

Wertz, Richard W., and Dorothy C. Wertz. 1989. *Lying-in : A History of Childbirth in America*. Vol. Expanded ed. New Haven: Yale University Press.

World Health Organization. 2015. “WHO | WHO Statement on Caesarean Section Rates.” *WHO*. Retrieved April 27, 2021. http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/.

Yoder, Hannah, and Lynda R. Hardy. 2018. “Midwifery and Antenatal Care for Black Women: A Narrative Review.” *SAGE Open* 8 (1). doi: 10.1177/2158244017752220.