

# Birthing Black

## Community Birth Centers as Portals to Gentle Futures

by Leseliey Welch and Nashira Baril

Imagine a world where birth is safe, sacred, loving, and celebrated for everyone. Imagine giving birth with midwives in a community birth center designed in response to the dreams, hopes, and needs of the community it calls home. We believe that when Black birthing people are centered, healthcare is transformed.

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The Black mother within each of us—the poet—whispers in our dreams:  
I feel, therefore I can be free.  
—Audre Lorde (“Poetry Is Not a Luxury”)<sup>1</sup>*

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ou walk through the door, so happy to be able to receive care at a community birth center right in your neighborhood. You, your partner, and your children are greeted by name, maybe even with warm hugs. You are asked how you are doing and can tell that the person asking genuinely cares. They offer you water, tea, snacks, and you settle into a cozy sofa. Art by Black artists graces the walls. There are shelves of birth, nutrition, breastfeeding, and parenting books for you to borrow, and a toy nook in which your little ones can play.

In the exam room, you feel at home with the warm colors and cozy furniture. Your partner feels they belong here too, with posters celebrating Black and Brown fathers and disabled, queer, and trans bodies. Your midwife greets you, and you remember how relieved you felt the first time you met, knowing that they were from your community. They welcome your whole family to the visit. Your kids listen to the baby and see them on the ultrasound. Your midwife asks you about how you’ve been feeling physically and emotionally, what you’ve been eating, and how much rest you have been getting. They talk with the whole family about ways to connect with the baby and how to support you. It’s unlike any healthcare appointment you have had, and when it’s time to go, you almost don’t want to leave.

When you go into labor, there is no frantic rush to the hospital. Your partner calls the midwife, who reminds you what active labor looks and feels like, and how to know when it is time to come in. Hours later, you are on your way.





*You walk into your birth suite and breathe a sigh of relief. Your midwife is there, and they have prepared for your birth journey. You feel loved, knowing that you can labor where and how you feel called to. Your power playlist comes through the speakers while you move and sway and breathe. You walk some, sit on the toilet for a time, then move to the birthing tub. Your partner whispers reminders of your beauty, your strength, your power. Your mother is softly singing your favorite childhood song. A familiar scent wafts from the kitchen where your aunts are warming food they prepared earlier. They take the kids into the living room to play. Labor is hard work, yet your surroundings are soft and gentle. You feel seen, heard, honored, and supported, assuaging any concerns that you can't do this.*

*You feel your baby's head emerge. The midwife's eyes are reassuring. You change positions at will, responding to the knowing in your body. The surges come with more intensity, and you burrow into your partner's chest. The newest member of your family arrives earthside in this sacred container of love—and everyone and everything is forever changed.*



Imagine a world where birth is safe, sacred, loving, and celebrated for everyone. Imagine giving birth with midwives in a community birth center designed in response to the dreams, hopes, and needs of the community it calls home. We believe that when Black birthing people are centered, healthcare is transformed—and the experience of birth has the power to transform and heal individuals, families, and communities. Mere survival is not the goal; we are creating birthing environments where so much more is possible.

We, the authors of this article, are Black women birthing community birth centers, and we are founders of a national network of Black people, Indigenous people, and people of color who are also leading community birth centers. Birth Center Equity has as its mission to make birth center care an option in every community by growing and sustaining birth centers led by Black people, Indigenous people, and people of color; the mission of Birth Detroit, founded by Welch, Char'ly Snow, Elon Geffard, and Nicole Marie White, is to “midwife safe, quality, loving care through pregnancy, birth, and beyond;”<sup>2</sup> the mission of Neighborhood Birth Center, founded by Baril, is to offer comprehensive midwifery care throughout pregnancy, labor, birth, and the postpartum period by integrating an independent freestanding birth center into Boston's healthcare and community landscape.<sup>3</sup>

Birth Detroit and Neighborhood Birth Center will be the first of their kind in their cities and states. Our work is guided by the belief that the world we want to live in—from a healthy family to a healthy planet—requires the reimagining of healthcare and the equitable distribution of capital.

### **COMING BACK INTO OUR BODIES: VISIONS FOR COMMUNITY BIRTH**

Increasingly, media coverage frames Black maternal health as a “crisis.” While attention to Black maternal health is certainly overdue, the current narrative does not offer a structural analysis of the root of the problem nor affirm Black power. This dominant narrative and the data and assumptions that result create fear in Black birthing people, cast Black birthing bodies as the problem—either explicitly or inadvertently—and suggest that white maternal health outcomes, white birthing bodies, and a white-dominated birthing system are the norms to which we should aspire. The resulting public health response is to “close the gap” and aim to level the rates of Black maternal and infant outcomes to match those of the white population.

The truth, though, is that maternal health outcomes across the United States, including for white populations, are atrocious when compared to similarly economically advantaged countries in which midwives are the leaders in providing maternity care and designing the systems of care.<sup>4</sup>

The narrative of a “Black maternal health crisis” ties the crisis to one racial group and ignores the fact that the system is not working particularly well for anyone—and that because of structural racism, the system bears down inequitably on Black birthing bodies. In fact, we argue that because of structural racism—policies and practices that implicitly or explicitly uphold white supremacy—the entire United States faces a crisis of maternal health.

Leading with the Black maternal health crisis narrative repeats the trauma of those of us who have been impacted by the tragedies of maternal and infant morbidity and mortality. Yet, we ourselves have often taken part in presenting and amplifying this frame—standing with our health department badges in front of a big screen projector and sharing the painful health disparity data, often in rooms full of people whose lived experience makes up the data on the maps and graphs. Being steeped in these data requires some desensitization. For years, our jobs at health departments required us to be in our heads and not in our bodies lest we never stop crying.

We knew we could not build liberated models of care for our communities from this narrative. Setting down our graphs and charts, and fueled by both grief and radical possibility, we chose to practice articulating liberatory visions for community birth—framing our visions not by the trauma and failures of the current system but by tuning in to Black joy and agency, and returning to the wisdom of our bodies. We committed to centering stories of joy and healing in our writing and speaking to remind ourselves and anyone listening that we are powerful and capable of birthing on our own terms, and that we deserve nothing less than transformative, radically loving, high-quality care that affirms our power.

In our practice of coming back into our bodies and feeling our own joy, pain, and power, we do not ignore that we are in a crisis of maternal health that bears down inequitably on Black people. Rather, our analysis requires that we learn and uplift the true history of midwifery and the stories of Black people being experts in their own reproductive health; celebrate firsthand accounts and images of elders catching their grandbabies; and honor Black midwives and the call to uphold reproductive justice—“the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”<sup>5</sup> Our practice of visioning and of honoring the past, present, and future helps us and our communities to hold steadfast to

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the legacy and vision of community midwifery and transformative spaces for collective care and collective courage.

### **“CATCHING THE BABY”—RECLAIMING OUR BIRTHING LEGACY**

“Birth centers are for crunchy white women,” she said, with an inflection that telegraphed *prove me wrong*. In many ways, this Black woman, surveyed as part of Neighborhood Birth Center’s needs assessment in Boston in 2016, was not wrong. The majority of planned community births (birth center and home births) in the United States serve white women.<sup>6</sup> Today’s midwifery workforce is predominantly white,<sup>7</sup> and more than 95 percent of the 384 established birth centers in the United States are owned and operated by white women.<sup>8</sup> This was not always the case. We need only look back one generation to understand the uniquely Black history of midwifery in the United States and the racialized policies that undermined it.<sup>9</sup>

At the time our grandparents were born, midwives, known in the community as “grannies,”<sup>10</sup> attended almost all the births.<sup>11</sup> For our ancestors, community-based midwifery care was not “alternative” birth care—it was birth care. The midwife, well known as a healer in Black communities, came to the house and “caught the baby.”<sup>12</sup> She and other women in the community tended to the mother and newborn—supporting breastfeeding, preparing meals, and harvesting herbs for teas and salves to facilitate healing.<sup>13</sup> The details of our grandparents’ birth stories had largely faded by the time we, the authors of this article, were of childbearing age. They were erased by government-backed campaigns to move

birth out of the hands of Black midwives and into the hands of white male obstetricians.<sup>14</sup>

In 1912, John Whitridge Williams, a professor of obstetrics at the Johns Hopkins University School of Medicine, published an article in the *Journal of the American Medical Association* titled “Medical Education and the Midwife Problem in the United States.”<sup>15</sup> One of the article’s key recommendations was to phase out the practice of midwifery in cities and rural areas. Williams joined the ranks of obstetricians who blamed midwives for infant and maternal deaths and discouraged people from trusting the midwives in their communities. The 1920s brought the Sheppard-Towner Maternity and Infancy Act, which legislated and designated funding for physician and nurse supervision and training and oversight of midwives. The Sheppard-Towner Act especially targeted Black midwives as too “uneducated and unclean” to provide healthy maternity care.<sup>16</sup> Moving into the 1930s and 1940s, white male obstetricians increasingly marginalized midwifery and pathologized childbirth, blurring the crucial line between “‘ordinary’ and ‘emergency’ practices” through the formalizing of med-surgical curricula and credentials,<sup>17</sup> establishment of authoritative medical societies,<sup>18</sup> and continued racialized smear campaigns.<sup>19</sup> Further, the passage of the Hill-Burton Act in 1946 resulted in funded “separate but equal” hospitals and health clinics for the underserved, leading more Black women in the South to birth in hospitals.<sup>20</sup>

This combination of legislated economic divestment and fearmongering wildly impacted the size and racial makeup of the midwifery workforce from that point onward and made hospitals the dominant settings for birth in the United States. Today, childbirth is the number one reason people are admitted to hospitals in the United States.<sup>21</sup> “In 2010, 98.8 percent of all US births occurred in hospitals,” and 86 percent of them were attended by physicians.<sup>22</sup>

The World Health Organization endorses midwifery as “an evidence-based approach to reducing maternal mortality,” and several studies “have found that midwifery-led care for women with healthy pregnancies is comparable or preferable to physician-led care in terms of:

- “Maternal (mother) and neonatal (baby) outcomes, including lower maternal mortality and morbidity and reduced stillbirths and preterm births.

- “More efficient use of health system resources, including lower use of unnecessary and potentially harmful interventions like C-sections for low-risk deliveries, epidurals, and instrument-assisted births.
- “Improved patient satisfaction and maternal psychosocial well-being outcomes, including those for postpartum depression.”<sup>23</sup>

The economic decision to undermine community midwives—mostly Black Grand Midwives<sup>24</sup>—and move childbirth into the hospital changed the entire maternity care system for everyone.

Even the American College of Nurse Midwives recently acknowledged that the United States has never redressed the divestment in midwifery.<sup>25</sup> Maternal health infrastructure, policies, and outcomes reflect this fact:

- US birth outcomes continue to pale in comparison to those of Sweden, Norway, France, and other European countries.<sup>26</sup>
- “[T]he U.S. maternity workforce is upside down relative to patient needs. . . .
- “Access to home visits after delivery varies in the U.S. but is guaranteed in other countries. . . .
- “The U.S. is the only high-income country that does not guarantee paid leave to mothers after childbirth.”
- Obstetricians continue to outnumber midwives nearly threefold in the United States.<sup>27</sup>

And our states, Massachusetts and Michigan, rank thirty-first and thirty-fourth, respectively, in midwifery integration—meaning that they lag far behind in incorporating the demonstrated effective midwifery model of care into their health systems.<sup>28</sup>

Birth center care is even less integrated and accessible, with physical access mirroring residential segregation and limited access to low-income families.<sup>29</sup> Out of the more than 384 birth centers in the United States, approximately twenty are owned or led by Black people, Indigenous people, and people of color.<sup>30</sup> Black people make up approximately 15 percent of the childbearing population, yet as few as 7 percent of that population give birth in a birth center.<sup>31</sup> Additionally, the



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primary insurance coverage for more than half of births to Black people is Medicaid,<sup>32</sup> and most Medicaid-eligible families are unable to access birth center care, even though the Affordable Care Act requires that state Medicaid programs cover midwifery care.<sup>33</sup> The end result is that Black birthing people are among the least likely to have access to midwives and birth centers.

Today, we face racially redlined access to midwifery that reflects our nation's deeply racist political, economic, and cultural history. Obstetrics is the dominant maternal health practice, while cultural narratives overshadow the Black her-story of midwifery with one that is white, wealthy, and/or alternative/"crunchy."

US studies of midwifery, as well as data from countries where midwifery is well integrated into the healthcare system, show improved outcomes for families, including lower infant mortality, increased breast/chestfeeding,<sup>34</sup> fewer interventions, and increased rates of vaginal birth after caesarean (VBAC).<sup>35</sup> It is shameful that the majority of people who have access to birth center care are white, cisgender, college educated, middle to high income, and insured or able to self-pay for services.

**COLLECTIVE COURAGE AND THE RISE OF THE BIRTH CENTER EQUITY NETWORK**

"We ask for nothing that is not right, and herein lies the great moral power of our demand."<sup>36</sup> As we write this article, we are reminded of this quote by Black artist and activist Paul Robeson—part of the canon of ancestral wisdom that buoys us up on hard days. The two of us are clear that without each other, what we are doing would feel insurmountable. After all, most birth centers—freestanding, homelike places where reproductive health and birth care are provided by midwives—are started by midwives, and these midwives are usually white. We are not midwives, and we are not white.

Of the nearly four hundred birth centers across the country, most are for-profit entities started by white midwives with resources from private practice, personal funds, loans, and family gifts.<sup>37</sup> In a policy and reimbursement context that has historically devalued midwifery, opening birth centers and ensuring that birth center care is accessible to families who need it most is challenging for everyone; and with outdated state regulations (or none at all) and abysmal or no Medicaid reimbursement, the sustainability of birth centers hangs in the balance. Layer on centuries of economic exploitation and

inequitable access to capital, and we understand that it is even more tenuous for Black people, Indigenous people, and people of color to build birth centers—especially when our commitment is to design with the most marginalized birthing people at the center.

Despite these obstacles and in the face of ever-increasing need, the two of us swing on a heavy pendulum between naiveté and boldness and scarcity and abundance, as we experiment with nonprofit community birth center models in two major metropolitan cities.

We are clear that the maternal and infant health crises in this country are not only problems of disparate outcomes but also of inequitable options. There are seven freestanding birth centers in Michigan and not one in the predominantly Black city of Detroit. There is one community birth center in Massachusetts and none in Boston. Why is this, when we know that birth center care improves the birth outcomes that healthcare professionals and politicians alike say are important (lower rates of low birth weight, fewer preterm births, higher rates of breast/chestfeeding, higher parent engagement); enhances the birth experience; and is cost effective? Studies have even shown that birth center care grounded in racial justice is protective for Black birthing people and improves autonomy and respect for all birthing people.<sup>38</sup> These benefits are attributed to care that "recognizes that the cultural identity of birthing people is a core part of the clinical encounter, incorporates a commitment to racial justice, and is grounded in the birthing person's agency and birth worker's cultural humility."<sup>39</sup> Further increasing the number of Black midwives specifically in our communities is important, as "racially concordant care" (having a healthcare provider of the same race) is increasingly "associated with greater healthcare utilization, improved patient–physician communication, greater satisfaction with care, and reduced Black–White disparities in infant mortality."<sup>40</sup>

It is time that community-based midwifery care be recentered in our communities. Recentering midwifery care would restore the sacred and social nature of birth. Black birthing

people would be honored, trusted, and supported to birth in our full power. Black midwives would once again be respected and revered healers, reestablishing the importance of community care in birth. We would no longer be forced to seek care outside ourselves and our own communities, because we would have the wisdom and expertise we need within our communities. Midwifery care that engages the whole family in pregnancy, birth, and postpartum care would support family engagement and nurture community kinship ties. Physical and emotional birth outcomes in Black communities would drastically improve with the high-touch, family-centered care midwives provide. And if all of these benefits do not appear enough to warrant large-scale investment, the cost savings alone justify significant investment. Cost analyses project “an annual savings of \$189 million with a shift of 1 percent of births from hospital to birth center.”<sup>41</sup> Midwifery care is high-quality, value-based care that saves lives and money.

Our courage as we do our work comes from the conviction that community-based midwifery care grows healthy and strong communities, from the power of being in this work together, and from the legacies of Black movement building. From abolition to desegregation to the birth of the reproductive justice movement, Black activists have a history of making the impossible possible. Our ancestors’ refusal to accept what is not right and not just led us to freedom. We refuse to accept highly medicalized birth and the racial redlining of midwifery. We aim to center Black midwives and Black birthing bodies as we grow exemplary models of community care. In her book *The Power Manual: How to Master Complex Power Dynamics*, Cyndi Suarez writes about liberatory power; in contrast to supremacist power, which focuses on domination and stems from scarcity, liberatory power is rooted in abundance consciousness and the transformation of what was once perceived as a limitation.<sup>42</sup> *The domination of obstetrics will someday be history, and midwifery will be the number one choice for birth care. Liberatory power is the power to create what we want to see in the world.* Thanks to our abolitionist ancestors, this power is in our blood. It is the substance of things hoped for and the belief in things not seen that fueled the underground railroad and the faith that pulsed through the civil rights movement and lives on in Black liberation movement activists of today.

We also share a commitment to caring for ourselves and each other as we work to make the impossible possible in

our communities. The day we met for the first time over Zoom, connected by our mutual public health mentor Dr. Renée Branch Canady, we were both working full-time jobs in public health and leading birth center planning on the side as volunteers. We agreed right then that overworking to the point of burnout to build sanctuaries for Black birthing people could not be the thing that “takes us out,” and that has been one of our mantras ever since. We started by sharing our stories of birth and becoming; why we chose midwives for our own births; and how we got to this place of leading teams of local birth advocates building birth centers. We talked about our families, our careers in public health, and what it meant to revere and work in service of community midwifery in this way—to embrace birth center development as persons who are not midwives. Between 2018 and 2020, we had countless virtual monthly coffee and tea talks, sharing ideas, budgets, strategies, tools, and wins and losses.

Our work is as much about the audacious goal of building birth centers where Black birthing people and midwives thrive as it is about healing and tending to the collective trauma of racism, scarcity, false histories, and limited thinking. During our combined thirty-five years of work in governmental public health, neither one of the big-city health systems we were involved with invested in the midwifery model of care—nor did the renowned schools of public health, where we delved into women’s studies and maternal and child health, teach the true history of the maternal health system in the United States. The public health field’s explicit focus in the early 2000s on “moving upstream,” so to speak, as a way to address racism as a social determinant of health,<sup>43</sup> had us, as young public health professionals, implementing programs that presumed that increased access to systems not designed for us would somehow improve our health outcomes.

The two of us also hold a mirror up for each other when our deeply ingrained government or nonprofit bias is showing—for instance, when we tensely move forward with the “well”-worn tools of funder-imposed urgency, perfectionism, and worship of the written word.<sup>44</sup> We make space for preparing and debriefing together as we practice being in radical relationship with each other, our funders, and our boards—growing shared leadership models and endeavoring to redistribute power within and outside our organizations. We remind ourselves often that there are enough resources available to meet our communities’ needs. Our greatest challenge

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is staying the course in the sacred design of the liberatory birth spaces of tomorrow while the structures around us are so deeply invested in the confines of today. Planning and strategizing together, we have felt “seen,” supported, encouraged—and stronger. In the face of uncertain funding, political will, and support—and with a commitment to centering values of safety, abundance, and liberation, and to birthing people who historically have not been centered—we understand that we are stronger and bolder together. We share a collective courage.

This leaning into each other in vulnerable ways is different from what we learned to do in “professional” settings and in our academic training, where white supremacy and heteropatriarchy call for staunch individualism. As we learned more about collective courage and the uniquely African American histories of economic cooperation and solidarity economies, we were brought back to a rich ancestral history. Black people on Turtle Island have always been discriminated against and marginalized, and therefore have always had to find ways to come together. Dr. Jessica Gordon Nembhard calls economic cooperation a stabilizing force.<sup>45</sup> Dr. Gordon Nembhard points to African American traditions of pooling resources to increase and democratize wealth; increase Black economic stability, group interdependence, and self-determination; and develop collective agency and action.<sup>46</sup>

In March 2020, as the pandemic locked down our communities and pregnant people scrambled for safe places to birth outside of hospitals overrun with COVID-19, we felt the call of Indian author and activist Arundhati Roy to recognize the pandemic as a portal. In April 2020, Roy wrote,

Historically, pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next. We can choose to walk through it, dragging the carcasses of our prejudice and hatred,

our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us. Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it.<sup>47</sup>

A dear friend and advisor, Julie Quiroz of New Moon Collaborations—who helped spark the creation of Birth Center Equity<sup>48</sup>—invited us to expand our vision as we experienced what the twin pandemics of the virus and racism were revealing in 2020. Together, we dared to imagine (to remember, really) a different system of birth in the United States, centering midwifery-led community birth centers—this time, with abundant resources to flourish for generations to come. We coauthored “Birth Centers Are Crucial for Communities of Color, Especially in a Pandemic,”<sup>49</sup> and launched Birth Center Equity. BCE is rooted in the premise that, as a growing network of Black-, Indigenous-, and people-of-color-led birth centers, we can assess and set our priorities and collectively attract and direct resources at a level of scale and power that none of us could do on our own. BCE takes the principles of collective courage and solidarity economies<sup>50</sup> and aims to leverage collectively sourced resources (financial capital, wisdom, social capital, narrative) and allocate them for the betterment of the birth center ecosystem and, ultimately, improved health outcomes overall.

BCE was founded on values of safety, abundance, and liberation to grow and sustain birth centers led by Black people, Indigenous people, and people of color. Today, we are a network of more than thirty birth center leaders of color who—despite entrenched inequity and in active defiance of it—have successfully opened or are opening birth centers in our communities. Together, we are building community

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among birth center leaders of color, growing efforts to transform the culture of birth, and stewarding capital to seed vibrant and lasting community birth infrastructure for generations to come. We are essentially reimagining the birth center model on local and collective scales by reclaiming ancestral principles of collective economics and bound liberation. Nwamaka Agbo, CEO of Kataly Foundation and managing director of the Restorative Economies Fund, puts it this way: “When communities come together to collectively own and manage assets, they can leverage their joint economic power to collectively assert their rights and exercise cultural and political power in a more impactful way than they would on their own.”<sup>51</sup> In liberatory economic models of birth centers, midwives—and communities—thrive.

### **OUR ANCESTORS’ TOOLS**

Black lesbian feminist poet Audre Lorde wrote, “The white fathers told us: I think, therefore I am. The Black mother within each of us—the poet—whispers in our dreams: I feel, therefore I can be free.”<sup>52</sup> The two of us hold these words close in our work as a reminder of our origins and the depths of embodied wisdom within us. This assertion starkly contrasts with white supremacist ways of knowing, which routinely exclude embodied wisdom and Black women’s experiences from what counts as authoritative knowledge. Because white male obstetricians have historically dominated maternal health knowledge production in the United States, “authoritative knowledge” on the topic has long reflected their perceptions and interests. Maternal healthcare remains an area in which current evidence-based science from diverse sources is not fully reflected in practice, and Black women’s experiences continue to be deprioritized.

Our approaches to birth center development in Boston and Detroit intentionally center the lived experiences of Black birthing people and draw upon four dimensions of Black feminist theory or ways of knowing:<sup>53</sup> *lived experience as criterion of meaning; the use of dialogue in assessing knowledge claims; the ethics of caring; and personal accountability.*<sup>54</sup> We see these four dimensions as *organizing ethics*—moral commitments or principles that, when combined with the evidence base for midwifery care, have the potential to transform healthcare infrastructure development in our communities.

### **LIVED EXPERIENCE, DIALOGUE, AND KNOWLEDGE CLAIMS**

In *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, Patricia Hill Collins explains how knowledge reflects the interest and standpoint of its creators. Collins discusses how epistemology, or theories “used to assess knowledge or why we believe what we believe to be true,” is shaped by dominant power structures, highlighting that who we believe and why are rooted in accepted hierarchies of human value that devalue Black women’s voices.<sup>55</sup> Historically and traditionally in Black communities, lived experience is valued. Lived experience as a criterion of meaning is best understood in the saying “a heap see, but a few know.”<sup>56</sup> This saying differentiates observing from understanding, knowledge from integrated wisdom, reading and studying from living. In Black feminist epistemology, dialogue and connectedness (rather than separation and isolation) are essential parts of knowing that have African and African American roots. Dialogue builds community, call and response demonstrates understanding—and both require active participation of all people involved.

We drew on this tradition of living and connecting as a valid way of knowing as the basis of our community assessments, focus groups, and conversations. We started our birth center planning efforts by asking our communities about their birth experiences—their desires, their choices (or lack thereof), the outcomes.<sup>57</sup> From stakeholder interviews, focus groups, and community assessments in both cities, we learned that Black birthing people want more care choices, including midwives and birth centers. People shared experiences of not being heard and of feeling disrespected. People described what it felt like to go through the birth experience without birth care providers who looked like them, spoke their language, understood their culture and lived experiences, and truly cared for them and their families.

Birth Detroit organized a community launch-and-learn event, where cofounders shared our own experiences, midwife Jennie Joseph spoke about the midwifery model of care,<sup>58</sup> and we mirrored back what we heard in the interviews and assessments. We created large posters summarizing survey data, and made time for participants to do a “gallery walk” through the data, adding information, notes, and questions. It is essential to Birth Detroit as a community-born health initiative that Detroiters feel seen, heard, understood, and connected to birth center planning—and we created opportunities beyond the launch-and-learn for conversations about midwives, birth centers, and how we can reimagine birth care together, as a community. Birth Detroit provided toolkits and questions for kitchen table “birth talks” (small group discussions about midwives and birth centers), attended community health and early childhood education outreach events, and organized virtual provider and payor forums to introduce Detroit healthcare providers, private insurance, and Medicaid payors to the planned birth center and to invite questions.

Birth Detroit cofounders—a public health leader, a certified nurse midwife, a certified professional midwife, and a doula and health educator—also shared our personal stories of pregnancy, birth, and loss, and we made space for community voices and story sharing, legitimizing and centering our collective experiences and multifaceted view of maternal healthcare in our communities as actionable data. In addition to connecting with our communities and centering community voices, we stood in our power as established credible leaders proximate to the issue of birth care in our communities and with more than thirty combined years of experience caring for Detroit families. Birth Detroit’s birth center planning efforts since the community launch-and-learn event in 2019 have continued to prioritize connection and dialogue—even in the latest phase of birth center building design, where community members are invited to give input into interior, garden, landscape, and playground design.

## ETHIC OF CARING AND PERSONAL ACCOUNTABILITY

The spirit of care and leadership matter. The values that guide one’s speech, care, and leadership are essential elements of how healthcare and health systems leadership are experienced. The ethic of caring situates empathy, emotion, and personal expression as central to knowing. The ethic of caring has three essential interrelated components: *individual uniqueness and expression, emotion as a key part of*

*dialogue, and empathy.*<sup>59</sup> Put another way: *we are unique emanations of spirit; to be in touch with our feelings is a source of power; and where there is no empathy, there is no care.* In an ethic of caring, we are conscious not only of what is said but also of how it is said; not only that care is delivered but also in what spirit that care is delivered. Understanding the spirit of care and the ethic of caring helps us to understand why increased access to healthcare systems that devalue Black birthing bodies will never significantly improve maternal health outcomes in Black communities. Values of safety, love, trust, and justice fuel our birth center development efforts in Detroit and Boston; and Birth Center Equity is committed to growing birth centers that provide safe, culturally reverent, midwifery-led care for all.

Upholding an ethic of personal accountability means that we not only develop knowledge in dialogue with our communities—and share in ways that demonstrate respect and care—but also that we are accountable for our beliefs and to our communities for what we say and do with respect to what we know. In other words, what we speak of, represent, and create in the world are demonstrations of our “character, values . . . ethics”<sup>60</sup> and commitment to our communities.

From our experiences as public health professionals, we know that many initiatives survey and assess health behaviors and outcomes only to create interventions that act upon populations as the source of their own problems.<sup>61</sup> Far fewer interventions actually endeavor to disrupt white supremacy in the structure and leadership of healthcare and health systems. To date, most interventions that address Black maternal and infant health inequities aim to tweak existing systems with checklists, unconscious-bias education, and the integration of doula care—none of which fundamentally challenges obstetrics as the dominant care model or hospitals as the site for birth, despite compelling evidence of the need for these to change. Dominant strategies continue to center white people as the experts, financiers, decision makers, and institution builders of healthcare and beyond. It is not enough to declare a crisis or to say one cares about Black birthing people; such declarations must be reflected in an ethic of caring and translated into action—into real work toward a liberated future.

The economic model for birth care in this country has to change. The master’s tools do not work and have never worked for Black communities.<sup>62</sup> In sharp contrast to the 83 percent of US birth centers that are for-profit

businesses,<sup>63</sup> of the BCE network of thirty Black-, Indigenous-, and people-of-color-led birth centers (both established and in development), the majority are nonprofit. With the dominant financial model of birth center start-ups being personal savings or debt, the capital tools available to white entrepreneurs and the philanthropic investment given to white-led nonprofits have never been equally available to leaders of color. As such, many Black midwives have started their birth centers on shoestring budgets and been forced to choose between caring for themselves financially and sacrificing their personal salaries to provide birth care for their communities. Many developing BCE organizations have landed on the nonprofit structure as the only way to generate necessary start-up resources, leaving us to write endless grants, launch bake sale after bake sale, host backyard parties, sell bricks imprinted with donor names, and create crowdfunding and T-shirt campaigns to generate resources. It leaves even the most renowned and celebrated Black birth advocates—like our beloved mentor Jennie Joseph—to engage in endless fundraising efforts to solve for problems that we did not create and to care for our communities.

Personal accountability shows up in our work as not asking permission,<sup>64</sup> a bias toward action, and a commitment to leading our own care. GirlTrek, the largest African American women's public health movement in the United States, says, "Never ask permission to save your own life"<sup>65</sup>—and history has consistently shown us that we cannot wait for others to respond to our needs. We cannot wait on the very healthcare-knowledge machine that delegitimized midwifery to champion it. Black people must reclaim midwifery now to save ourselves and our futures. Until the US healthcare system grapples with the true root cause of disparate maternal health outcomes—the legitimizing of knowledge and the distribution of money, power, resources, and opportunity based on a hierarchy of human value that privileges whiteness—interventions that maintain the status quo will continue to be funded and prioritized, and health systems will continue to be shaped by knowledge claims that devalue midwifery and Black bodies.

Linking Black feminist epistemologies' assertion that Black women's experiences can serve as a social location for "examining points of connection among multiple [ways of knowing]"<sup>66</sup> with the concept of targeted universalism (universal goals pursued by targeted strategies), we offer that improving Black birthing people's experiences of birth care

can be the foundation upon which we examine and improve birth care for all birthing people. Consider: What would it look like to apply Black feminist epistemology to birth care as a whole in the United States? What if obstetrics and midwifery were both situated as valid standpoints of partial knowledge with the potential to make up a stronger whole? What if each group could consider the other group's standpoint "without relinquishing the uniqueness of its own standpoint or suppressing other groups' partial perspectives"?<sup>67</sup> What if true and authentic connections were attempted across historically entrenched lines of professional and philosophical division? What if we celebrated birth as a common thread, and made how we care for birthing people and families a shared moral, ethical, and economic priority?

## **BELOVED COMMUNITY AND BELOVED ECONOMY**

In his writing on centering Black epistemologies, Dax-Devlon Ross asks the visionary question, "Once we are liberated from the straitjacket of received histories curated to confine our imagination . . . what other options for organizing our affairs become available to us?"<sup>68</sup> We do not have to accept what is given simply because it is given. There is another way. It is time we move beyond the naming of the racist history, end the hold of obstetrics and hospital birth on our bodies, and courageously create alternative futures with midwifery and community birth at the center.

Neighborhood Birth Center and Birth Detroit are striving for ownership of ourselves, our care, and our futures. We are committed to working with community birth center leaders and philanthropic, investor, and policy partners to overcome capital and policy barriers and make birth center care equitable, accessible, and sustainable. We are committed to radical experimentation and investment in Black leadership to create a unique care system rooted in values of safety, abundance, liberation, and love.

Beloved community envisions cooperation, shared abundance, and collective thriving. Beloved economy invites us to consider what is possible when we decenter capitalism and center values of love, healing, and well-being. Rather than accepting that community birth centers are not sustainable economic models, we are broadening the conversation and asking: What if birth were at the center of a beloved economy? What if how we cared for birthing people and how we brought our babies into the world were a true

**We believe that when birth is held sacred, not only are individuals and communities transformed but also the public, the economy, and even the planet are healthier.**

moral, cultural, and economic priority? What is currently a boutique model of care available only to some should be a population-health strategy to heal our communities. From our own experiences, we know that childbirth is a portal through which people can be transformed—and we believe that when birth is held sacred, not only are individuals and communities transformed but also the public, the economy, and even the planet are healthier.

In a beloved community and a beloved economy, equity means ownership. Instead of retrofitting rented space in Boston and Detroit, our economic models involve buying sizable portions of city blocks to build from the ground up—including incorporating sacred spaces for collective care. We are working with designers, architects, city planners, and investors to build warm, inviting, beautiful healthcare spaces surrounded by community food and flower gardens and children's playgrounds. During our property search in Boston, a prospective seller gruffly asked why we insisted on buying when "it's so much work to own." He promised he would hold the risk as owner while we signed a multiyear lease to rent. Our response? "We want to buy for the same reason you don't want to sell. We want the asset." We cannot leave the sustainability of community birth to the whims of landlords or investors, or limit our growth by renting too-small spaces. Our big visions are to nestle our clinical care among movement leaders and care providers who provide holistic health and other services that build power; to include dedicated space for midwifery training, education, and student housing; and to work in solidarity with organizations and organizers who share our values and who are working toward a just and sustainable future. Midwifery and childbirth are the center of a beloved community and economy, and Boston's and Detroit's birth centers are love letters to our communities.

When we feel overwhelmed by the uphill battles ahead, we remember that "the Black mother within each of us—the poet—whispers in our dreams: I feel, therefore I can be free."<sup>69</sup> We think of the Grand Midwives of years past and the midwives working tirelessly today. We think of our grandchildren's grandchildren, and the world we are seeding for them—a world in which birth can be both gentle and empowering.

*How we birth matters.* Author and activist Alice Walker is said to have posited that "how we come into this world, how we are ushered in, met, hopefully embraced upon our arrival, impacts the whole of our time on this Earth."<sup>70</sup> Indigenous midwife Marinah Farrell offers that "reimplementation of birth as ceremony means babies can be born (and communities reborn) into an ancestral cultural ecology characterized by safety and cultural reclamation of healing."<sup>71</sup> Their wisdom delivers infinite possibilities.

A funder recently asked what the impact of our work would be. Rather than quantify the number of childbirth-ed classes taught or the number of babies born, we mused: What if we as Black birthing people were honored, trusted, and supported to birth in our full power? What if Black babies were born into rooms full of love and celebrated for all that they are and have the power to be? What will be the impact when midwives are once again revered as experts and healers in their communities? What will be the impact of Black midwives, Indigenous midwives, and midwives of color leading a reclamation of the tradition such that midwifery care is restored as the optimal care model in *all* communities? And we said unto that funder, "Fuck around and find out."

**Midwifery and childbirth are the center of a beloved community and economy, and Boston's and Detroit's birth centers are love letters to our communities.**

## ROOTED

by leseliey rose

we are bowls of light  
forgiving and remembering

we are mistresses of the moon  
keepers of stories, goddesses of the hunt  
becoming, remaking, reimagining—building together

we are mist from the heavens over gardens of holly  
womb holders of epic love stories past and futures deep  
we are flowers the sun never forgot

like the wisdom and roots of tall oak trees—we remember  
strong storms, righteous rebellion, journeys to new lands, resistance  
we dream winds of revolution  
we nurture the promise of safety and peace

we are descendants of underground railroad visionaries, masterminds,  
sojourners in love, joyful dancers and freedom songs  
we are ancestors seeding new worlds

we are bowls of light  
forgiving, remembering, and leading

we are curanderas, healers, and spirit-centered creators  
with backyard chapels and great-grand-basins  
from which to pour light and hold sacred space  
for babies, mamas, papas, families—and leaders—  
to be born in rooms full of love  
healing past, present, and futures

*born of radical love  
guided by the wisdom of Black women  
we are revolutionary leaders  
rooted in spirit, trust, joy, and vision*

*we are Birth Detroit*



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