Interview with Midwife Jennie Joseph

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In this interview, JOPPPAH Associate Editor, Dr. Jazman Allen, spoke with Orlando midwife, Jennie Joseph regarding Jennie's experience working with underserved populations during the concurrent COVID-19 pandemic and heightened racial tensions in the United States. This interview was edited for clarity only.

Jazman Allen:
Thank you so much for taking the time to speak with me, Jennie, and to share your knowledge with APPPAH. We really appreciate it. I am on APPPAH's journal team and I am also on the Diversity Committee. So, I do a little bit of work on both committees. I would love to know a little bit more about you and your work, and working with underserved populations.

Jennie Joseph:
Well, it's been quite a journey. I arrived in the United States in 1989. I was born and raised in England. My parents are from the West Indies and immigrated to England in the 1950s. I'm the eldest of four, born and raised

Jennie Joseph is a British-trained midwife who fights to ensure every person has their healthiest possible pregnancy, birth and postpartum experience with dignity and support. Jennie created The JJ Way® which is an evidence-based, maternity care model delivering readily-accessible, patient-centered, culturally-congruent care to women in areas that she terms "materno-toxic zones." Her focus and drive are to ensure that Black women and other marginalized people remain safe and empowered inside broken and inequitable maternity health systems that have become dangerous and all too often, lethal. Jennie is the Executive Director of her own non-profit corporation, Commonsense Childbirth Inc., which operates a training institute, health clinics and a birthing center in Orlando, Florida, and is also the founder of the National Perinatal Task Force, a grassroots organization whose mission is the elimination of racial disparities in maternal child health in the USA. Jennie is the founder and a proud member of The Council of Midwifery Elders, she serves on the Advisory Council for the Congressional Black Maternal Health Caucus and is a Fellow of The Aspen Institute. **Jazman Allen, PsyD** is a postdoctoral psychology fellow whose work focuses on promoting healthy early attachment relationships between very young children and their caregivers. She hopes to continue working within underserved and diverse communities with limited resources to increase visibility and accessibility of prenatal and perinatal psychological services. Dr. Allen serves on APPPAH's Diversity Committee and is the Associate Editor of JOPPPAH.

there. My family is still in England as we speak. I've been in the United States since 1989, so that's 31 years. I was already a midwife. I had been a midwife for 10 years at that point and had no clue actually, didn't do any research. I just showed up [in the US] thinking I'll just go get a job as a midwife because I know Americans have babies. And no.

I met this really amazing man and we had this long-distance romance, and he came to England and proposed. I said yes, of course. I'm coming right back to the United States because I had all that Disney background in my head, you know, Orlando and Disney. So, I'm married to the United States and was ready to live my Disney life, and I had a rude awakening. The first big awakening was that no one wanted to hire a midwife, especially in the hospital, with my credentials. So that was a big shock.

The second thing was then understanding and learning the history of midwifery in the United States. Also a big shock. I had no clue, no idea. So, I'm used to, and have been raised around [in England], the fact that midwifery is normal and that midwives take care of normal perinatal care for women in their childbearing years. Physicians take care of complications and abnormalities of women in their childbearing years. So, to me, that was a distinction. And I didn't see the combination of physicians taking care of normal cases as a normal and sensible thing to do. Quite the opposite. And I also was very concerned when I started learning about midwifery, particularly in the South. How it was racialized, and how there were so many different campaigns and ways to eradicate midwifery successfully.

Because here we are. You know, even in 2020, no less than 10% of the birthing population of the United States uses a midwife. The majority of those that do, use a hospital-based midwife. And that's not to say hospital-based midwives aren't midwives. But it is a different type of midwifery practice to the rest of the world. American nurse midwives, hospital-based, hospital-practicing midwives, are following the obstetrical model, even though they try to impart some of the midwifery art into that model. But it's the hospital system and a recognized medical approach to birth. It's very difficult to do the true midwifery that, you know, midwives around the world offer.

So typically, in out-of-hospital settings, the community midwives are closer to the model that I actually was accustomed to, that I actually practiced, even in hospitals. And so, it's been a struggle for me, these 31 years, to understand how, I guess, we get away with providing obstetric care in the US in this way. And at the same time throwing our hands up and saying, the system's broken. Then these women are suffering, in fact, even in many cases, dying, but we don't know what to do. That's where I kind of get really frustrated, because actually, we did know full well, what to do. We just choose to not do it. And that's really because American

medical care is capitalized. It's capitalism and it's meant to create a bottom line product. And you cannot force women's childbearing experiences into anything that's commodified.

Jazman Allen:
Absolutely.

Jennie Joseph:
And so when I talk to other midwives, work with other midwives, even train midwives, I'm holding out for this other model of midwifery—the original and initial model that historically has been practiced for millennia. Which is about the meaning of the word midwife: "with woman," and "being with woman," and "supporting a woman through the process." The pregnancy, the delivery, and the postpartum, and breastfeeding worldwide is the same. Except for here. I would love to see the change in America, the transformation of maternity care and maternal health into the midwifery model of care.

But, I mean you don't have to be a midwife to practice the midwifery model of care. Certainly tenants that always remained with midwifery model can be practiced. Number one, it's respectful. By its nature, if practiced correctly, it's culturally-safe care. It's patient-centered, woman-centered, family-centered, person-centered care. It's, "Let's not cause any additional harm. In fact, let's just support you in your process." However, you want that process to be, okay. All of those things are missing for the most part.

Not to cast any aspersions on any one midwife or one practice or one group. But as long as we buy into the party line that this is okay and we can keep trying to shelf midwifery into a medical model, we'll be unhappy. And we're going to keep getting the outcomes that we get because the outcomes speak to what's wrong. In the most developed nation in the entire world, we have the worst outcomes for maternal and infant health, and there is no excuse, whatsoever. It's totally unconscionable. I would go as far as to say criminal. So, the fact that people lose their lives, or that babies lose their lives—behind many of these preventable ills is that we don't have a midwifery model of care to provide support and service to American childbearing people.

Jazman Allen:
Yes. I would completely agree with that. Once I started to see the numbers, I realized that this was significantly impacting women of color, even women of color who have "money." You hear about women like [tennis player] Serena Williams and her birth experience, and you think, oh, well, she has money, and you expect that she would have better

maternal care. And that's not necessarily true. I think that was a rather shocking realization for me, and I'm sure for many. I kind of want to know your thoughts about that, and about disparities between women of color and socioeconomic status.

Jennie Joseph:
I think two things. There was my lived experience as a Black British woman, who came back [to the US] to say, I was oblivious—no clue, no research, no thinking. I knew about civil rights. But just like the rest of the world, I thought it was all over after civil rights. Laws were changed. All was well with the world, at least with America. And I did not have any expectation of any of the things I've experienced as a woman of color, a Black woman in the South. But my own experience speaks to what I think is the basic underlying problem. And the reason why we not only don't have midwifery, but we also don't have any political will or even social will, to change anything. And that is because of deeply-embedded, systematic racism, classicism, gender, oppression, ableism. You name it—like, all the -isms.

Jazman Allen:
Yes.

Jennie Joseph:
It's led by racism. It's the way the system is set up and, in fact, the system isn't really broken. It's working very well. So on a personal level, I arrived when I was 29 years old in Orlando. And by the age of 30, I had had my uterus and both ovaries removed because of endometriosis. I had suffered with these my entire adult life. I'd had various physicians and gynecologists and I even did a study in in England, in London. We were working on it, but nothing was really helping. Endometriosis is similar to fibroids; it's not life-threatening, but miserable. And because I had no understanding of how deeply wrong the system can be, as a medical professional, I had always had power agents in privilege. So that was my lived experience, my personal experience of being at-the-hands of the system, within a year of being in this country—surgery. But I didn't really get what that meant, until it was happening. I knew and understood medical jargon. I had some sense of understanding how to negotiate well—so I thought—as a medical professional, but look what happened.

And then the other side of the coin, to answer your question, is that these 31 years, every year that I work in this country is compounded by the fact that it's not about the woman. It's not about, "Oh, well, she doesn't eat, right? Oh, well, she's too poor to afford good nutrition. Oh, she's so bad, she shouldn't be having children." All of this, as I call it, this is the

Blame the Woman mentality, that allows us to continue to research, to know, to fund, to keep the non-profit, industrial complex, the public health, industrial complex running. To say, "Well, while we try to figure out what's wrong with these Black women, maybe we can come up with an answer as to why these babies are premature, or that they are more at risk of morbidity and mortality." While we keep working from that perspective, we're doing a complete disservice. In fact, it's quite inhumane. Because, again, the problem isn't that problem. It's the way the system is set up and the way we operate as Americans. So, implicit bias, even explicit bias, whether it's personally mitigated, or whether it's group herd mentality, or whether it's systemically embedded into how you do things, is acceptable. There's no impetus for change, deep change, because you don't have to. You don't, there're no repercussions for not changing.

It could be quite detrimental, too—making money, or building power, and prestige—to change, because now what's going to happen? Who are you going to get to make your widgets? You know, we fill hospitals, we build hospitals in low-income areas. So we have a plethora of unwell and underserved folk who are suffering in the hands of these structural social determinants of health, to practice on, and to make money off of, and to move through, in large groups, while we study, and blame them, for their condition. And at the same time, we have schools—medicine, nursing, and research, that need to perpetuate that structure.

And then we make a distinction with, well, actually, if you have this insurance or that insurance, so you can pay, you deserve a different set of ways of being treated. So, as an example, I could point to a labor and delivery ward to connote which room has a patient with which type of insurance. It's not about the physiological process. It's pointed out, so everybody on the floor knows, "Oh, we'll do this in this room, but don't do that in that way. You can get away with more over here then you can get away with over there. If the physician says, "Blah, blah, blah," and the chart says this type of patient, then great. This is the way we train, and employ, and condition, and allow structural and systemic bias to be embedded. And then we turn around, and we say we just don't know [why outcomes are worse]. Maybe they should eat better. This is where we're wrong. This is where the criminal element slips, and because we want to do this with any other marginalized group.

Jazman Allen:
All right?

Jennie Joseph:
If we take, as an example, disability, you know, of course, disabled folk are marginalized, but there's a little bit more compassion. There's a little

bit more. We understand all the laws for that. Let's try to at least adhere to what the law says. Let's make the bathroom wide enough to accommodate the wheelchair. Let me show the sidewalk is safe. So when we want to, we can work it out. We can fix things. We can make change. We can all do better, and when we don't, this is what we get.

And this is not to be catchy. I'm not trying to say everybody's badly wrong. But something's wrong. Wrong enough to kill somebody. Wrong enough to create such stress and pressure that you literally take the helm that God gave a right to health and happiness and self-determination. It's not just about socioeconomic status. It's about race. It's about power. Nothing to do with whether or not your cervix will hold tight and keep your baby until full term.

Jazman Allen:
Yes, exactly. We continue to see the numbers increase. The numbers continue to increase in the US. Like you said earlier, how is it that we have all of these resources, all of this money? Yet, the number of maternal and fetal death rates, especially for Black women, are disproportionately higher. It is scary, especially, like I said, if people who have money and supposedly have the resources still are not getting the adequate care. It leads one to wonder about the people who do not have access to quality resources and how much more danger they must be in with this type of healthcare model.

Jennie Joseph:
Racism, cuts across all socioeconomic status. You know, sadly, we have too many stories of affluent Black women, educated Black women, powerful Black women, who still suffered and/ or died. Too many stories. It's not an absolute norm. We have hospitals that build massive NICU units so that they can then say, "We have the best NICU service in the area." Yet whose babies are in those units? Black and Brown babies. Something's going on here.

How many years should we keep marching and walking and fundraising to figure out how to stop prematurity? Well, actually, if you just treat people right, they go to full term invariably. And that's what I discovered by accident with my work. And I'm not the only one. You know, I have so many midwife colleagues and perinatal health worker colleagues who found the same thing. All people need to be treated well, with dignity and respect. And when you think about it, at the end of the day, that's absolutely free. There's no expense. And in the absence of that, you get what we've got right now.

Whether it's implicit or explicit, whether it's on purpose or by accident, it doesn't matter how you get there. But if the end result is somebody is harmed or somebody is dead, there's a problem.

Jazman Allen:
Yes. I understand people are hesitant to talk about it. It is a difficult topic and it brings up all types of emotions. But I think it's important to have these conversations, and to not only have the conversations, but to also have action.

Jennie Joseph:
Finally, the action. And, you know, these times that we're in now, we see protests and we see some understanding of, "Oh, there's really a problem. Now we need to do something about it." Well, that's a good start, and that's, you know, in one arena. But there are so many more arenas.

Think, if we fix this one, you know, we can only hope, right? Then, there're another 100 right behind them that need to be addressed as urgently. Because they're the same. They're all interlocked and interchanged.

So, police violence perpetrated against Black people has the same impact as medical violence, obstetrical violence, perpetrated against Black women, and the same impact as school discrimination against Black children. On and on and on. Why? Because this is a *structural* problem. This is a disregard of rules, laws, rights, humanity problem. I happen to be a midwife but it's not about midwifery. And that's been a hard road for me because obviously that's the credential I bring and that's the experience I have. And often when I'm talking to, sharing, or even explaining how I do my work, people are quick to jump to the medical model that will solve everything. No, it will not.

Because midwifery has as many races as everybody else. They're racist—hospital systems. You know, this is the country that we live in. And so as we begin to look at dismantling racism, as we begin to look at embedding anti-racist policies into our structures, we may see some change. And if we don't, we won't see any change and time line. So while we're in this sort of dilemma, this conundrum, which way is it going to go? How is it going to get there? How is it going to be sustained? As usual, Black and Indigenous people continue to suffer the centuries-old trauma—generational trauma. There isn't any other way out of it.

Because I've heard since the COVID-19 pandemic began, the word *dystopia*, on the hour, every hour. I'm like, "What are you talking about? This is normal?" One thing we've had is a pandemic of racism. We've had a pandemic of brutality, a pandemic of violence. Pandemics are like, this is what we do. How we live. Why are we using the term dystopia? It doesn't matter.

I'm concerned. So, for solutions, we—as Black people, people of color, Indigenous people—have to figure out how do we manage our trauma?

How do we support and empower ourselves to weather the storms, which need to be perpetual of thrive? That's where we are now.

And, yes, it does make a difference if you choose an out-of-hospital birth, or you choose a natural birth in the hospital, or you choose a birth supported by a midwife, or you choose a birth supported by a doula. It increases your odds of surviving your birth.

But that's just one piece. Because once you've had your baby, what kind of a world is this child being born into? What kind of support is there for you? And I know with APPPAH, with the work that you do in terms of appreciating the psychology and all of these other areas encompassed in this holistic view, okay. In birth and parenting, we can't just stop because the baby came out. Much of the morbidity is in the postpartum period and we certainly don't care about postpartum in the United States of America. Toss somebody out the door two days after they've had a child—get on with it. If you're very lucky, we might let you have a six-week postpartum exam.

It doesn't work. I've never seen anything like it. It doesn't happen like that in the rest of the world. Support is embedded into care. Medical care is accessible, people are in place to do this work with an understanding of why they're doing it.

Jazman Allen:
All right.

Jennie Joseph:
Okay, the obstetric episode ends when the baby is born. So in other words, once the child has exited the body, let the billing begin. There's no postpartum interest whatsoever, because the baby has been born. Now a claim can be billed and money can change hands. Everybody's happy with the end result. Doesn't matter if it's a 25-week baby or a 41-week baby. Same money, same trial, right. So postpartum means, well, you don't belong anywhere anymore. You're not pregnant. I know you could stay, but we don't bother because there's nothing we can do for you So women and families are in a dilemma in the postpartum period, which can be for some women six months to a year before they kind of recalibrate. You do that at your house. You do that while you're back in the workforce. You do that while you're trying to juggle daycare. You do that while your depression is out of control.

Who's there? No one is coming. This is not quite just about midwifery; it's deeper than that, and I think there's some beginning recognition. I'm just a little frustrated because I've been here, like I said, 31 years, and I'm wondering, how long does it take? And then we have to do generational healing. Well, what else are we going to do?

Jazman Allen:
Exactly. It is a trauma system—racial trauma—so it just keeps getting handed down, and you're right, there is a lot of systemic work in this country that needs to be done. Otherwise, there are not going to be any changes. As we've seen, there is very, very, very slow progress. As you can see, midwifery is only starting to become, to my knowledge, more popular in the US. Until recently, I didn't really know what a midwife was. I had heard of midwives, but I didn't really know about the practice of midwifery. I was like, "Oh, what does a midwife do?" and I learned more about the practice. Then I thought to myself, "Why is this not an actual promoted practice in the US?"

Jennie Joseph:
It's extremely sad. And it's also dangerous, this lack of a community provider, or community-based providers, which have served women for millennia. What we faced in the United States in the early 20th century, were myths and the 20th century purposeful eradication of midwives, particularly in the South. The Black midwives they named the *granny*. We call them grand midwives, out of respect for their work. And the nurse midwives and the immigrant midwives, the immigrant community, brought their own midwives with them, because that's what happens. There're always midwives in every society, in every community. There was a purposeful push to eradicate the midwives and to replace them with obstetricians. And money was changing hands to allow the obstetricians to bill for birth. And particularly, of low income or poor communities, Black women, especially when they were led into the hospital, they were in through the basement, through the back door, because of segregation and Jim Crow laws.

Midwives were slowly eradicated. They were given licenses, but once they got their licenses, they were not allowed to practice anymore. So when midwifery wasn't empirically handed down from mother to daughter, those ways were taken, and no training and accreditation and certification was put in place. Then it was used to eradicate the midwives.

So the Black communities, Indigenous communities that had depended on the midwives for essentially centuries, the enslaved women delivered Black and White babies. They delivered everybody. Slave owners could lend out their midwife and make money, sending a midwife to other plantations to service other slave owners and their families as well as their slaves. A whole tradition of midwifery was how all of America was delivered until the physicians got in on the act because there was money to be made. And so, now we have an entire country that believes birth is a disaster ready to happen. Pregnancy is like life and death, touch and go, and if you don't find a physician, how are you going to survive it?

And there's an effort to make sure you stay scared out of your wits for the entire experience.

So during this COVID-19 pandemic, we've been using video calls, connecting with our patients in so many different ways. But guess what? All of a sudden, the women are coming down and saying, "I'm fine. Actually, I don't need to come into the office for you to poke and prod and mess around with me, because I'm doing well anyway." And what we're seeing is the resilience come back, the power come back. Because if you can't come into the office every four weeks or every two weeks or every one week, you still have a baby that's building. We're talking to them and supporting them the same way we do when they are in the office. Once it works through the video call, they feel as empowered and supported as if they were in person. And so I haven't seen anything yet [during the pandemic]. I don't anticipate any of our mothers having pre-term babies No one has since the pandemic started. We have not had any problems. Nothing has changed.

Jazman Allen:
Wonderful.

Jennie Joseph:
It's great. Because it really confirmed, not only for us, but for the moms themselves and the families that they can manage. There's actually nothing wrong with just having a baby, right? You know, it's just like in a natural disaster. You know, if you're in the middle of a hurricane, when you go into labor, what happens? You have the baby, boom, because you're in the middle of a hurricane, and there's nowhere else to go, right? It's a really interesting phenomenon to see women, especially women of color, women who've been told how they're broken, how the system will not support the baby, how they're not able to carry a baby, how they need to determine how the cervix is. They're stuck in their house-on-fire, actually doing really well, right? Yeah, it's really interesting. I think we've got an opportunity here to grow into understanding how to care for ourselves and each other better.

I also work with supporting providers of care to populations that I'm describing because the supporters need the same level of support as the people they're serving. The supporters are as traumatized as other mothers, as the fathers, as other communities. And we've been really working on what we call collective care, where we come together frequently to share and just lift each other up and to encourage each other to keep going. And just like the grand midwives of old, the birth workers do well, when we stay in community. When we reach each other. And in

this modern day, that's not harmful. No, thank goodness for the webinars, and phones and FaceTime, and you name it.

So, there's hope, but, I don't think I'm hopeful for the societal change that is necessary and imperative. I expect that will survive once again. Another generation of injustice. I'm hopeful that we will survive well enough and come up with answers that the next generation doesn't have to suffer the way this generation has had to and former generations have had to. That's what I'm hopeful for. I'm hopeful that people won't not know what a midwife is or was, and not be able to access that knowing because the system says we don't want that anymore. Those are the things I'm hopeful for.

Jazman Allen:
Me too, and I think we could see such a shift in maternity care and in racial inequality if those things happened in this country. I know you touched on it a little while ago when you described your practice, but I'm also wondering, have you seen any changes, whether positive or negative in some of the families you treat? In regard to current racial tensions, coupled with the impact of COVID-19, have you seen it impacting your expectant and new families in any way?

Jennie Joseph:
Yes. Basically, it's the non-physiological impacts. Like I said earlier, I think physiologically, they're doing fine. But we see the impact of being unemployed, or losing resources, or the impacts of having more family members and community members at risk or already infected. They don't have access to the health care level that other people have access to. The fact that hospital systems, when they have this type of excuse to behave differently, have locked down. Many of the practices that we fought for so many years to get rid of are still there. There are some small wins, certain states and areas that they have said, "Okay, we'll let the doula in. We'll let the midwife in." But there are many that don't. We know that that support is lifesaving.

We have seen more of a quick propensity towards getting women induced. Or, "Let's get a C-section going because of the timing of these things." It took us many decades to fight for this to improve mothers' chances of a better outcome. Using the pandemic as the reason why you can't have those things is kind of like somebody saying, "Hey, you can go back to the old guys if you want because we've got a pandemic." But they are again the people who have suffered the most and have less power in society.
Alternately, for Black people, even if you have power, or insurance, you still aren't going to necessarily get the equity that you would think you would automatically have, being able to pay for your care or to find the

best doctor or these kinds of things that should be protective. You mentioned Serena Williams, and, you know, that's the perfect example of when even celebrity is not protected.

And so, from a perspective of the pandemic, the other pieces are impacting our families and our moms much more so than any physiological impact whatsoever. And I'm pleased on that front because it proves that the models that we use where we are providing culturally-safe care, with humility with respect with dignity are protective.

Jazman Allen:
Yeah, the more protective factors a family has, we know the more resilient these families can be. What's more, the higher the chances of survival and a better outcome. I think that's so important, and I love that you highlighted having protective factors, because I think we talk a lot about the risks, and not enough about what are some of the protective factors. What are some of the things we can do to help mitigate some of these challenges? I am wondering how you help your families navigate some of these challenges, racial inequities, within larger systems of care. What are some of the things you do or utilize to help them navigate through these areas?

Jennie Joseph:
I love that word navigate, Jazman, because that's exactly what we're doing. And some things are disguised as midwifery. And the majority of women that I'm serving are choosing hospital birth, first and foremost. They are not interested in the home birth or the birth center option, which is their choice and I understand it. So we then go into navigation mode. So my organization is called Common Sense Childbirth, and I base all my navigation tips and techniques on common sense. And the first thing we have to do is to find out where that person is and what's going on with them at that moment. And how do we move forward from there?

So, it could be this is somebody who has a partner who is not very keen on the idea of speaking up in the hospital. So we might then work with that partner to do role play. Like, we might think about being in a prenatal checkup, and what happens if the nurse says something and you think, "What is she talking about?" We practice. What if you get upset, and you want to make sure they understand that you're upset? Is that a good idea, or are they going to call security?

Navigation. Not, "We need to really study how the cervix dilates." We don't need any of that. We need to know, "How are you going to survive this? Are you going to be the one person that goes in with her and stays?" Because now, with COVID-19, you can come out of the room only once, and maybe you're going to lose your job being that one person. Maybe it would be better to switch out an auntie, or stay on FaceTime all the way,

instead of being with your wife and your child because you don't want to lose your job? Because this new rule says, you can't go out the door, no matter what's going on, until they discharge your wife.

Navigation. When the charge nurse speaks, she has the final word. Did you know that? Never mind what your doctor says, or you say. She's in charge of telling these nurses how to behave. She might be in charge of putting a sticker on the bill that says, you've got Medicaid.

Navigation. What has this got to do with good obstetrics? Nothing.

But we take a common sense approach. First of all, where are you? What's in your mind? What are your fears? What do you know? What do you need to know? That's the work. Sometimes, the only goal we have for the family, particularly the father, is when that child exits her body, get it skin-to-skin and don't take no for an answer. That's a fight you can fight over getting skin-to-skin. So we've got these kinds of conversations going on, trying to think about what if this scenario happened, or that scenario? What do you want? What don't you want? Some people would rather go straight to C-section. All right, that's your choice. Here's how we get that done, healthily.

Common sense saves lives! That's it. That's how we roll, because what is the point of giving anything other than that? Why are we blowing smoke? Why are we pretending? Why are we sending you out there to fend for yourself? You will just be a statistic. That's where they come from.

Jazman Allen:
Yes, absolutely. Have you noticed an increase in concerns, particularly from your Black families in regard to the racial tensions and being treated, whether it's by doctors, nurses, and/or in hospital settings? Or have you noticed an increase in anxiety, or concerns about equity in care?

Jennie Joseph:
No, that isn't necessarily something we would know. It's different because we operate from the stance of, "We're here to support you with that from inception, pandemic, or no pandemic." We have so many repeat families, where we do each pregnancy with them. There're new patients coming on board all the time, but so many have had babies with us already. They come in with, "We know how you treat people. We know what you do to support us. We aren't worried about the rest of them because we got some plans here. We got some tools here. We're ready." And they send folks. They'll send people to say, you know, go over there because they'll treat you right.

And it's not because they won't get good care in a health department or with a private obstetrician. But we're doing prenatal care plus. So, I think it almost preempts the possibility of being worried because this

empowers an agency in how you get into the labor room. So I say that for many years, we had that phase where the C-section rate was 30% or more. And during that time, what we noticed was that our rate was always lower than everybody else's. We've been maintaining around 20% to 25% for the women that are in-hospital, and not talking about the home birth moms. The midwives have never gone with the hospital moms because we haven't got enough midwives and when we have doulas, we share them out as best we can, but not everybody has a doula. So, trying to do that was proof that the mitigation, the navigation, the common sense approach, the meeting you where you are approach, the making a solid plan approach, was enough, because our C-section rate is at least 10 percent lower than everybody else's. Our midwives are not on the floor when the moms are in labor. It's the hospitalist doctors, the trainee doctors.

The group practices that receive our patients also receive the health department patients and the community health center patients. Patients know patients who are having prenatal care in the community but are not being delivered by the providers. So, I think to answer your question, whatever it is that we've been doing forever works well enough, such that perhaps they aren't as concerned or worried or feeling the impact of racism or bias, because they can fend for themselves.

Jazman Allen:
Okay. That's great.

Jennie Joseph:
I think it is. I mean, that's really empowering. This model, the JJ Way Model [Jennie Joseph Way Model] has four basic tenants. The first one is access without any restriction or barrier to whatever it is you want, whether it's prenatal care, a listening ear, or having a midwife, whatever you want. You have access to that if you come in the door. The second one is connections. Once you trust us, you'll connect. You will learn. And the third one is knowledge, and that always leads to empowerment. So those four tenants over and over again.

If you provide unrestricted access, you will get a connection. Because the line is fluid, and it's personalized. It's crafted to your individual case. Your particular situation is unique, and therefore, we have to address it in a unique way. The navigation is around your system, not so much around the hospital system, not about what's a barrier and a problem, but rather, how can we have you ready to go, fully capable of having enough power, and agency that you'll come out the other end of this whole. And so, the empowerment, as an end result, is that we can step aside. The goal is not to get ourselves in the middle. Sometimes I talk about, you know, there's a certain propensity in both workers and physicians, even where

we center ourselves. Centric care. This is mother-, baby-, family-centered care. It has to be. Then, in everything they need or want, has to be around them, first and foremost. Then you can't go wrong.

Jazman Allen:
Yes! Absolutely. I think that's wonderful. I love how you stated that. I think that's necessary, and what is needed, especially now. I'm kind of wondering, how would you encourage a birth-worker who works with people of color or desires to serve underserved populations? How would you encourage them to have more culturally congruent care? Such as understanding the importance of culturally sensitive care and how to support the families that they are treating.

Jennie Joseph:
First and foremost, do some work. Ask yourself if you are really up for the work of being an ally. And ask yourself what that really means. And that doesn't mean you have to be instantly there, because it's not an easy journey. But the other simple way is to find the people of color who are already in action and support them. If we were to decolonize funding, if we were to decolonize these ways that we have created, where we're going to just keep pushing forward with what we think is the answer without having the humility or even the humanity to stop and ask the questions, we'll keep getting what we get.

It's not to suggest that other races and ethnicities cannot serve people of color and particularly Black people. This suggests that they cannot have an understanding of that lived experience, no matter how hard they try. So if they're not open to them, then we're not going to get anywhere. And then if they're not open to dismantling the various systems that they may be supporting without realizing, then we're not going to get anywhere. And so the wheels and the spinning and the ringing of hands—all of that is extra energy that we don't have if taken away from the outcome, which we all are looking for, which is better health. Better equity. Better access.

So I really urge White women, White men, White people, people who have more power to consider if they can see any of their power. Rather than, can you be the one? Can you take up the, "Let me learn and understand what anti-racism even means?" Rather than, "Can I be the one it may not serve?" It may be detrimental to be the one, when actually your help could be so much more powerful and impactful if you would step up.

Jazman Allen:
Yes, absolutely.

Jennie Joseph:

Right. There's no shortage of people of color—Indigenous, Black birth workers—who already can't get a foot in the door, can't get a piece of it, or can only get 10%. Well, what they're trying to do or have been doing can't get recognized for all kinds of reasons. Really, at the end of the day, please stop it. Stop it. It's time. And so I really appreciate so many people who do want to help, they do want to support. But if we stop and reconsider what does support truly look like, and what is the most useful and purposeful support, that doesn't take away at the same time—that's what we need to do. That's what we need you to do. That's what we want you to think about. That's what we've asked you for before, and we'll continue to ask you for, until that maybe changes.

Jazman Allen:
Yes, I agree. I appreciate having allies and people that are passionate and compassionate about that. I have heard people who do not identify as people of color say things like, "Well, I don't really know what to say. I don't really know what to do. I feel so, so bad about my privilege." It is almost as if they feel paralyzed. I encourage them to continue speaking up by saying, "We need your voice. We need you to speak up. We need you to reach the people that would not necessarily listen to us, but would be more receptive to hearing from you." You are able to make an impact by going into those places where we may not be able to go into necessarily." And I think what you said, and giving some specific examples of what they can do is really important. Having some concrete ways to support them navigating these cultural challenges.

Jennie Joseph:
I think the only difference is not if you don't do it then okay, that's fine. That's your choice. Understand then why and how it is the way it is and you're not doing something about it. If you are okay with that, okay. If you genuinely want to do something, do something that's useful, helpful, supportive, and you'll feel better, too. So, you know, it's a win-win. There's no obligation. There's no question. It's just a choice. Yeah!

Jazman Allen:
Absolutely. I learned so much from you through hearing you speak about your work today, and how it is impacting the communities you serve. I admire the work that you do and want to thank you for being so passionate and bold, and vigilant in all that you do. It is not easy work by any means, but thank you. As we are concluding here, I am wondering if you had any closing thoughts—anything you thought would be important for our readers to know. You gave some really great insights and practical steps

for allies earlier in this interview. However, if there is anything pressing you would like to say, please feel free to say that now.

Jennie Joseph:
Yeah, and not to sound disingenuous, but I just feel like making an appeal to humanity to find that humanitarianism, if you can. Just realize, if this was your family, if this was your sister, your daughter, your mom. Yeah, there isn't any argument then, when it's personal. And, you know, we all have that place where we're touched by injustice. Minutes close to home. And so, hoping that as we all dig deep and come together, maybe that's a place to start. Because, what you wouldn't tolerate for your loved ones, maybe you might begin to think about how hard it would be to tolerate for everybody, and maybe look at it that way. Because at the end of the day, you know, it's about love. It's about compassion, about humanity.

Jazman Allen:
That was beautifully stated, Jennie. Thank you so much. Thank you for sharing your wisdom with us, and taking time out of your busy schedule to talk about some of these really hard things, and how it's impacting our communities today.

Jennie Joseph:
Well, thank you for having me. It was quite an honor to be able to do this interview, and I'm grateful for the opportunity.

Jazman Allen:
You are most welcome, and we hope to have you back in the future.