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**Black Birthing Mothers:
The Historical Context and Potential Benefits of Midwifery-Based Care**

By Julie Morel
26 April 2019

A Senior Thesis
Advised by Professors Jill Schneiderman and Abigail Baird

Submitted to the Faculty of Vassar College in Partial Fulfillment of the Requirements for the
Degree of Bachelor of the Arts in Science, Technology, and Society

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Introduction

In this thesis, I will argue that the historical context of midwifery in the United States has perpetuated a majority middle-class white clientele demographic currently being served, and that it is imperative for midwifery care to be extended in order to benefit people more likely to experience traumatic birth, namely, black women.

The necessity of focusing specifically on racial disparities experienced by black birthing women stems from the alarming statistics recently revealed by a 2010 Amnesty International report – despite socioeconomic class and educational status, black women in the US are nearly four times more likely to die from pregnancy-related complications than white women.¹ While maternal mortality rates for white women between 2011 and 2014 averaged 12.4 deaths per 100,000 live births, black women experienced rates closer to 40.0.² Not only are these disparities seen in mortality rates, but in cesarean section, low birth weight, and myriad other complication rates as well. However, genetics and biology are only minimally responsible. Rather, research has suggested that accumulated biological effects of stress in response to systemic racism is predominantly at fault for these poor health outcomes.³ Racism's effects have carried forward from the time of slavery, affecting all circles in which its implications are not adequately addressed. The injustices experienced during slavery have not disappeared, they have simply shifted form. Thus, I write this thesis in an effort to attract attention to the existing thread drawn throughout the history of midwifery – from the Antebellum period to modern midwifery – and to examine how this thread can be unraveled to uplift the communities that have been wronged, thereby returning agency to black birthing women and black birthing providers.

As I was considering how to present this thesis, I came across the concept of reproductive justice and felt compelled to make it central to my argument. Growing out of activist mobilizing

and awareness-raising, the reproductive justice movement was one created specifically to empower the most marginalized after recognizing that the mainstream women's rights movement – led by and representing middle-class and wealthy white women – could not defend the needs of women of color. More than simply abortion rights, reproductive justice encompasses the full range of procreative activities and acknowledges that reproductive decisions are made within a social context, with a focus on decision-making as a matter of social justice rather than simply one of individual choice.⁴ It includes the right to parent children in safe and healthy environments, beginning with the way a child is brought into the world. As Loretta Ross, one of the black women who coined the term “reproductive justice,” says:

Reproductive justice includes our right to mother and parent in radical opposition to thinly disguised race- and class-based manipulation... however, reproductive justice does not privilege the production of babies as the only goal of women's biology; nor does it insist that only biologically defined women experience reproductive oppression... instead it insists on the human right to make personal decisions about one's life and the obligation of government and society to ensure that individuals have access to the resources necessary for implementing those decisions... it draws attention to the lack of physical, reproductive, and cultural safety that constrains “choices.”⁵

Reproductive justice and the fight for holistic care do not stop at healthy birth outcomes, but extend to advocating for empowering, welcoming, and wholesome birthing experiences in which black mothers can exert their authority, manage their own care, and be firm in their expectations. In response to this notion, this thesis aims to consider how black women can not only have more positive health outcomes following childbirth, but have more empowering, loving, and nurturing birth experiences for themselves and their families.

In following with this notion of striving to encourage a more supportive birthing environment for all women, I saw a direct connection to the midwifery model of care. Often presented in contrast to the physician-led technocratic model of care as coined by medical anthropologist Robbie Davis-Floyd, the holistic midwifery model of care is woman-centered and

considers birth inherently healthy rather than pathological.⁶ The midwife is seen as the nurturer, the home as a nurturing environment, and the mother and baby as an inseparable unit. The safety of the baby and the emotional needs of the mother are valued equally, and both experiential and emotional knowledge are valued just as highly as, or more than, technical knowledge. Time constraints are irrelevant in the holistic model of care, because labor can be short or take several days, with its own rhythm of slowing down or speeding up. Most importantly, the midwife is simply a skillful guide supporting the mother, whose responsibility it is to give birth.⁷

The technocratic model, on the other hand, purports that birth is an illness of complication for which the mother holds the blame of wrongdoing. Davis-Floyd argues that “the female body is viewed as an abnormal, unpredictable, and inherently defective machine” that must operate under certain conditions;⁸ failure to do so suggests that the machine is broken. The male-centric technocratic model convinces women they inhabit “unruly bodies”⁹ which they cannot control or manage on their own accord. Women are constantly reminded that they are at the mercy of the biomedical technology if they are considered to be “good mothers” and maintain their children’s health. Within this system, the doctor is viewed as the technician, the hospital as the factory, and the baby as the product. The safety of the fetus is often pitted against the emotional needs of the mother, and technical knowledge is the only valued knowledge. Time is essential in the technocratic model, where birth should happen within 26 hours with steady progression, while the doctor is in control and has a responsibility to deliver the baby.¹⁰

Jennie Joseph, a black midwife who has created a practice fully embedded in the midwifery model of care, shares the following:

My biggest critique is that there’s no humanity inside of that complex... midwifery provides humanity in whichever way it is delivered inside of the perinatal care system. Whether...the midwife herself is delivering the care or whether another practitioner employs the midwifery model of care. Basically, the midwifery model of care is patient

centered, is culturally competent, is humanistic, is supportive, is all of the things that will allow that the patient is working for her own best interest in an empowered way with knowledge, informed consent, informed decision-making, and respectful care.¹¹

During one of the most vulnerable and intimate moments in one's lifetime, all women should have the opportunity to experience the advantages of this care.

In order to simultaneously advocate for the necessity of reproductive justice and the midwifery model of care, I craft my chapters in the following way to explore my central argument.

First, I begin chapter one with a history of maternity care in America to identify the nation's first midwives as black enslaved women. As the primary birthing providers for enslaved people, these women shouldered the responsibility of caring for the poorest and least healthy in the south. As childbirth gradually became medicalized in the 19th century, however, black midwives were eventually pushed out of their professions with laws that targeted and blamed them for poor birth outcomes. Highlighting America's racism, this chapter lays the groundwork for midwifery history's implications on the profession's current clientele demographics.

I continue chapter two by analyzing how the second-wave feminist movement shaped by middle-class, educated white women caused a revival of midwifery that rewrote the historical importance of black midwives into a frame of whiteness. Rather than being driven out of their professions as black midwives were, white midwives of the 1970s experienced tangible progress. As attention and recognition were received on a national level by midwifery's revival, the legacy of black midwives became erased. This chapter aims to critique how the reconstructed portrayal of midwifery's narrative and context emphasizes the importance our society places on the work practiced by these two different groups of women, despite their similar goals of maternity care.

Next, chapter three explores how, in addition to the rewriting of this past, modern midwifery has upheld barriers to racial diversity. Midwives today attend white births to a much

greater extent than they do black births, particularly when in an out-of-hospital context. The gap between these statistics is only widening. This chapter asserts that access to midwifery is not simply a matter of choice – it is a matter of social circumstance prescribed by prohibitive economic barriers, lack of midwife visibility, social norms, and a lack of midwives of color translated from the regulation of black midwives during the Antebellum period.

Chapter four then considers the consequences of medicalized birth and the immense healthcare disparities faced by black women during pregnancy, labor, and the postpartum period. In exploring several of their causes, the experiences of stress and racism are highlighted as most notable. By placing in conversation the issues of hospitalization and the trauma specifically encountered by black women, this chapter posits that, in spite of the numerous obstacles to access outlined in chapter three, the benefits of this care are enormous. Though likely true regardless of race, I use this chapter to focus particularly on the benefits black women can reap from midwifery care in an out-of-hospital setting, in comparison to the harm perpetuated by technologized medicalization.

Finally, chapter five offers solutions for how the utilization of midwifery can return political power to black women and best support their needs, highlighting the possibility of transforming clientele demographics. In an attempt to foreground black women's activism, this chapter examines recommended paths to success and shares accomplishments by women of color groups that have promoted equity in midwifery.

Final Notes: On Terminology, Personal Decision, and Positionality

Although this thesis uses the terminology of “women” to describe people who give birth, I acknowledge that people identifying as women are not the only people that may be pregnant, laboring, or birthing. The choice of the word “woman” reflects the literature centering this term

and by no means reduces the analysis to cis-gendered women. Additionally, as this thesis continuously addresses race, I would like to acknowledge that “black” is loosely defined, and largely self-characterized by the individuals who identify as such. By referring to black women and communities as a collective, I do not wish to imply the existence of a universal black identity, but rather emphasize that identity is dynamic and multifaceted despite common roots.

Furthermore, while I discuss midwifery as a positive option for people bearing children, this thesis does not advocate for a best way to give birth. It simply emphasizes one of many options and reiterates that where and how a person wishes to give birth is ultimately their own decision.

Lastly, this thesis is born out of a deep passion for midwifery, but only that which is equitable. As I have journeyed through this topic, met with midwives, attended conferences, and uncovered my post-grad plans in midwifery, my efforts have been led with intention, mindfulness, and introspection. I have aimed to carefully balance the acknowledgement of black women’s pain and oppression without sensationalizing these atrocities, choosing primarily to center black voices and initiatives by women of color. However, my positionality as a white woman implies that there will be portions of this argument left unsaid, unanalyzed, and uncritiqued. I apologize in advance for failing to recognize these missing links, and I welcome the continuation of conversation moving forward.

*Chapter One: A History of Obstetrical Services in Early America***Women in Medicine: The Status of Medical Knowledge in Early America**

Without the establishment of formal medical schools or healthcare systems in Early America, communities in the Colonial Period relied on local healers to serve the health and wellness needs of their families. Men wanting to earn their doctor of medicine (MD) needed either to travel to Europe to complete university training or to apprentice with a local physician in the colonies, after which they could present themselves as doctors.¹² However, graduation from medical school was not mandatory in the colonies to act as a practicing physician. As a result, holding the title of “physician” in Early America meant relatively little; although “physicians” were required to meet a qualification standard, most men were not thoroughly trained in their trade. Furthermore, without the presence of technological advancement in Early American medicine,¹³ male physicians and female practitioners had similar access to basic equipment and techniques that could be used for their patients. Eighteenth-century America had not yet seen the invention of the stethoscope, the second-hand watch, or the clinical thermometer,¹⁴ for example, preventing men from having strong advantages over women in treating patients. Consequently, women served as the primary carriers of healing knowledge in seventeenth- and eighteenth-century America and were respected as such.

Women healers relied on healing techniques that encompassed expulsion, baths, plasters, and blisters, for example, and even utilized local plants to create herbal remedies that soothed common ailments. Although physicians did wield power in utilizing more complex techniques such as bone setting and bloodletting,¹⁵ women practitioners wielded power in practicing within a sphere of social medicine. Midwives in particular engaged multiple roles within the social fabric of their communities; they depended on the personal relationships built with the women

around them and identified closely with the public. As a woman's ties with her community grew, her practice grew. Due to this system of experiential learning and with help from other women, medicine in Early America was rooted largely in relationship-building and caring for one another, enabling women to care for a wider network of people than their male counterparts who could not as readily access these social relations.¹⁶

The Founders of American Midwifery: Black Midwives in Early America

The knowledge of midwifery has existed for centuries and can be traced back to ancient Egypt and Greco-Roman antiquity;¹⁷ as long as women have been giving birth, people have been present to help. While this holds true for America as well, the nation's historical context of slavery has significantly shaped the origins of American midwifery. Although enslaved black women were the nation's first midwives, little is known about their work and the contributions they made within their communities. The value of their positions during and after the Antebellum period (the late 18th century until the start of the American Civil War in 1861) has been historically overlooked; their narratives are limited. What few narratives remain have taken the form of memoirs co-authored by historians and anthropologists, largely scattered and fragmentary given the oral basis of information-sharing and the immense exclusion of black voices from historical archives.¹⁸ The involvement of coauthors suggests that we should pay careful attention to recognize that words may be manipulated or omitted to serve an agenda or portray these midwives in a certain way. Linda Janet Holmes, coauthor of midwife Margaret Smith's *Listen to Me Good* explains an awareness of this phenomenon in her own writing:

In editing the transcripts, I was tempted to present Mrs. Smith in a way that would make her acceptable to present-day health care professionals. In a society where those who wield medical power tend to be members of the economic and social elite, I kept asking myself, what is the cost of failing to present Mrs. Smith in the image of today's health care professionals? Should I include traditions, or would they be misunderstood and labeled ignorant and backward? Some professional midwives have difficulty reconciling

the image of the old-time southern black midwife with the formally trained professional nurse-midwife. In the end I realized that my task was simply to present her as she is.¹⁹

Although the history of midwifery in America has been kept largely on the periphery of public awareness by people hoping to protect their narratives from scrutiny,²⁰ it is essential that the legacy of these midwives lives on, ensuring that the racist predispositions perpetuating the elimination of black midwives are not rewritten, lost, or forgotten. In recognizing the hardships endured and contributions made by these black women, I hope to strike a balance of representing justly their oppressive degradation while uplifting their rightful agency.

Much of the literature that speaks about black midwives in the Antebellum South references them as “granny midwives,” a term thrust upon these women.²¹ Although enslaved black midwives gradually came to embrace it, I choose to support the decision of several black women writers who suggest using the term “grand midwife” instead. The term “granny” instills images of passivity and servitude, quite similar to the “mammy” image of enslaved women.²² Furthermore, the derogatory term is reminiscent of white southerners’ avoidance of addressing these midwives with “Mrs.,” and incorrectly suggests them all to be old and inflexible to change.²³ To avoid these racialized stereotypes, I will use “grand midwife” for the remainder of this thesis to refer to enslaved black midwives during and immediately after the Antebellum period.

For both black and white people in the South prior to the Civil War (1861-1865), attending to childbirth was primarily in the hands of traditional African midwives who had been brought to America as slaves as early as 1619, or their enslaved descendants.²⁴ As prominent figures throughout the southern part of the United States, grand midwives served dual roles as caretakers both for their own enslaved communities and for their plantation owners and neighboring white people. As the primary birthing providers for enslaved people, grand

midwives shouldered the responsibility of caring for the poorest and least healthy in the south.²⁵ As providers of these services for their masters, they garnered a sense of respect and mobility unknown by other enslaved people. Often called “Aunt” as a sign of respect and affection,²⁶ grand midwives held positions of high status within the social structure that honored matrilineality.²⁷

Relying on their traditional knowledge, grand midwives guided women through labor and delivery, often dealing with difficult conditions such as infections, placental retention, breech presentation, premature labor, blood poisoning, convulsions, hernias, vesico-vaginal fistulae, uterine prolapse, puerperal fever, and uterine rigidity,²⁸ for example. They also counseled women on fertility cycles, the onset of labor, comfortable and efficient birthing positions, herbal medicines, and placental disposal, as well as facilitated the mother’s transition back into community life following delivery.²⁹ Although they considered childbirth to be dangerous, they also knew it to be natural and therefore refrained from intervention, rather encouraging women through their own active labor with moral and physical support until it was time for “catching babies.”³⁰ Many grand midwives discussed the origins of their knowledge as *mother wit* – “a blend of God-given wisdom, common sense, and instruction of older women...built on religious and ancestral authority.”³¹ This innate sense of bodily understanding provided grand midwives with a uniqueness not found in mainstream medicine.

Given this knowledge, grand midwives were able to use their position to transgress boundaries of entities to which they both did and did not belong to. As historian Sharla Fett describes in her book *Consciousness and Calling*, definitions of birth, spaces of belonging, and obstetrical knowledge were constantly challenged within chattel slavery.³² Grand midwife Mildred Graves suggests that her position “could bring status, independent income, [mobility]

and even some personal latitude within the constraints of slavery.”³³ When attending to white mothers, midwives often moved into the family’s house several days or weeks prior to the birth and stayed for a minimum of nine days afterwards as well.³⁴ This allowed them to blur boundaries between their own time and their master’s time by taking a break from typical plantation duties. Due to their inexpensive services, grand midwives were also hired by white families other than their owners, allowing them geographic mobility unknown to other enslaved people. Several women remarked that this granted midwives a sense of freedom even within enslavement. One woman said, “In slavery times, my grandma was almost as free as she was in freedom because of her work [as a midwife].”³⁵ Nonetheless, although midwifery in the Antebellum South was considered a unique and respectable skill, grand midwives were trapped between two modes of labor – the gifted healer and the plantation health worker servant.³⁶ While they were able to gain a sense of confidence and self-worth in maintaining the health of their black community, they were subject to operating within a system based on their oppression.

Grand midwives were similarly key figures in providing hidden spaces of resistance for their communities. Their range of mobility allowed them to utilize their position as a mode of communication between family and friends torn apart by slavery,³⁷ and their understanding of plantation owners’ motives enabled them to operate as “translators” for the different meanings of birth.³⁸ For instance, midwives leveraged their power as experts on childbirth to warn owners that work in the fields was unsafe for late-term pregnant and recovering mothers. They served as a protection against white doctors as well, for “black people were treated so dirty and they was afraid of doctors giving em a dos of something just because they was black,” says grand midwife Onnie Lee Logan.³⁹ Furthermore, grand midwives passed down aspects of their African culture and traditions and acted as what feminist theorist Patricia Hill Collins called other-mothers,⁴⁰

“biologically- and socially-related women that provided care, nurturance, and empowerment to children, other women, and their families.”⁴¹ Their status as transgressors of boundaries provided black people with a collective identity and agency not easily accessed by other enslaved people.

Midwives were respected by white plantation owners as well, though in a light very different than that of black communities. As additions to their source of income and assets, grand midwives were deemed valuable to the growth of the plantation.⁴² Slavery’s continuation relied on the reproducing capabilities of black women – they “carried the race and literally extended the existence of slavery in their wombs.”⁴³ Ironically enough, however, white owners still subjected enslaved women to excessive labor and unhealthy pregnancies regardless of their supposed interest in black women’s fecundity.

Non-Black Midwives in Early America

Interestingly, black midwives were not the sole midwives of Early America. White midwives also acted during colonial times, although their social contexts differed drastically from that of enslaved black midwives. The first white midwife to arrive in the colonies, Bridget Lee Fuller attended to three births on the journey of the *Mayflower* to Plymouth, Massachusetts.⁴⁴ During the Industrial Revolution in the late 1800s and early 1900s, an influx of European immigrants contributed to urban settlement in cities such as New York City, Boston, Philadelphia, Newark, Chicago, and Saint Louis, for example, where pregnant mothers sought out care from women in their own ethnic groups, with most midwives hailing from Austria-Hungary, Italy, Germany, and Russia.⁴⁵

Perhaps the best-known midwife in Early America is Martha Ballard. Historiographer Laurel Thatcher Ulrich’s *A Midwife’s Tale: The Life of Martha Ballard* is the account most commonly referenced when American midwifery’s history is considered. Ballard’s diary clarifies

that white midwives in Early America held many roles. They “mediated the mysteries of birth, procreation, illness, and death; they touched the untouchable, handled excrement and vomit as well as milk, swaddled the dead as well as the newborn,”⁴⁶ and were held in high esteem. They served in a sphere of social medicine, caring for their neighbors and communities.⁴⁷ As such, the tasks and responsibilities of white midwives and grand midwives overlapped: they both were community-bringers and served as a common thread between people in tending to birth and death alike. Authority was derived from these midwives’ communities, providing each group with a sense of belonging.⁴⁸

However, it is possible that drawing such comparisons obscures midwives’ contrasting struggles. Scholars like Gertrude Fraser have critiqued this tendency to compare the history of grand midwives to the struggles of white midwives.⁴⁹ Fraser maintains that although they both experienced a lack of access to medical schools, healthcare systems, and organizations of recognition, each group faced obstacles that stemmed from drastically different roots. Martha Ballard, for example, was respected enough to be a valued legal witness during a rape case,⁵⁰ while grand midwives were respected by white folks largely for the extent of producing new workers within slavery. Although white midwives also faced struggles due to the medicalization of childbirth, I will spend the remainder of this chapter examining the forces that led to the targeting of black midwives specifically.

The Medicalization of Childbirth and the Gradual Disappearance of Midwifery

As medical and technological knowledge began to expand, the medicalization of childbirth gradually found its roots. Starting in 1628, blood circulation began to be understood, followed by the invention of the microscope and the thermometer in 1677 and 1709, respectively. In the 17th century, better comprehension of glands, respiration, and the nervous

system was gained, and information specific to childbearing, the uterus, ovaries, and fallopian tubes was discovered. The 17th century also saw the understanding of pelvic anatomy and the mechanics of labor.⁵¹ In the 1820s and 1840s the introduction of the stethoscope to monitor fetal heartbeat and the development of ether anesthesia further contributed to advances in medicine.⁵² By the 1840s germ theory became officially recognized as well, when Dr. Oliver Wendell Holmes and Dr. Ignaz Semmelweis began to institute handwashing practices. As physicians learned about the links between disease, infection, and microscopic microorganisms, they changed their techniques.⁵³ By the 1860s, “sanitary science” promoted an obsession with cleanliness; midwives became considered unsafe and unclean, while hospitals became beacons of sanitation and safety.⁵⁴

The transition from midwifery to physician-led medical care happened gradually, but in distinct steps. At first, obstetricians (in comparison to other medical professionals) held positions of low status and respect, reflected in their low wages and relegation to poorer hospital working conditions.⁵⁵ Considered to be the least-experienced type of physician, obstetricians were thought of as people wanting to gain “simple” skills before transitioning into a more lucrative specialty.⁵⁶ Oftentimes, obstetricians needed to convince their patients that their skills were superior, or at the very least equal, to those of midwives.⁵⁷ One woman said, “If deprived of midwives...women would rather have amateur assistance from the janitor’s wife or the woman across the hall than submit to this outlandish custom of having a male doctor.”⁵⁸ Birthing women preferred mostly anyone to a male physician.

This changed quickly, however, as early Americans were building on a culture introduced by their European counterparts a century earlier.⁵⁹ White American men had the opportunity to be educated abroad, where established medical schools taught them about the practices of

medicalized childbirth; because women were unable to leave the household and enjoy the same mobility as men, they lacked the knowledge proliferating in Europe during the 1700s and 1800s.⁶⁰ As men returned from Europe, the specialty of obstetrics became more respected as it claimed to offer more well-versed knowledge. Male physicians essentially incorporated midwifery into their practices of medical science, which were supposedly safer than leaving childbirth to nature. As one physician claimed, “the trained obstetrician knows that no case is normal until it is over.”⁶¹ Interestingly enough, doctors began supplanting women by imitating them; historian Judith Walzer Leavitt contends that physicians attending homebirths “conformed themselves to a female-centered environment,”⁶² perhaps in order to fit in and gain the trust of these women. However, doctors subsequently began literally and figuratively pushing women out as spaces became crowded;⁶³ what used to be a woman-centered communal, social experience, became one mediated by the male physician. Physicians began competing for patients, even refusing to aid midwives who sometimes called for assistance.⁶⁴ Although both parties theoretically had the same objectives of providing safe childbirth, physicians resisted teaching midwives how to carry out life-saving operations. As wealthier women began hiring physicians as a protective safety measure, midwives began to lose their power in middle- and upper-class families by the 1800s. At the same time, poorer women, too, began to seek physicians’ care. Although they could not afford personal physicians at home as could middle- and upper-class women, their presence in hospitals provided training medical students with copious experience.⁶⁵

Not only did men take over this previously woman-led field of care during childbirth, they also discredited women’s abilities to conduct this work. A physician’s manifesto dated 1820 and entitled *Remarks on the Employment of Females as Practitioners in Midwifery* suggested

that women are uneducable, have no “active power of mind,” have “less power of restraining and governing the natural tendency to sympathy, and are more disposed to yield to the expressions of acute sensibility.”⁶⁶ The author even argued that midwives’ knowledge was rooted in “quackery and empiricism” and suggested that male physicians were more likely to provide a continuity of care in examining the woman as a whole. Men argued that women have a social interest in staying at home and are passive in comparison to men, lacking the physical and emotional strength required to manage the tools of childbirth.

Unfortunately, some women held similar opinions. Conservative organizations such as the Woman Patriots detested the efforts of “spinsters” to “teach the mothers of the US how to rear babies.”⁶⁷ Others such as anti-suffragist Elizabeth Lowell Putnam argued that “if they were to be sufficiently educated to care safely for mother and baby, they would cease to be midwives by becoming physicians or surgeons.”⁶⁸ Clearly, not all “feminists” were pro-midwifery.

Male physicians owed much of their power in obstetrics to the development of forceps and the use of pain medication during childbirth. Developed in Great Britain during the 17th century, forceps were a surgical instrument invented by surgeon Peter Chamberlen and brought into the American sphere soon after.⁶⁹ Not for lay use, the obstetric forceps were an invasive device that enabled the mechanical and forceful delivery of a child in times of emergency. As women became aware of these apparently life-saving instruments, midwives became encouraged to call physicians. Their use became popularized, however, even for non-emergency purposes, and the “hands of iron”⁷⁰ served as intermediaries for the direct touch that midwives had so tenderly applied. The use of these external devices eliminated the use of birthing stools used among midwives. As a result, the standard birthing position was reconfigured to best accommodate the physician: the supine bedridden position.⁷¹ Similarly, pain relief via ether in

1848 and chloroform in 1854 became attractive to women as well.⁷² Consequently, physicians could better control their patients. After the Civil War, physicians relied often on laudanum, opium, and morphine to make women “drowsy and inert during labor.”⁷³ Physicians’ ability to ease women’s pain contributed to the increasing public acceptance of medicine’s control over women’s bodies.

The professionalization of medicine soon followed these advancements, fully contributing to a change in childbirth culture. In the early 1800s, only four medical schools existed in America, all of which admitted only men.⁷⁴ By 1847, when the American Medical Association (AMA) was created, standards for medical education increased.⁷⁵ *The American Journal of Obstetrics and Gynecology* was founded in 1869, followed in 1876 by the American Gynecological Society (AGS), the world’s first organization to recognize obstetrics as a specialty.⁷⁶ Although *The American Midwife* was established as the first American journal for midwives in 1895, most articles ironically were written by physicians.⁷⁷ In the 1920s, the American Board for Obstetrics and Gynecology was founded to create formalized standards for practicing obstetricians.⁷⁸ Midwives had no access to this professionalization, for they had no training schools or national organizations through which knowledge could be transferred, curricula created, or standards defined. As society began recognizing the apparent value in this “authoritative knowledge”⁷⁹ ascribed by institutions, physicians grew in number and strength. Pregnancy became reconceptualized as a timeline with a trajectory, shifting the provider-patient relationship and transforming birth into something to be managed rather than attended.

As male physicians became the dominant obstetric providers in the early 1900s, they began fighting to maintain this dominance by belittling the status and validity of midwifery. Physicians warned the public about what they termed the “midwife problem” by advocating for

their abolishment and stating that motherhood should be “zealously guarded and cared for by trained physicians and not by ignorant midwives.”⁸⁰ Official reports blamed midwives for high maternal mortality rates although studies proved that their statistics were typically better than those of physicians.⁸¹ A report from Washington DC even stated that although the percentage of births attended by midwives decreased by more than 35% between 1903 and 1912, infant and maternal mortality in the first day, week, and month of life all increased⁸² – though midwife-attended births decreased, infant and maternal mortality rates did not. Additionally, although blamed for low quality care due to their illiteracy, lack of education, improper equipment in their bags, and cleanliness, a report from the Division of Child Hygiene of the Department of Health in New York City contrarily stated, “of the 1,344 permits held by midwives in 1910, 93.3% could read and write in their own language or in English; 1,085 had a diploma from a school of midwifery; only 21 were judged to have an unsatisfactory condition of their bags; and 18 were personally not clean.”⁸³ The claims of midwives’ inadequacy were deeply unfounded and did not align with the evidence. Obstetricians on the other hand, though perceived as highly trained, often lacked the technical skills that midwives possessed. For example, while some obstetricians accidentally disfigured mothers or babies when using forceps,⁸⁴ some illiterate midwives successfully performed cesarean sections purely due to their understanding of the human body.⁸⁵

Despite this difference in skill level, the blame on midwives was considered justified by society, and steps were taken to prevent their practicing. John J. Hanlon’s *Principles of Public Health Administration* said, “the ultimate goal in most instances, however, is the elimination of this type of service in favor of medical attendance.”⁸⁶ Between 1900 and 1930, the percentage of midwife-attended births plummeted from 50% to 15%, and by 1939 nearly half of all women gave birth in the hospital.⁸⁷ Clearly, the practice of midwifery was dwindling.

Targeting Grand Midwives

Although the growing trend of physician-managed hospital births was generally seen across the country, trends were different in timing for white and black women. In the rural South in particular, where the number of black residents surpassed that of white residents, midwifery was still largely concentrated, with grand midwives attending nearly two thirds of black births in the early 1900s.⁸⁸ During this time in Alabama, up to even 90% of black women's births were attended by grand midwives.⁸⁹ White southern physicians did not often concentrate on obstetric care,⁹⁰ thus granting grand midwives control for a little while longer. Furthermore, as standards of care were being defined by national organizations such as the American College of Surgeons, protocols for hospitals became stricter and accreditation boards called for stronger regulations.⁹¹ Although this may have improved quality of healthcare in these institutions, it also increased costs. Grand midwives' fees, on the other hand, were typically much more affordable and even took the form of bartering at times, varying according to location, nature of the birth, and the family's ability to pay.⁹² Contrarily, as much as physicians denounced midwifery, they refused to offer maternity services to women unable to afford them.⁹³

Grand midwives were also preferably called upon for a longer period of history than white midwives because they were trusted community figures protecting women against racial discrimination in the hospital system. Although hospitals were advertised as vacation spots where white women could be waited on hand and foot, this was not the reality for black women. Relegated to the basement wards or separate wings,⁹⁴ Jim Crow laws – state and local policies enforcing racial segregation – kept hospital units separated, with white nurses even instructed to avoid touching black patients.⁹⁵ Out-of-hospital births attended by grand midwives, on the other hand, promoted a welcoming environment rather than one of harsh discrimination.

Even so, while 67.4% of non-white deliveries in North Carolina were attended by midwives in 1936, this rate had dropped to 23.6% twenty years later.⁹⁶ Although the dropped rate was more than twenty times higher than that of white deliveries,⁹⁷ it was decreasing quickly, foreshadowing that the obstacles threatening grand midwives would become insurmountable. Though they faced challenges similar in nature to those faced by midwives as a whole, grand midwives experienced racism that deeply exacerbated impediments to their careers and struck specific identity-based politics. Grand midwives had no access to medically advanced knowledge via professional schools or journals because of their exclusion in both male circles as women, and in white circles as black. Because black women were seen as lower-order women – a default “other” – the male takeover of medicine reinforced their exclusion from obstetrical spheres. While medical students in the late 19th and early 20th centuries were able to graduate as obstetricians without having been present at a single birth, black women were not considered midwives until they had witnessed, assisted, and supervised multiple births.⁹⁸ The emergence of germ theory impacted black midwives to a greater extent than it impacted white midwives, as their hands were considered filthy due to their color while forceps served as tools to avoid making contact with black skin. As I will detail in the following section, grand midwives were blamed for poor outcomes in ways that highlighted America’s racism.

Sheppard-Towner Maternity and Infancy Protection Act of 1921: A Racialized Attack

While the targeting of grand midwives was largely rooted in society’s beliefs, the legal hurdles put in place solidified the attack on black midwifery and the eventual death of its legacy. By 1915, the “midwife problem,” as it was called, had become a source of alarm; nearly six women and one hundred infants died per 1,000 live births.⁹⁹ Although these statistics were found to be due to poverty and not a lack of quality in midwifery care,¹⁰⁰ public health solutions

specifically targeting midwifery began to develop. As middle-class and wealthy white women gained the power to vote, they became a more powerful political force and pushed for the establishment of infant health clinics, urging the government to assume responsibility for child welfare.¹⁰¹ As a result, the US Children's Bureau was developed in 1912, which passed the Sheppard-Towner Maternity and Infancy Protection Act in 1921. Introduced initially to implement healthcare programs for maternity and child wellness, this act actually ended up playing a large role in the extinction of black midwifery. By utilizing specific legislation that controlled regulations for midwife licensing, the act suggested that midwives were responsible for mothers' poor health. Using training courses, propaganda encouraging cleanliness, birth registration rules, and implementation of nursing supervisors, the act attacked grand midwives in particular, positioning them as intermediary "necessary evils"¹⁰² until medicalization could be fully achieved. Although the act was established to serve all racial and ethnic groups,¹⁰³ its culturally insensitive approaches left little room for respect of black culture or traditional healing, essentially destroying the position of the grand midwife.

Under the Sheppard-Towner Act – the "new law" as midwives called it – training and annual recertification of birth attendants was required.¹⁰⁴ Run by state health departments, these midwife education classes focused on cleanliness, consultation with physicians, and appropriate completion of birth records. In an effort to eradicate non evidence-based practices, the courses also advised grand midwives to abandon their cultural superstitions. Unfortunately, this led to the elimination of countless African traditions.¹⁰⁵ Although several classes were mixed in race, most classes were segregated and taught by white nurses speaking down to grand midwives with little respect,¹⁰⁶ a phenomenon that was exacerbated for elderly grand midwives who were

perceived as less compliant than younger ones.¹⁰⁷ Songs of simplicity and repetition taught to midwives during these courses indicated perceptions of them as not only illiterate, but dumb:

Give me that good old midwife meeting
 Give me that good old midwife meeting,
 It is good enough for me.
 We will wear our caps and gowns, (*repeat three times*)
 They are good enough for me.
 We'll use our soap and brushes, (*repeat three times*)
 They are good enough for me.
 We will always clean our nails, (*repeat three times*)
 It is good enough for me.
 Then we'll save our mothers and babies (*repeat three times*)
 And it's good enough for me¹⁰⁸

Furthermore, formal educational training of these midwives broke the master-apprentice relationship by preventing elderly grand midwives to choose and train their successors – this task was now largely in the hands of public health nurses and officials.¹⁰⁹ This eroded the prestige of elderly midwives as teachers and eliminated the sense of honor and authority that younger midwives gained from apprenticing with experienced grand midwives. As a result, younger midwives began losing confidence and working under the supervision of physicians, eventually transitioning to their ways and following their methods.¹¹⁰

Grand midwives' cleanliness status was often attacked during these courses as well, urging them to change their behavior beyond just handwashing and sterilization techniques.

Historian Molly Ladd-Taylor writes:

Claiming that women who were not 'spotlessly clean' were 'unworthy' to care for new babies, nurses promoted their own cultural values of order, purity, and discipline. Sheppard-Towner administrative reports chronicle numerous 'successes,' such as the transformation of a 'disorderly' group of tobacco-chewing midwives wearing fancy hats and wool dresses into an eager, well-behaved class wearing starched dresses. Clean, sterile, and dressed in white, midwives were symbolically cleansed of their race, their sexuality, and their motherhood.¹¹¹

More specific than sanitation practices, grand midwives were attacked for their appearances as black women in particular.

The Sheppard-Towner Act also required midwives to register all births, a task on which their midwifery permits depended.¹¹² Keeping track of permits in this way enabled public health officials to identify the number of practicing grand midwives while simultaneously eliminating many older grand midwives who did not have functional literacy.¹¹³ Despite the fact that literacy seemed to have little effect on the success of health outcomes,¹¹⁴ older midwives who were not capable of reading and filling out birth registration forms were forced to retire by receiving “certificates of retirement” from their state’s Department of Health. They were subsequently replaced by younger white women.¹¹⁵

Birth registration was also used as an instrument to track populations of color by requiring midwives to record the skin color of all newborn children. In an attempt to preserve white “racial purity,” Sheppard-Towner legislation mandated grand midwives to note even a “drop of non-white”¹¹⁶ on these documents. Additionally, requirements to record a name on the birth certificate immediately after birth undermined traditional African practices of waiting to settle on an appropriate name.¹¹⁷ Forcing compliance with these regulations for the sake of receiving a permit proved to be detrimental, reducing the numbers of midwives to less than half their previous numbers in some cities.¹¹⁸

The Sheppard-Towner Act also demanded periodic inspections of grand midwives’ supply bags to ensure they contained nothing more than the supplies designated by the Department of Health as official.¹¹⁹ Soap, Lysol, Vaseline, silver nitrate drops, a sterile apron, and tape for the umbilical cord were among the required materials. Supplies traditionally used by grand midwives, however, such as rose water, a comb, nail file, smelling salts, castor oil, roots, herbs, or homemade salves, were prohibited. Cultural knowledge was erased and disrespected.¹²⁰

Funded by the Sheppard-Towner Act, public health nurses and nurse-midwives worked alongside each other to help train and supervise grand midwives, eventually leading to a more pronounced schism within the midwifery community, resulting in white nurse-midwives and black grand midwives.¹²¹ Nurses were responsible for inspecting midwives' supply bags, ensuring they attended monthly meetings, and validating that they were not past the mandatory retirement age. If any of these circumstances existed, a license renewal would not be approved.¹²² Nurses and public health workers often blamed mortality rates on the traditional remedies practiced by grand midwives, regardless of whether they inflicted harm or not, simply because they thought midwives might depend on these remedies rather than call for a physician.¹²³ Several nurses even admitted that superstition was the main factor contributing to the distrust of midwives' work and that experienced midwives did indeed have "some skill." Some nurses even recognized that midwives helped develop their own philosophy of work:¹²⁴

I have developed poise by watching them, have learned to talk in public by getting experience with them, and their ready response has taught me that the listener has as much to do with the success of a speech as does speaker.

We have learned lessons of tolerance, kindness, generosity of giving and sharing, sympathy, and assignments.

I have learned the simplicity of dignity and the dignity of simplicity.

My midwives have conjured me out of my intolerance.

Unfortunately, nurses and officials refused to admit this directly to grand midwives or to other officials, thereby acting complicit within a system that tore them down.¹²⁵

Furthermore, white doctors were never scrutinized to the extent that black midwives were, despite studies showing that white women under physician care experienced infant and maternal mortality rates higher than those of poor and rural black women under midwifery care.¹²⁶ Even in official medical journals, doctors ridiculed the practices of grand midwives' methods, despite never addressing their efficacy.¹²⁷ Though maternal health issues in northern

white urban communities were often linked to poor economic conditions by bureau officers, similar issues in the south were instead attributed to grand midwives' inadequacy.¹²⁸ A study in 1918 confirmed that of black families in rural Mississippi, 40% did field work throughout pregnancy, 94% continued housework throughout pregnancy, and only 39% were still resting in bed a few days after birth.¹²⁹ Given these statistics, it would seem obvious where poor health conditions stemmed from; nonetheless, midwives' work was blamed. In effect, the Sheppard-Towner Act and US Children's Bureau served to control grand midwives through systems of subverted colonialization by utilizing racist stereotypes and attacking grand midwives as people rather than as professionals.

Despite these racist attacks suggesting inadequacy, grand midwives felt dedicated to their work, and many were excited about the opportunity to come together and learn new techniques from the training sessions.¹³⁰ Women's commitment is exemplified by the 70-year-old woman who walked five miles to class in the freezing rain, the mother of 17 children who rode on horseback to classes 30 miles away, and the 60-year-old woman who always arrived on time despite the 8.5-mile walk.¹³¹ Grand midwives were eager to attend the educational sessions and learn new techniques. Nonetheless, the legislation which revoked midwifery licensure upon the failure to properly supply a midwifery bag, attend a monthly training, or retire upon the retirement age ultimately led to, the decline of midwifery. One grand midwife heartbreakingly shared: "This type of thing someone killing your career, is just like killing some member of the family that's real close... you ask yourself questions, "well, what have I done wrong?" "¹³² Grand midwives' livelihoods were stolen from them through this legislation. Despite their skill, dedication, and value in the community, black midwives were efficiently driven out of America's context by the Sheppard-Towner Act.

Solidifying Changes

By the middle of the 20th century, birth culture in America had shifted and physicians became the primary maternity care providers. With the US Congress' establishment of the Hill-Burton Act in 1946, hospitals in rural areas began receiving federal funds, causing percentages of hospital births to increase rapidly from 27% in 1935 to 88% in 1950 and finally to 96% in 1960.¹³³ By the end of WWII, fertility patterns changed as families became smaller; women were urged to seek the best care they could afford for such an exceptional event.¹³⁴ Population migration from rural to urban centers prompted the disintegration of the traditional support system of large family and friend groups, and the rise of access to automobiles pushed the trend of hospital birth even further.¹³⁵ Although the hospital had previously been a place for ill and dying women, it transformed into a desirable birth location due to anesthesia, surgical instruments, advanced techniques, and cleanliness. Midwives had been abandoned, and “catching babies” became exchanged with “studying obstetrics.”¹³⁶ The grand midwives of the south became “women who lost their high cultural status, their bodies becoming the terrain where a history of desire and defiance was fought,”¹³⁷ clinging to their roots and hopeful for a revival of their trade.

Chapter Two: The Resurgence of Midwifery and its Changes

A Changing Social Movement

While the movement into hospitals and away from grand midwives' care blazed a strong path for the growth of obstetrics as it is known today, several pockets of revolt against medicalized birth appeared as the 20th century progressed. With the 1945 WWII victory, America's people gained a newfound sense of optimism and energy that created an aura of coming change.¹³⁸ People began to develop their own "countercultures" and to question traditional authority figures through the civil rights, consumer, antiwar, environmental, and most central to this thesis, healthcare movement.¹³⁹ Feminists at this time believed that paternalistic physicians denied them the ability to take control of their own medical decisions by failing to share decision-making responsibility or engage them in conversation about their needs, leaving them subject to routine medicalized practices of the time.¹⁴⁰ As women became aware of the growing cesarean section rate and routine induction of labor when a woman "failed to progress,"¹⁴¹ they began to mobilize and make their voices heard.

Alongside this activism, publications about alternatives in childbirth gained popularity as well. Although Grantly Dick-Read published *Childbirth without Fear: The Principles and Practices of Natural Childbirth* in 1932, it became widely popular in the States by the 1950s. Encouraging a search for personal pleasure through natural birth, Dick-Read was convinced that the fear associated with childbirth induces bodily tension that increases the labor pains, and that this response could be avoided with education.¹⁴² In the 1960s and 1970s, Dr. Fernand Lamaze popularized his Lamaze technique of "childbirth without pain," a method that used Pavlovian conditioning to desensitize women to uterine contractions with deep breathing and relaxation.¹⁴³ Because this required women to be awake and aware during labor, women desiring to practice

this technique were now in control rather than sedated and passive. Dr. Robert Bradley pushed a similar agenda as he advocated for fathers entering the delivery room and for women leaving the hospital as soon as possible following birth, and Ashley Montagu's 1955 article "Babies Should Be Born at Home" was one of the first regarding homebirth to gain wide attention.¹⁴⁴

The second wave of feminism seeping into America in the 1960s created a new norm that childbirth was not a disease, and that hospitalization nor obstetrician supervision was required for normal deliveries. Books such as Suzanne Arms' *Immaculate Deception*, Raven Lang's *Birth Book*, and Ina May Gaskin's *Spiritual Midwifery* paved the way for women to control their own birth experiences and encouraged women's groups to learn gynecological self-care, reviving the practice of lay midwifery.¹⁴⁵ One of the most well-known publications engaging the feminist movement with the fight for quality healthcare was *Our Bodies, Our Selves* published in 1969 by the Boston Women's Health Book Collectives. The book centered women's knowledge of their own bodies by encouraging them to learn how to provide care for themselves and their sisters rather than seeking out legitimized medical services. By 1984, the comprehensive self-help guide sold over 2.5 million copies.¹⁴⁶

Associations such as the National Association of Parents and Professionals in Childbirth, Midwives Alliance of North America (MANA), the International Childbirth Education Association, and the American Society for Psychoprophylaxis in Obstetrics were founded during this counterculture period as well, certifying childbirth educators and establishing preparation classes for parents.¹⁴⁷ Periodicals such as *Birth, Mothering*, and *The Practicing Midwife* similarly provided this activism with a sense of legitimacy.¹⁴⁸ The natural childbirth movement was reviving practices of midwifery now in a new era, producing clear patterns of change away from hospitalized, obstetrician-led births.

Rising rates of unwanted intervention and medicalization of birth had clear effects on rates of hospitalization. Between 1970 and 1977, the percentage of out-of-hospital birth more than doubled from 0.6% to 1.5%.¹⁴⁹ Data show that between 1980 and 1994, the percentage of doctors at births decreased while that of midwives increased both inside and outside the hospital, displaying a shift in childbirth provider preferred by women.¹⁵⁰ Attention and recognition were even received at a national level in a way that was unseen during the time of grand midwives of the Antebellum period. Midwifery began to be embraced rather than rejected as the downtrodden lower-class role it had transformed into post-Sheppard-Towner.¹⁵¹

The Faces of Midwifery Resurgence

The demographics of women selecting midwife-attended out-of-hospital births, however, varied from America's overall population demographics. Planned homebirths were disproportionately deliberate choices of middle- and upper-class, well-educated, older women active in the feminist movement.¹⁵² As the ideology of the "birth story" grew – narratives of experiences including reflections on emotional, sexual, and physiological sensations, often with accompanying pictures compiled in scrapbooks to hold memories – it became clear that a majority of these compilations showed only white faces. The movement's revival served a specific demographic and reinforced a racial division of labor.

Birth Story, a 2012 film, portrays this phenomenon. The documentary follows the story of Ina May Gaskin and the midwifery community she cultivated during the 1970s – a resurgence led primarily by white middle-class women. Started as an intentional living community in 1971, the Farm Community began with a caravan of over 200 hippies traveling from San Francisco to Tennessee. When one woman on the journey gave birth, Ina May became captivated by the woman's transformation through labor. Ina May then committed herself to helping women

deliver their own children through the practice of midwifery. Once the caravan settled down in Tennessee, Ina May and several other women passionate about midwifery received knowledge and assistance from a physician who encouraged an emphasis on spirituality and family involvement.¹⁵³ As members of the counterculture gathered in community, over 800 deliveries were attended to in 1978 alone. After Ina May published *Spiritual Midwifery* in 1975, word about the Farm spread like wildfire. Selling over half a million copies in 12 different languages, her book popularized the movement. Over the next decade, the Farm grew to house over 1,200 people and by 1980 over 2,000 children were born, all delivered by the community's midwives.¹⁵⁴

Though most births happened at home, facilities included a birth center with oxygen, incubators, and other equipment for women with twins or breech fetal presentation, as well as 90 people involved with healthcare, two ambulances, an outpatient clinic, a laboratory, and a pharmacy.¹⁵⁵ Following a study of 1,707 births at the Farm, a 1992 issue of *American Journal of Public Health* declared that home births at the Farm and hospital births had comparable safety indicators, and that homebirths required less operative assistance.¹⁵⁶

Although 53% of births at the Farm were from women within their own community, the remaining 47% consisted of mothers from around the nation.¹⁵⁷ However, though the *Birth Story* documentary claims that the community was welcoming and open to everyone, the extreme lack of racial diversity in the film tells a different story – one of erasure. Even when the film briefly features a Belizean woman teaching Ina May a Guatemalan technique that reduces shoulder dystocia complications, it is revealed that that the movement is later termed the “Gaskin maneuver.”¹⁵⁸ This narrative of erasure apparent in the documentary likely replicates that in real life midwifery circles.

Furthermore, the modern midwifery world has named Ina May Gaskin the “mother of authentic midwifery,” a title that questions the roots of midwifery in America and the authenticity of grand midwives. It is telling that the face of midwifery is that of a white woman serving a select group during the hippie movement, rather than that of a grand midwife black woman serving a wide variety of birthing mothers during slavery. This reconstructed portrayal of midwifery’s narrative and context displays the importance our society places on the work practiced by these two different groups of women, despite their similar goals of maternity care.

Professionalized Midwifery: Certified Professional Midwives

As the number of midwives increased, various associations and groups began creating boards to certify and regulate midwives in order to move towards professionalization. The Midwives Alliance of North America (MANA) was established in 1982 as a professional organization for all midwives,¹⁵⁹ laying the foundation for certification regulations. As professionalization continued among different developing boards, midwives were eventually split into two distinct groups with slightly different practices and standards.

In 1987, self-taught lay midwives were able to certify their skills through the North American Registry of Midwives (NARM), an international certification agency establishing standards for what they titled the Certified Professional Midwife (CPM) credential.¹⁶⁰ CPMs – practicing primarily in homes and birth centers, but never in hospitals – typically require a high school diploma and enter the profession through a variety of avenues: apprenticeship, self-study, private midwifery schools, or college-based midwifery programs, for example.¹⁶¹ CPMs have no nursing degree and generally describe their growth in practice as being in touch with “embodied knowledge,”¹⁶² the knowledge which is derived from a woman’s perception of her own body’s natural processes throughout pregnancy and labor. This knowledge is expanded through

apprenticeship periods in which students observe and aid experienced midwives by helping them manage emergencies and talking with them “about every detail.”¹⁶³ This enables CPMs to trust and create their own knowledge through experience and instinct rather than simply receive the information that trickles down to them from higher-status professional groups creating knowledge for ulterior motives.

Nonetheless, despite the lack of “formal” education, many CPMs have acquired skills for high-risk births, while others have learned to suture and perform episiotomies during their varied apprenticeships. However, although CPMs are often skilled enough to perform these procedures, they lack the infrastructural support that other midwives with hospital privileges have. Many CPMs argue that they could benefit from access to tools and drugs to reduce labor complications that might otherwise result in a cesarean section. Without these privileges, CPMs are forced to hand over their patients to obstetricians once they enter the hospital following a complication,¹⁶⁴ breaking the continuity of care.

This disadvantage has sparked conversation among CPMs regarding whether or not licensure would be beneficial to the profession. On the one hand, licensure would provide CPMs with legal recognition and protection through a solidified occupational status. Ideally, universal licensure would improve partnerships with medical professionals while diminishing the threat of prosecution for practicing illegally in certain regions by enabling CPMs to advertise their services, apply for third-party insurance payments and malpractice insurance, obtain supplies, consult with obstetricians, and transfer patients when necessary.¹⁶⁵ However, surveillance from state agencies may prevent CPMs from exercising personal freedom in their decision-making, one of the key reasons many CPMs entered the profession to begin with. For example, licensure may restrict midwives from accepting high-risk patients as defined by physicians; women with

twins, previous cesarean sections, more than four previous births, those between the ages of 15 and 18 or over the age of 35, those with premature labors, those with chronic or acute medical conditions such as diabetes, active herpes, severe mental retardation, drug addiction, or alcohol consumption more than two ounces per day, for example, may be unable to receive care from CPMs following licensure.¹⁶⁶ Regulating midwives, therefore, regulates the type of care patients can receive even though parents selecting midwife-attended out-of-hospital birth select their care with knowledge of the risks. One parent said:

Home birth parents have made a voluntary choice of a radical alternative. Even in those rare instances when infants die, the parents almost always believe that the midwife provided care superior to that obtainable from an obstetrician and, consequently, refuse to swear out a complaint. When physicians initiate complaints, the parents usually defend the midwife's actions.¹⁶⁷

Furthermore, licensure puts midwives under the control of medicine to some extent, requiring examinations and costly trainings created by physicians that encompass highly medicalized knowledge about the birth process rather than non-intervention techniques midwives base their professions on. In effect, though granted with official status, this results in presenting CPM certification as a submission to authority. Sociologist Raymond DeVries sums this up: “licensure therefore benefits the profession of midwifery while damaging individual professionals.”¹⁶⁸ The status is gained, but the individual flexibility is lost. Currently only 31 states offer licensure.¹⁶⁹

Professionalized Midwifery: Certified Nurse Midwives

The Certified Nurse-Midwife (CNM) stands in contrast to the CPM. CNMs typically have a graduate degree – either a bachelor's degree or higher from an accredited college¹⁷⁰ – as well as a registered nurse (RN) license, where requirements are in accordance with the American Midwifery Certification Board (AMCB) through a certification exam. The American College of Nurse-Midwives (ACNM) is responsible for accreditation of CNMs.¹⁷¹ In the US, the ACNM sets the standard for excellence in midwifery education across the country, producing somewhat

of a schism between CPMs and CNMs. This schism is further deepened by the fact that the ACNM clearly values formalized educational paths and fails to acknowledge midwifery schools without university affiliations or whose professors are not CNMs.

Although both groups of midwives and accreditation boards have the same end goal of providing quality maternity care, the voice of the CPM has become an alternative group within an already marginalized group of healthcare providers. Indeed, although it can be difficult for CNMs to find a physician willing to partner with them for support during obstetrical complications due to hiked costs in malpractice insurance premiums, this requirement ensures that CNMs have more professional stability.¹⁷² In 1971, even the American College of Obstetricians and Gynecologists (ACOG) approved CNM-attended births for normal pregnancies.¹⁷³ As the most professionalized midwifery option, this status may not be attainable for some who cannot afford the expenses and time required for schooling. Additionally, professionalism can never be mistaken for expertise; expertise is derived from experience and work, while professionalism is often hierarchical and therefore exclusive. This is not to say that the two cannot overlap or that the status of CNMs precludes their expertise, but expertise should always precede professionalism for it to be meaningful. If practiced with true expertise and mindfulness of midwifery's roots in non-medicalized birth, the collaborative relationship fostered with physicians can allow valuable teamwork and a continuity of care that benefits pregnant mothers.

CNMs are far more commonly utilized than CPMs. In 2014, 91.3% of midwife-attended births were attended by CNMs, with only 8.7% attended by other midwives.¹⁷⁴ Nearly 94.3% of CNMs attend births in hospitals, with only 3% at a birth center and a mere 2.7% at home,¹⁷⁵ which is in contrast to CPMs' place of work. This is largely due the profession's greater

flexibility for licensure in comparison to that of CPMs – licensure for CNMs is available in all 50 states,¹⁷⁶ symbolizing the legitimacy they receive in correspondence with their educational training requirements.

Changing Work Environments: Home Birth and the Birth Center

Although CNMs are the most common type of midwife and primarily attend hospital births, I will use this section to depart from the American standard of hospitalized birth and instead focus on exploring the benefits of out-of-hospital birthing environments. Out-of-hospital births, though minimal, have been on the rise. Between 2004 and 2012, births at home and in birth centers rose from 0.79% to 1.28%,¹⁷⁷ indicating that options are slowly shifting.

Home births themselves increased by 29% between 2004 and 2009, and although still relatively uncommon, rates rose from 0.56% of births to 0.72% of births during this period. Interestingly, although home birth generally costs less than hospital birth, a majority of home birthing families are not of low socioeconomic class. Myriad advantages for homebirth include: the parents do not have to decide when labor is dire enough to go to the hospital, the midwife can leave the parents alone for some privacy if desired, the midwife can stay with the mother the entire time to provide continuous support, there are no admission procedures or forms, the mother can choose what to wear, can move around, and can eat or drink if she desires, there is no audience other than those invited, familiar surroundings can assist in relaxation, the mother's partner can play a more active support role, intervention is significantly less likely, the mother can hold and feed her baby when she wants, and the newborn is much less likely to develop an infection, for example.¹⁷⁸ One couple shared:

Foremost, and underlying our whole enthusiasm for homebirth, was our desire to be in control of the situation. The setting was familiar and comfortable. We could arrange it to suit our needs. Instead of us being intruders into the medical personnel's world, the midwife and doctor were visitors... we were freed from having to respond to new and

unfamiliar hospital routines and [having] to adjust ourselves to conform to the behavioral expectations of others.¹⁷⁹

Furthermore, Dr. L.E. Mehl and associates conducted a study in 1980 retrospectively comparing midwife-attended home births with physician-attended hospital births. Even after controlling for maternal age, education length of gestation, number of children, fetal position, and risk, there were no significant differences in birth weight, perinatal mortality, or any other complications, and home birth babies had less fetal distress, meconium staining, birth injuries, postpartum hemorrhage, and infant resuscitation.¹⁸⁰ A second home birth study found that approximately 90% of women planning to deliver at home did so. Only 4% of the sample required induction or an epidural, 94% were spontaneous vaginal births, and 5% were cesarean births.¹⁸¹

Although rates of home birth are growing, delivering at home is not a new concept – it is a return to practices of the past. However, the creation of birth centers is a new phenomenon that provides women and families with a new delivery space. After the nation's first birth center opened in 1975, the Commission for the Accreditation of Birth Centers (CABC) was established ten years later to ensure national standards,¹⁸² further showing the legitimacy of the alternative birth movement. A birth center became defined as “Any health facility, place, or institution which is not a hospital or in a hospital and where births are planned to occur away from the mother's usual residence following normal, uncomplicated pregnancy.”¹⁸³ Generally, birth centers resemble comfortable living spaces with a large bed, kitchenette, and living room area with plenty of space to move around and invite family. Because birth centers are only for use in uncomplicated labor, the CABC-accredited facilities do not carry equipment that engages in intervention; for example, medication to speed up labor, vacuum-assisted delivery, continuous electronic monitoring, or epidural analgesics are not present.¹⁸⁴

Notably, birth center birth outcomes have been found to be similar, if not better, to those of hospitals. As a 1989 *New England Journal of Medicine* study found after following over 10,000 low-risk women choosing birth centers as their location of delivery, over 94% of women delivered vaginally, compared to the national average of 73%.¹⁸⁵ This suggests that the birth center cesarean section rate is four times lower than typical low-risk women in the hospital. As of 2015, 313 birth centers exist nationwide, with an approximately 57% increase in their presence since 2010.¹⁸⁶ The beneficial health outcomes as well as the emotional security women receive from birthing in controlled and comfortable spaces serve as reminders that women can be empowered when allowed to thrive in the right situation.

A Shift in Birth Work

Although this philosophy of nurturing birth has been a common thread throughout midwifery's history, the profession's trajectory has evolved dramatically. With the development of licensure boards and accreditation committees, midwifery has transformed from being an independent practice to a position of professionalized status. Although it is understandable that some form of professionalization is necessary to provide quality care protecting both the birthing person and the provider, formalities tend to construct schisms implying a shift in demographics.

There has been a complete transformation from a position originating in black roots in Early America to one dominated by white women in the 1960s. Although this may have been an unintended consequence, the nature of the second-wave feminism movement shaped by middle-class, educated white women failed to adequately consider black women and families in their progressive agendas. They overlooked the fact that marginalized groups require a different approach to revolution than privileged groups who already wield the power to carve a direct route to change. Rather than directly working with black communities and addressing their

desires and needs within maternity care, natural childbirth activists pushed a generalized agenda that suited their white-centric preferences. While grand midwives had to battle the regulations of the Sheppard-Towner Acts driving them out of their practices, white midwives of the 1960s and 1970s had several publications to back their fight with legitimacy, boards and organizations to support their endeavors, and funding to meet their financial needs. Rather than being driven out of their professions as grand midwives were, white midwives experienced tangible progress, as seen in statistics of rising home birth and birth center rates.

Although both groups of midwives strove for the same goal of providing safe and empowering birth experiences, it is unfair to overwrite history and neglect the efforts of grand midwives by turning to white midwives as the sole role models of inspiration for positive maternity care. Ina May Gaskin, the so-called “mother of authentic midwifery,” does not accurately represent the devotion of grand midwives delivering black and white babies on their plantations, nor the sacrifices they made to continue working despite legislation targeting them on the basis of race. Though Gaskin and other activists deserve applause for their own accomplishments within their own era, there is danger in conflating their roles with the roles of grand midwives. The ease in doing so has shifted the public’s view of midwifery from one led by black women attacked systematically by legislation and considered dirty and subservient to physicians to one led by white women supported by mainstream organizations and considered empoweringly alternative. In an effort to analyze how the history of the America’s midwifery has impacted the racial composition of its clientele demographics today, I will spend the remainder of this thesis exploring how modern midwifery has upheld barriers to racial diversity and how it can be adjusted to serve a wider clientele demographic and reconcile with its history to best serve pregnant black women.

*Chapter Three: The Contemporary Challenges of Access to Midwifery Care****Demographics of Midwifery Clientele**

As introduced at the onset of this thesis, midwifery clientele demographics reflect a lack of diversity, most notably in terms of race. Mothers seeking out and ultimately utilizing midwifery services are predominantly white women, to a greater extent than the national distribution of racial demographics. Statistical data from 2015 revealed that although midwives attended approximately 9.3% of all births in the US, they attended 10.3% of white births and 7.5% of black births.¹⁸⁷ Furthermore, while approximately 1.8% of white births were out-of-hospital and attended by a midwife, the same was true for only 0.2% of black births, meaning that white women were nine times more likely to have a midwife-attended hospital birth. More specifically, midwife-attended births in birth centers consisted of 0.7% of all white births though only 0.1% of black births, a statistic seven times smaller, while midwife-attended births at home consisted of 1.1% of all white births, compared to only 0.1% of all black births, a statistic eleven times smaller.¹⁸⁸ Clearly, there is a discrepancy in the proportions of black women benefiting from midwifery care and out-of-hospital birthing options.

This trend has continued, and the difference between these statistics for black and white births is widening. Between 2010 and 2015 alone, the percentage of white births attended by midwives increased by 1.6%.^{189,190} However, in examining the same data for black births, percentage increases rose a mere 0.3%.^{191, 192} When examining the data solely for out-of-hospital midwife-attended white births, a 0.5% increase can be noted, although the statistics for black births did not change at all from their base of 0.2%.^{193, 194} Even the increase in percentage for

* NOTE: In an effort to center the voices of black women, I have included many quotes and clips of black women's statements rather than paraphrasing them, to provide transparency and capture the true essence of their valid thoughts, rather than explain them myself as a white woman. These experiences deserve direct quotation.

white births is larger than the baseline level for black births, indicating that there are severe disparities between races regarding the use of midwifery services, likely stemming from a lack of accessibility. In the remainder of this chapter, I will address how insurance coverage, awareness of services, visibility, preconceived expectations, social norms, media representation, and midwife demographics impact accessibility and prevent black families from seeking out midwifery care.

Prohibitive Economic Barriers

Although it is often touted that out-of-hospital midwifery care is significantly less expensive than that from an obstetrician in a hospital, this may not be the case for all families. Of course, for several families, midwifery care may be the least expensive option. Oftentimes hospital bills soar to unforeseen levels as interventions accumulate. Families are left with totals ranging from \$2,500 for a low-intervention vaginal birth to a \$30,000 caesarian section – which does not include costs of pain medications or hospital room and board fees.¹⁹⁵ Even with private insurance, not all services in the hospital are covered. Americans pay more to give birth than residents of any other country, with states' average prices reaching up to \$14,528, even with private insurance.¹⁹⁶ Out-of-hospital births with a midwife, on the other hand, cost on average approximately \$4,000 total. This includes prenatal care, birth, and postpartum services.¹⁹⁷ For families with private insurance, the midwife's bill is substantially more affordable, even if it is out-of-pocket.

However, for families with Medicaid – government subsidized insurance for low-income families – giving birth in a hospital may actually be more economically efficient; all costs are covered. Although variations in insurance regulations for birthing centers, water births, and home births attended by midwives and doctors exist from state to state, Medicaid and other state

health insurance programs typically do not cover out-of-hospital birth. Only 21 states reimburse CNMs and only 7 states reimburse CPMs, whereas 10 do not reimburse birthing centers or home births at all.¹⁹⁸ Although at first glance it may seem promising to have 21 states allowing CNMs to be reimbursed through Medicaid for out-of-hospital birth, their position within the hospital (in contrast to that of CPMs) often prevents them from serving those who give birth outside of the institutional network.¹⁹⁹ Furthermore, reimbursement does not always imply full coverage. For example, although reimbursement is technically permitted in California, midwives can only be reimbursed for home births if they are supervised by a physician. And of course, midwives can only be reimbursed if they are practicing with a license. This inaccessibility to Medicaid coverage bars countless black women from utilizing midwifery services, as 65.9% of Medicaid payments benefit black women in comparison to 30.5% benefiting white women.²⁰⁰ Private insurance, on the other hand, serves mostly white women (63.1%); black women make up a mere 27.7% of privately insured clients giving birth.²⁰¹

Though those on Medicaid are clearly affected, families with private insurance plans may also find it difficult to finance the expenses of out-of-hospital midwife-attended birth due to high out-of-pocket payments. Approximately half of out-of-hospital births are paid out-of-pocket,²⁰² pointing to the generally higher socioeconomic status of those hoping for a birth center or home birth. The estimated \$4,000 can be a hurdle, and though some coverage options exist for midwifery care, they vary situationally. Most insurance companies consider home delivery to be medically inappropriate and refuse to cover any costs, though a few are more generous albeit with restrictions. For example, Anthem covers midwifery services based on location and health plan, Aetna contracts with midwives who attend births in hospitals and birthing centers, and UnitedHealthcare covers hospital and home births attended by licensed midwives.²⁰³ Only 16.4%

of out-of-hospital births are covered by private insurance, with only four states in the US requiring all insurers to cover home birth – New Mexico, New Hampshire, New York, and Vermont.²⁰⁴ Clearly, consumers must read the fine print to ensure they can afford the final bill.

Interestingly enough, however, home birth would actually save insurance companies money. One CNM birth center owner stated the following:

If you imagine we have 40 Medicaid births a year, the average hospital bill for a normal vaginal birth and two-day stay is \$10,000. If we keep 40 patients out of the hospital, we have just saved the healthcare system \$400,000 of hospital costs. They want to give me \$2,020 for what I do, that is not right. The system is not set up for home birth.²⁰⁵

Despite insurers saving money if home birth were to be covered, the financial politics indicate that any delivery occurring out of the hospital is not supported.

Visibility of Midwives

Without a wealth of professional ties via national organizations – especially in comparison to obstetricians – midwives are rendered generally invisible to the public. The lack of standardized professional networks prevents community awareness-raising or publicity of midwifery services, inhibiting their visibility. This places restrictions on who in the community considers midwifery care to be available, as awareness about midwives is often spread via word of mouth. A social circle only extends so far and often remains within a particular geographical location; if that region is not racially or ethnically diverse, people are oblivious to the benefits of midwifery care.

A well-known mapping study conducted primarily by CNM Saraswathi Vedam confirmed this notion that inadequate midwife incorporation into diverse communities leads to poorer birth outcomes.²⁰⁶ In particular, the study concluded that access to and density of midwives was significantly lower in states that had higher proportions of black births. Regions in which midwives were not well integrated tended to be more homogeneously black and had lower

Midwifery Integration Scoring System (MISS) scores, which were significantly associated with poorer birth outcomes.

As the statistics presented at the beginning of this chapter display, midwives predominantly work with white families in proportions higher than the racial demographics of the United States. Paired with the data from the mapping study, this information clarifies that predominantly white midwifery practices solely serve their own insular communities, failing to expand outward. As a result, the network of clients is limited.

Increasing visibility in communities which have no demand for midwifery can be difficult, however. Without demand, midwives have no incentive to open a birth center or home birth practice; a lack of clients will simply drive midwives out of their profession. The dearth of black pregnant mothers requesting midwifery services likely stems partially from the lack of awareness that communities of color have about homebirth options or benefits. JayVon Muhammad, a black CPM from Sacramento shares:

My clients don't know a thing about homebirth, nor do they understand why they would even consider such a thing. They are not educated about the benefits of birthing out of the hospital or birthing without interventions. Many of them think the elective cesarean sections are okay, and can't wait to schedule theirs, as they have friends that have.²⁰⁷

Without knowledge that midwifery can be beneficial, people cannot be expected to know their options. Though this lack of understanding about midwife-attended birth and maternity care is representative of Americans as a whole, it is likely exacerbated for black communities.

Social Norms

Knowledge about midwifery services is similarly informed by social norms and expectations constructed for black women within their own communities. While women in low-income black communities started giving birth almost exclusively in hospitals three generations

ago when they were granted the rights and access, homebirth became something that poor people did if they had no other option.²⁰⁸ One black CNM said the following:

When there is a history of not being treated fairly, of facing discrimination, especially on a personal level, women of color and low-income women are suspicious of not getting what everyone else has and not receiving the same value of care. The implication is ‘you are not giving me the same care as someone else in a hospital.’ Why women of color don’t seek out home births, they see that as less ‘good’ care. It is a barrier of sorts. It’s a mindset. It’s societal stigma. Some women don’t know how empowering home birth can be. How it’s not less, but more. They are conditioned to believe otherwise.²⁰⁹

Now given the opportunity to receive the seemingly best possible care after being previously denied it, it can be understood why black women continue to birth in hospitals. This is what CPM Kathi Mulder calls the “White Bread Theory”: low-income people eating the more affordable whole grain bread aspire to eat the fluffy white bread that wealthier people eat, without knowing that their own bread is more nutritious. She says the same concept follows when thinking about choosing where to give birth; people always aspire to have what people above them in the social hierarchy have, despite its quality.²¹⁰

The influence of social norms may also affect a woman’s decision to use pain medication during labor, a choice that may alter the birth location or provider type. For countless decades in America’s past, black women have been subject to pain via experimentation without anesthesia, and if they prefer to avoid this pain, their needs should be respected. Nonetheless, a desire to avoid the subjection to pain and a repetition history may deter women from an unmedicated out-of-hospital birth.

Additionally, the valid fear of black women being four times more likely to die during childbirth than white women in the US has likely encouraged black women to be more attentive to their health outcomes and opt for hospital birth to avoid being a part of this statistic.

Unfortunately, as I will explore in chapter four, what is not discussed enough is how the medicalization of childbirth can produce worse health outcomes for both mothers and babies in

low-risk cases. However, if black women *do* take what might be considered a risk by birthing outside of the hospital, they will likely be deemed bad mothers much more quickly than their white counterparts.

Lastly, social media's white-washed representation of birth in the midwifery community largely impacts black birthing norms. For example, while the 2008 film *The Business of Being Born* remarkably documented several issues with the over-medicalization of birth in hospitals, it showcased almost entirely middle-class white families.²¹¹ As a result, the film only reached and spoke to a limited audience. Of the film, CPM Muhammad says:

The midwives that are promoting it don't typically have low-income women in their client base...[Even when low income women see the film, they] don't see women that look like them, economically and ethnically, they can't see themselves. They think that only 'those' women do that.²¹²

The film was not made for them and did not address their needs. The same can be said for the film *Birth Story* mentioned earlier, as well as countless Instagram feeds, mommy blogs, and photograph series portraying mostly white families. One black midwife shared her qualms about the type of birthing mother these narratives suggest:

There's a type, you know? Well educated, a naturalist, only organic foods, paraben free products...with few exceptions, they is a type. They generally are paying with private insurance or out of pocket. This is one of the challenges with my work because I want to serve more black women but it's more about a kind of....status.²¹³

The contemporary lack of representation in the home birth and birth center movement led by midwives directly leads to discomfort within the social space, and thus to a lack of access.

Demographics of Midwives

The lack of racial diversity in midwifery clientele can also be explained in terms of midwife's lack of racial diversity. As of 2015, the department of Education has determined that 76.6% of CNM degrees were awarded to white women, in comparison to 6.4% to black women.²¹⁴ Statistics from the North American Registry of Midwives state that 87% of CPMs

identify as white, while less than 2% identify as black. Racha Tahani Lawler, a black CPM who has been practicing for 16 years, estimates that the US has fewer than 100 black CPMs.²¹⁵

This stems most notably from the lack of support for midwives of color within the larger midwifery community. Black midwives often face significant hurdles when entering the profession. As studied by sociological scholar Sheryl Nestel, gatekeepers of the profession typically impose standards of white cultural competencies on practicing students, informed by racism both obvious and more subtle, whether it be ways of dress or conversational diction.²¹⁶ Even within professional organizations that claim to support marginalized people – both members and clients – there are few actions or commitments to reach these goals. Empty promises represent an unwillingness to compromise with black midwives who are asking for what they need. Several midwives express this sentiment throughout their own experiences:

In general, when I used to go to the meetings...and I went to MANA and ACNM...the very few of us banded together. But, over the years, less and less of us stopped going even though we kind of created our own network but outside of the organizations. We got fed up because there was not a lot of attention to race and, to be honest, it was racist. [Another black midwife] even tried to get involved, you know in leadership, but she had some horrible experiences. She felt kind of silenced, you know? So most of us don't even go to those meetings anymore.²¹⁷

So even when I was a student I went to both MANA and NACPM and, you know, it's a real expense. I was really struck by the lack of people of color, especially black people. The black midwives I met have been so wonderful to me and have helped me so much along the way but outside of the organizations. At one point....and I don't even know when this happened...but I realized why am I a part of an organization that doesn't seem to put money and people behind diversifying midwives of color. Don't get me wrong MANA's MoC [Midwives of Color Section] does great work and I have relationships with the women active in there but, in general I found the organizations a bit racist to be honest.²¹⁸

So there are a lot of benefits to being a member of ACNM. That I am not going to deny. But the race stuff is terrible. It's the big issues of really needing more financial support for recruiting and keeping midwives but it is also the smaller stuff.... those acts of privilege. You can't keep talking about wanting and needing more midwives in this country without talking about race. And that is, unfortunately, what's happening. I have chosen to stay active and remain a part of it but a lot of sisters have left. Talk to them.²¹⁹

The lack of racial diversity at the conferences and meetings, the absence of financial support, the inability to keep midwives of color in leadership positions, and the constant silencing of specific needs has left black midwives exhausted, and ultimately unable to participate. This is most notably highlighted in the resignation letter MANA received from their Midwives of Color (MOC) Section Chair Darynée Blount in 2012. The letter, presented publicly to the MANA Board of Directors, stated the resignation of herself and five other midwives and students that comprised the Inner Council Leadership Team while detailing the multiple difficulties they have faced while working with MANA:

...A question to be asked – if the MOC Chair is a 3-year term, how come all of the recent Chairs resigned after roughly one year into the term? What about MANA and its leadership, the MOC membership (or lack of membership involvement) and their relationship, that such firmly committed, hardworking, bright women relinquish this position?

The answer lies in examining MANA, both the organization and the individuals in leadership positions, interaction with the MOC. It is clear to us that MANA's ethos of their unearned entitlement that continues to dis-value and ignore us as a group and as individuals. At best we are an afterthought.

MANA continues to spout canned responses in support of: various race, gender, social justice issues; 20,000 midwives by 2012; more midwives of color to serve communities of color; end racial disparities in health care;, etc..., while not actually developing workable strategies and expending resources (and if so, begrudgingly supporting after endless negotiations) to achieve any of them.

We can no longer continue to participate in MANA's disrespect of us as a group, a race, as the Women our community respects. We cannot keep our heads held high and take this shit. Our view of ourselves will suffer and eventually the young ones will look at us with less than admiration. We are not "The Help -2012 Version". This treatment is not good for us, mentally, physically, emotionally and psychologically – this is the stress that kills us in so many ways, drains our energy and distracts our focus.²²⁰

This comprehensive letter (abridged above) details the injustices that have been served to the midwives of color working with MANA recently and in the past. This is unfortunate, as positions within the MOC Board and Inner Council were created to help MOC succeed and to provide them with a support system for networking, mentoring, tutoring, and emotional support. The

rapid turnover in positions of leadership specifically reserved for women of color indicates a lack of communication and initiative from the larger organization to listen to the requests necessary to elevate these women. If the midwives themselves cannot be met with the respect necessary to progress professionally, clients of color cannot be supported either. It is not enough to encourage women of color to sit on boards of organizations; the internal structure and resources must support them once they are in leadership positions as well.

The lack of support black midwives experience translates to a dearth of midwives representing the communities that most need to be reached. This affects clients as well as other midwifery students, further decreasing accessibility. For example, many black midwifery students looking for apprenticeship preceptors have experienced a multitude of microaggressions – subtle, indirect, and unintentional though harmful discriminatory behaviors – when paired with white midwives in predominantly white communities:

I'll never forget...I asked a white midwife here in [northeastern city] if I could apprentice with her. She said no because she didn't think patients...white...would feel comfortable. Sick. But here I am black woman, brown skin, locks, head wraps...you know. That is a threat. Without other options, it took me a long time to find someone.²²¹

I was looking around for a preceptor. Man, that is so hard for us... But this white woman who I actually had a relationship with. I respected her. She...she said, you know basically I can't work with you because my clients may not feel comfortable with your hair [long dreadlocks]. She did this thing about my hair being beautiful but in the same breath told me it was too distracting. Sick. But it's me and I will never change it.²²²

Women are either told they have to fit the mold in order to comfort their preceptors, or they are viewed as a threat to the norm that contemporary midwifery has created for both its providers and clients. As one midwife shared:

As people of color in these situations where our livelihood or our very lives are at stake, our confidence becomes viewed as arrogance, disrespect, or worse, is viewed as a threat. Most of us have learned when we may need to dampen that confidence for appearances, to be “humble,” speak in whitewashed tones, keep our heads still, our faces without too much expression, and apologize when we have nothing for which to apologize. Most of us have played the game at some point or another.²²³

Making these compromises perpetuates an unhealthy work environment and widens diversity gaps by failing to encourage midwives to hold space for their identities.

Similar sentiments are felt by black women looking for maternity care providers. It can be healing to have a person that looks like you and understands you in ways another person may not, particularly during one of the most vulnerable and emotional moments of life. There is often a sense of shared understanding between people in black communities – about obstacles faced in a white-centric society, about day-to-day experiences and interactions. One midwife shares this understanding:

When I see another black woman giving birth...you know, when I am there with her...I know her and can relate to her like I can't other women. I mean...all women can relate to one another but another black woman, I know her. You understand? I know her. I know how it feels to be a black woman in this world...walking down the street, at work. Stupid stuff people say. The way stuff makes you feel. That small stuff. I also know what it feels like to be a black mother in this world. I know what we been through as people and what that mean for her and her baby. We are a strong, smart, prideful people but it's hard. And I know them...I know her.²²⁴

This sense of shared experience allows the provider and laboring person to be in the same mental space. Sociologist Ron Eyerman posits that this phenomenon stems from what is termed “cultural trauma”²²⁵ Defined as “a memory accepted and publicly given credence by a relevant membership group and evoking a permanent negative event or situation,”²²⁶ Eyerman suggests that the collective memory of slavery solidifies cultural trauma for black communities in the US. Although slavery as it existed in the 19th century and prior no longer exists, the lived experiences of black people have carried forward emotions which have guided actions. This transmission throughout generations has been adapted in new situations as black Americans continue to be marginalized.²²⁷

Although this notion of shared mental space can be found in white communities as well, it generally stems from the opposite end of the power hierarchy: white supremacy and privilege.

This can be detected in myriad ways within midwifery, though perhaps most prevalent in implicit bias, which can contribute to health care disparities and encourage treatment differences.²²⁸ White privilege conditions white people to center their own cultural needs and consider this the norm by forgetting that their own realities are not the realities of other people. This ultimately results in countless microaggressions perpetuated towards non-white people, creating an uncomfortable and unwelcoming birthing environment. Consequently, women of color report feeling disconnected from the primarily white women's health movements due to inattention of concerns raised specifically by non-white women and birth attendants.²²⁹ Chanel L. Porchia-Albert, the founder of women of color organization Ancient Song Doula Services, said at the opening plenary for MANA's 2018 conference, "while black midwives have always cared for everybody, white midwives are struggling to figure out how to serve people that don't look like them."²³⁰ Naturally, then, the lack of black midwifery representation and the clientele demographic that contemporary midwifery practices attract is connected.

The regulation of black midwives during the Antebellum period has translated to the racism black midwives experience today, and the dearth of racial diversity to advocate for marginalized clientele consequently results in invisibility of midwifery services within black communities. This, in addition to poor or no insurance coverage, word-of-mouth advertisement of services, insular visibility, preconceived expectations, social norms for black women, and social media misrepresentation, are some of the multiple obstacles to consider regarding access to midwifery care. Accessing a midwife is not simply a matter of choice – it is a matter of social circumstance.

Chapter Four: Why Midwifery, and for Whom?

Despite the numerous obstacles causing a lack of accessibility to midwifery-based care, the myriad benefits of its model suggest that access should be expanded in order to serve those disproportionately at the mercy of over-medicalized birth. However, in order to discuss how the midwifery model of care can benefit birthing women, I will first explore the implications of the medicalized model provided in hospitals. By contrasting these two models of care, I intend to portray how the midwifery model is superior to the medicalized model for low-risk pregnant women. This is true regardless of race, but because black women are more likely to experience disproportionate trauma during labor and the immediate postpartum period, I will focus particularly on the benefits black women can reap from midwifery care.

The Technologization of Birth

Today, approximately 98% of women give birth in a hospital, primarily under an obstetrician's care. Despite hospitals being proclaimed as the safest place to give birth, data from the United Nations has portrayed that the US maternal mortality rate has worsened, falling from 41st to 50th best in the world – women in the US are more likely to die during childbirth than in 49 other countries.²³¹ In 2010 the nation's maternal mortality ratio (12.7 deaths per 100,000 live births) was three times higher than the Healthy People goal, a national target set by the US government.²³² With between 700 and 900 maternal deaths occurring per year in the US, the nation is one of only 13 globally that has a current maternal mortality worse than it was 25 years ago.²³³ Additionally, the Center for Disease Control and Prevention (CDC) has reported that over 50,000 maternal near-deaths are preventable, a statistic which has risen 200% between 1993 and 2014.²³⁴ Simultaneously, annual hospital bills for birth currently amount to over \$98 billion – a value twice that of other countries.²³⁵ Clearly, America's health system capitalizes from

hospitalized birth, though high mortality rates suggest that patients hardly reap benefits from such intervention.

The expectations of intervention during birth in the hospital are normalized for both physicians and patients. The list of interventions is extensive. When a woman in labor enters through the hospital doors, she is commonly placed in a wheelchair and carried off into an unknown room, sometimes even separated from some of her accompanying support people according to hospital policy. She is asked to remove her own clothes and change into a hospital gown, her pubic hairs are shaved for the physician's benefit, she is sometimes given an enema to extract any fecal matter from her bowels, and she is typically restricted from eating or drinking anything in preparation for the possibility of general anesthesia. An IV is inserted into her arm, through which Pitocin – synthetic oxytocin that increases contraction occurrence and strength – is administered. An electric fetal monitoring (EFM) monitor band is placed around the mother's stomach to measure fetal heart rate, a manual vaginal exam is generally performed at least every two hours, and if the pain is too extreme, an epidural is administered. Upon the time of birth, she is transferred to the delivery room, placed on her back, covered in sterile sheets, and an episiotomy – an incision from the vagina to the anus – is occasionally performed to create a wider opening. The cord is cut, the baby is cleaned off, it receives silver nitrate eye drops to prevent blindness and a vitamin K shot to ensure proper blood clotting, and then is returned to its parents for a short time until it is placed in the nursery for proper observation.²³⁶

Although some of these interventions can be life-saving and may dramatically improve outcomes, they are typically overused in hospitals, causing injury and detrimental side effects that may severely compromise a woman's health or birthing experience. For example, although EFM is meant to monitor fetal heart rate, the strap's positioning around the birthing mother's

stomach restricts her movement, often requiring her to be laying down in the horizontal lithotomy position. This increases the length of labor due to a lack of optimal gravity positioning; the weight of the fetus compresses major blood vessels of the uterus, thereby decreasing blood pressure, which subsequently decreases fetal oxygen supply and distresses the fetus.²³⁷ As a result, the EFM tends to produce the exact abnormalities it is meant to measure. Laying horizontal has suboptimal effects on the fetus and often results in lack of progression during labor, resulting in more administration of Pitocin,²³⁸ which intensifies contractions and calls for a larger dose of painkillers. These painkillers require physicians to take more frequent blood pressure measurements, catheterize the bladder, and if effects are not sufficient, administer an epidural. Epidurals often slow labor or can stop it all together, perhaps calling for a larger dose of Pitocin, and even raising body temperature in 10-15% of women, making it unclear whether the cause of the temperature increase is the epidural or fetal infection.²³⁹ Furthermore, epidurals can cause severe headaches and present a risk to the fetus who absorbs the drug across the placenta within a few minutes. Studies have shown effects such as impaired motor and sensory infant responses, reduced processing and response to incoming stimuli, interference with feeding, sucking, and suckling responses, increased irritability, and decreased bonding.²⁴⁰

Although these interventions all appear singular, they often occur together in what has been termed the “cascade of interventions”²⁴¹ – one intervention promotes the use of the next one. In the final stages of this process, a cesarean section often occurs. Although the World Health Organization (WHO) considers a cesarean section range of no more than 5% to 15% appropriate, the US rate rose for the 13th consecutive year to reach a value of 32.9% in 2009 – today it remains at 32%.²⁴² Studies have shown that states with cesarean section rates higher than the national average had a 21% higher risk of maternal mortality than states with cesarean

section rates lower than the national average.²⁴³ Cesarean sections are considered major surgeries and can have detrimental outcomes in some cases. They have been shown to increase risk of infection, hysterectomy, kidney failure, newborn respiratory problems, chronic pain, pulmonary embolism, difficulty bonding and breastfeeding, as well as uterine rupture, ectopic pregnancy, preterm delivery, and placental complications in future pregnancies.²⁴⁴ Furthermore, the mortality rate for infants born via cesarean section is four times higher than those born vaginally, and rate of illness is ten times higher. Seven percent of babies born via cesarean section are premature and therefore remain in the hospital three times longer than their non-cesarean section counterparts, making them more susceptible to disease and infection. Furthermore, the post-op pain medications utilized often leak into breastmilk – toxins that affect the baby.²⁴⁵ Although originally intended to save mothers and babies, the increased rate of unnecessary cesarean sections has largely done the opposite.

Additionally, a typical physician's expectations of labor in the hospital is quite particular. Steps, protocols, and stages must be followed, and birthing women are expected to comply. For instance, each stage of labor is assigned a rate of progression as follows:

the first stage should progress at 0.6 cm/hour; active phase, acceleration subphase, should progress at 0.6 cm/hour; active phase, subphase of maximum slope, should progress at 1.2 cm/hour or more for a first labor, 1.5 cm/hour for later labors; second stage should progress at 1 cm/hour and 2 cm/hour for a first and second labor, respectively.²⁴⁶

If a woman deviates from these measurements, she is diagnosed with a “prolonged” phase or with an “arrest” of labor.” Uteruses are described as producing contractions that are either efficient or inefficient, and labor is judged as either good or bad according to the amount of “progress” made in a certain time frame.²⁴⁷ These expectations often disrupt the natural flow of labor. One woman describes it as such:

you're having sex with your husband and you're all ready to climax and then they put you on this table and say, “now hang on, wait there, we'll take you to this other room and

then you can climax”. It’s almost the same thing; you’re getting all ready to have this baby and then they switch you to this table and rush you down to the delivery room and say, “okay, now you can do it.” it’s so intrusive and interrupts the whole thing; it’s hard to get back to where you were.²⁴⁸

Hospital procedures produce a culture of submission among birthing women that promotes a loss of autonomy and self-esteem by creating dehumanizing experiences and placing them in unfamiliar surroundings. Even the non-technological expectations promote this loss of identity during one of the most intimate moments of a family’s life. Being placed in a wheelchair reinforces the notion of disability and incapability to control oneself. Being changed into a hospital gown and receiving an ID bracelet removes all semblance of familiarity and reinforces the notion of sickness. Undergoing pubic hair shaving degrades women to a sense of infancy. The lithotomy position places the mother’s vagina forward in the physician’s direct line of sight for his benefit. Enduring multiple vaginal exams during moments of extreme pain interferes with privacy and intimacy, thereby inducing anxiety. Being infused with an IV rather than physically eating removes the belief that one can feed themselves.²⁴⁹ Laboring mothers are treated as if they are ill and are forced to depend on the physician.

Medical anthropologist Robbie Davis-Floyd describes these analyses of hospitalized childbirth practices under the concept that birth in America has become a ritual, a rite of passage.²⁵⁰ Rites of passage transform both an individual’s perception of themselves, as well as society’s perception of this individual – birth fits within this definition; a childless woman transforms into someone responsible for another being. It is the creation of a family. Although rituals have a sense of comfort and confidence in their predictability,²⁵¹ participants are easily lost in their pattern and fail to question the purpose behind them. Very few families, for example, know that they can choose their maternity care practitioners. Medicaid-insured women, in particular, have to act as their own advocates if they are seeking low-intervention birth because

hospitals generally will not refer or help women access this information.²⁵² Practitioners can get lost in the patterns of ritual as well. Medical residents and practicing physicians express the following:

Most of us went into medical school with pretty humanitarian ideals. I know I did. But the whole process of medical education makes you inhuman... you forget about the rest of life. By the time you get to residency, you end up not caring about anything beyond the latest techniques and most sophisticated tests.²⁵³

We shave ‘em, we prep ‘em, we hook ‘em up to the IV and administer sedation. We deliver the baby, it goes to the nursery and the mother goes to her room. There’s no room for niceties around here. We just move ‘em right on through. It’s hard not to see it like an assembly line”²⁵⁴

The culture of hospitalized birth reinforces an assembly line of procedures that chip away at the humanity of creating a family. The emotionality of the ritual is forgotten and replaced by interventions that purport safety above all else, with minimal concern for actual effects. Habituation to the rituals has perpetuated a lack of interest in determining their efficacy and a disregard for the scientific evidence that discourages their use.

Why, then, is all this technology used? Technological intervention is financially profitable for both hospitals and physicians, and these institutions often accumulate multiple procedures to ensure successful revenue. Use of technology also saves physicians’ time; rather than waiting for labor’s normal progression that can sometimes take up to 72 hours, intervention allows quick turnover of patients and larger profit for the hospital. The sheer availability of top-notch equipment also encourages its use. If it is available, why let it sit in a corner and go to waste? Furthermore, technology allows the physician to be less personally involved and thereby justifies the large medical fees for such a small expenditure of patient contact time. Lastly, technologization of birth is solely what medical schools teach – there is no other way taught.

Fortunately, official organizations have begun making statements that call for the restriction of unnecessary intervention. In February 2017, the American College of Obstetricians

and Gynecologists (ACOG) issued a Committee Opinion recommending that low-risk laboring women receive minimal intervention in order to increase satisfaction of the birth experience and improve health outcomes.²⁵⁵ For instance, instead of using EFM, ACOG suggests listening to the baby's heart beat with a handheld Doppler device. Instead of laboring while lying down, ACOG suggests staying upright and moving around. Instead of pushing when 10 centimeters dilation is reached, ACOG suggests resting while the baby moves down and waiting for the urge to push.²⁵⁶ Although this promotion of physiologic birth is an advancement that will hopefully start to reverse the medicalization and technologization of birth, the recommendations are not commonly followed due to prioritization of hospital revenue and time constraints. More change needs to be made.

Why Midwives?

The midwifery model of care, on the other hand, avoids intervention at all costs. Studies have shown that women receiving care at practices with midwives are more likely to have a spontaneous natural vaginal birth – one study suggested that 80% of women in a collaborative practice with CNMs and obstetricians achieved a vaginal birth, compared to 63% in a physician-only practice.²⁵⁷ Midwifery practices also generally achieve lower rates of labor induction, perineal tears, and use of anesthesia. Perhaps most impressive, midwives have significantly lower rates of cesarean section than the national average produced largely by physicians. This holds true across comparable populations.²⁵⁸ One study determined that midwives had a 9.9% primary cesarean section rate – in comparison to the nation's 32% – and another determined that New Mexico, where CNMs attend a third of all births, has the lowest cesarean section rate of the country.²⁵⁹ Other data have shown that midwives' rates of episiotomy are lower than the national average (3.6% compared to 25%) and that breastfeeding initiation rates are higher than the

national average (78.6% compared to 51%).²⁶⁰ The rates of technological intervention shown to be oftentimes detrimental to women's health are significantly lower within the midwifery model.

This can also be seen in studies that do not look particularly at midwifery care, but rather at place of birth. However, because home births and birth center births are nearly exclusively attended by midwives, it can be deduced that the midwifery model of care influences these results. Among 16,924 women who planned home births between 2004 and 2009, 89.1% gave birth at home, while only 4.5% required oxytocin and/or an epidural.²⁶¹ Those who did not give birth at home were transferred due to lack of progression in labor, rather than due to emergency, and only 5.2% had a cesarean section. 93.6% were spontaneous vaginal births, and 1.2% were assisted vaginal births. Even out of women attempting a vaginal birth after cesarean section, 87% were successful. Postpartum maternal and neonatal transfers were rare (1.5% and 0.9% respectively), and 86% of newborns were exclusively breastfeeding at six weeks. The intrapartum, early neonatal, and late neonatal mortality rates were 1.30, 0.41, and 0.35 per 1,000, respectively.²⁶² These statistics stand in contrast to the high rates of hospitals.

Birth centers produce similar results. Of 15,574 women who had planned birth center labors between 2007 and 2010, 84% gave birth at the center. 4.5% were transferred to a hospital prior to being admitted at the birth center, while 11.9% were transferred after admission.²⁶³ 84% of these in-labor transfers were first-time mothers, and most were done for non-emergent reasons, such as prolonged labor. Nonetheless, 93% of all women had a spontaneous vaginal birth, 1% assisted vaginal birth, and only 6% via cesarean section. Although 2.4% of women birthing in the center and 2.6% newborns required transfer postpartum, most were non-emergent. The intrapartum and neonatal mortality rates were 0.47 and 0.40, respectively.²⁶⁴ Once again, these statistics stand in contrast to the high rates of hospitals.

In addition to the medical and health benefits of midwifery, this model of care also provides birthing women and families with invaluable social and emotional benefits. It primarily strives to create a space for choice and agency by being a support system that empowers women to decide their own birthing plans and choose what works best for them. The midwife's role in supporting the physical, psychological, and social well-being of mothers not only during childbirth, but throughout the childbearing cycle is a role commonly unseen in the medicalization of pregnancy and birth attended by physicians. This family-centered model emphasizes individualized education, counseling, and hands-on assistance, creating a space for families to become involved in the process as a unit instead of as separate parts. Countless studies have shown that the presence of a support system improves health outcomes tremendously, and that those without adequate social support have higher risks of low birth weight and preterm birth.²⁶⁵ Women birthing with midwives typically feel welcomed and empowered to make their own decisions about their birth, without the influence of an authority figure telling them what must be done. Two women shared their reasons for choosing midwifery care:

I wanted a birthing experience that was neither determined by chemical interventions and induced paralysis nor reliant upon blind, uncritical submissiveness to medical protocols. I wanted a birth that was as loud or quiet, messy, active or still as it needed to be. I wanted a birth that was not institutionalized and predictable, not conquered or colonized, but instead self-determined and free. I wanted my black child to enter this crazy world on his own terms, in his own time, if he could.²⁶⁶

I didn't want my child to be exposed to the toxins flowing through an epidural. I didn't want my daughter to be weighed down with drugged grogginess during her first moments in this life. I wanted to experience the joy and self-fulfillment of pushing my child into the world. I wanted to feel and be present for each moment. I wanted to meet my daughter immediately. I wanted to hold her. I wanted to breastfeed her. I wanted to smell her. I wanted to sing to her. I wanted to say, "Hello, baby. Welcome to the world."²⁶⁷

Although the pain may be excruciating, the endurance may be difficult to withstand, and the experience may be vulnerable, "vulnerability is the only way to tap into our strength and infinite power."²⁶⁸ For those willing to experience it, this vulnerability can be so rewarding when a

woman can feel that she has labored through an experience that unites her with other women and signifies the start of a new life, to know that she has done this herself, on her own terms. Rather than being subject to interference and authoritarianism that may have left her or her child's health compromised, she has birthed with guidance and love from her support system.

Black Women and Birth Outcomes

Although most women could benefit from the midwifery model of care, I spend the remainder of this chapter arguing that black women, in particular, may benefit from a humanizing and empathetic model of care that directly minimizes medical complications. As a population that is significantly more likely to have traumatic birthing experiences, both physically and emotionally, black women may find the midwifery model of care to be of great use when seeking a satisfactory labor and delivery.

In 2010, an Amnesty International report titled "Deadly Deliveries" revealed that black women in the US are nearly four times more likely to die from pregnancy-related complications than white women.²⁶⁹ Between 2011 and 2014, the pregnancy-related mortality ratios displayed a maternal mortality rate of 12.4 deaths per 100,000 live births for white women, compared to 40.0 for black women and 17.8 for women of other races.²⁷⁰ Clearly, there is a disparity. However, this is nothing new. The risk of maternal mortality has remained three to four times higher among black women over at least the past six decades.²⁷¹ Put into perspective alongside other racial disparities in women's health, black women are 22% more likely to die from heart disease than white women and 71% more likely to die from cervical cancer, but 243% more likely to die from pregnancy or childbirth-related causes.²⁷² These disparities also fluctuate across regions, increasing in select rural counties and dense cities alike. The maternal death rate in Chickasaw County, Mississippi, for example, is higher than Rwanda's. New York City, supposedly one of

the most forward metropolises, has a pregnancy-related death rate 12 times higher for black women than white women, and this disparity has more than doubled as of late.²⁷³

Black infants, as well, have significantly higher mortality rates than white infants, with 11.3 per 1,000 black babies dying compared to 4.9 per 1,000 white babies – a disparity larger than in 1850, 15 years prior to the abolition of slavery. Amounting to over 4,000 black babies lost each year, these severe differences point to the improvement in healthcare access for white communities, but not black ones.

Furthermore, though these high rates of maternal and infant mortality do indeed paint a grim picture, they do not paint a full picture. As one doctor shared:

Maternal deaths are the tip of the iceberg for they are a signal that there are likely bigger problems beneath – some of which are preventable. It is important to consider the women who get very, very sick and do not die, because for every woman who dies, there are 50 who are complications of pregnancy, labor and delivery.²⁷⁴

To have a comprehensive understanding of black women's maternal health, other pregnancy-related health indicators should be examined as well. For example, one study has shown that for every maternal death, 100 women experience morbidity, a life-threatening diagnosis, or endure a life-saving operation while delivering in the hospital, though most of this is preventable. The most common morbidities include disproportionate rates of hypertensive disorders, cardiomyopathy, and postpartum hemorrhage, and most occur following cesarean sections. With 36.8% of black women undergoing cesarean sections in comparison to 32.7% of non-black women, there is a clear significant difference in birth outcomes.²⁷⁵

Infant birth outcomes are affected as well, with pregnant black women twice as likely to experience preterm birth and three times as likely as white women to give birth to low birth weight babies.²⁷⁶ Studies have also shown that while 83.0% of white women initiate breastfeeding, the same is true for only 66.4% of black women. At three months, only 33.4% of

black women are breastfeeding exclusively, compared to 48.0% of white women.²⁷⁷ Even black women who intend to exclusively breastfeed are more likely to receive formula samples or offers from hospital staff (64% versus 50%) and their babies are more likely to be supplemented in the hospital (45% versus 32%).²⁷⁸

These disparities exist beyond birth itself as well. In comparison to white women, black women are less likely to receive clinical support during the prenatal period²⁷⁹ and more likely to experience hospital readmittance rates following birth.²⁸⁰ Postpartum, babies born to black mothers are twice as likely to be hospitalized as those born to white mothers. Lastly, 13% of postpartum black mothers experience poor emotional well-being interfering with their ability to care for their babies after delivery, while the same is true for only 4% of white mothers.²⁸¹ These disparities, combined with the lack of medical attention experienced during the postpartum period, can be dangerous for black women due to the fact that over half of maternal deaths occur during this time, while one third happen within one week following delivery.²⁸²

Most noteworthy of all, these racial disparities exist even when controlling for differences in socioeconomic class and educational status. Several studies have shown that even when controlling for low income, low education, and alcohol and tobacco use, the gap widens as socioeconomic levels increase.²⁸³ For example, black, college-educated mothers delivering in local hospitals are more likely to suffer severe pregnancy or childbirth complications than white women without a high school degree.²⁸⁴ Similarly, studies examining effects of upward socioeconomic mobility correlated with rising income found that a poor white woman's increase in family income resulted in lower probability of a low birth weight baby, although the same benefit was not statistically significant for poor black women with similar income increases. Thus, adverse birth outcomes for black women are not related to disparities in socioeconomic or

educational status, but rather are directly related to race and perceptions of race within American society.

Unfortunately, however, the reasons for these racial disparities are often misinterpreted, and the onus of blame is put directly on black communities. The condemning of black bodies for their susceptibility to illness has existed for all of American history and carried forward to fault black people for their health outcomes. However, work done by sociologists and anthropologists have argued against this belief, and science has refuted it as well. Several studies have shown that new immigrant mothers from Africa tend to have better birth outcomes than black mothers who grew up in America, indicating that the experience of racism while in the US likely plays a role in health and wellness.²⁸⁵

Additionally, there is little empirical evidence of heightened genetic patterns for hypertension and preterm birth among black people. Geneticist Mike Bamshad argues that racial health disparities can only minimally be attributed to genetics; rather, environmental and social influences play a larger role.²⁸⁶ Efforts to define particular genes such as a “preterm birth gene” related to race have been unsuccessful, and from ten leading causes of death, black people generally have lower death rates for only two: Alzheimer disease and chronic lung disease.²⁸⁷ As one article points out, “it is highly unlikely for any given population to have concentrated multiple deleterious mutations in such a way that they are at a higher risk for almost all of the common complex disorders on a genetic basis.”²⁸⁸ Rather than having a biological root, higher likelihoods of illness and poor health outcomes more reasonably stem from social, economic, and cultural processes.

Although it can be simpler to point to genetic explanations, this introduces an “aura of inevitability”²⁸⁹ that minimizes the necessity of active intervention to prevent these disparities.

The simple solution of conceptualizing race as something that is purely genetic ignores the abundance of evidence indicating that race is socialized just as much, if not more, than it is genetic. Therefore, it is not purely race that negatively perpetuates the health disparities among black families, but rather the exposure and experience of racism. Present in a multitude of ways, intergenerationally and daily, navigating systems of oppression can strain social environment and in turn affect one's biology. As legal theorist Kimberly Crenshaw urges us to remember, there are countless processes by which "race has endured as an omnipresent social fact with powerful material repercussions despite its lack of moorings in biology."²⁹⁰ This exists in several manners; in the next section I discuss the implications of race in regard to social determinants of health, as well as discrimination within the health system and impacts of stress on biological processes.

Causes of Disparity

Social determinants of health – defined as the social and cultural factors outside of genetics and personal choice which determine how healthy one is – include aspects of life removed from one's direct control.²⁹¹ A myriad of social determinants may be impacting the health outcomes of black mothers. Though these factors may not be having a particularly large effect on the surface, their summation can be immense. Income level, neighborhood safety, advertisement content on billboards in the neighborhood, grocery store or liquor store presence in the community, presence or absence of rent protection, housing options, access to reliable transportation, pollution in the area, presence of a toxic dump site nearby, job availability, school quality, drinking water safety, noise level, crowding, presence of crime, extremes of temperature, hunger, and infection, for example, are all factors impacting quality of life and health outcomes in black communities to a greater extent – in frequency, duration, and intensity – than in middle- and upper-class white communities.²⁹²

This correlation of health with social determinants is often incorrectly conflated with individual choices and habits, portraying black families as responsible for their own outcomes. Even Ina May Gaskin, the purported “mother of modern midwifery,” when asked about how racism affects black infant and maternal health, chose to discuss the importance of hard work (specifically, the physical labor of farming), prayer as stress reduction, the impacts of drug use, and one’s personal health responsibility, rather than addressing systemic racism’s impact on health.²⁹³ Focusing on these points overlooks the history of agricultural work prescribed to enslaved people, the mostly religious black populations in America, and the stereotyping of black parents as inattentive and dependent on poor drug habits. The blame is placed on the mother, rather than on society, understanding her to be too young, unmarried, eating badly, drinking, smoking, not resting enough or taking the correct prenatal vitamins, and unable to ask questions during prenatal visits or attend them at all. Birth outcomes are commonly not the result of individual failure or irresponsibility, but rather due to social determinants predisposing communities to different risk factors.

Secondly, discrimination within the health system is a significant cause for the birth outcomes of black women. As a primary barrier, black women are often assigned prenatal care providers without being informed of their options by their medical establishments (55% of black women compared to 29% of white women).²⁹⁴ Furthermore, discrimination can affect access; hospitals serving predominantly black communities are often the products of segregation and are of lower quality than those serving predominantly white communities.²⁹⁵ In multiple interviews and recordings of black mothers’ accounts, feelings of being disrespected and devalued by medical providers was a recurring concept.²⁹⁶ One study discovered that 21% of black women

avoid seeking health care out of fear of being racially discriminated against, while 33% have previously been racially discriminated against in a healthcare setting.²⁹⁷

This discrimination can present itself in many forms. Though it may not always appear to be blatant, it can often be equally as harmful, if not more harmful, than outright racist comments. For example, black mothers' pain is often not taken seriously due to physicians' assumptions of higher pain tolerance. Studies have found that white medical students and residents often believe incorrect biological fallacies that black people have less-sensitive nerve endings than white people, that black people's skin is thicker than white people's, and that their blood coagulates more quickly.²⁹⁸ Another study indicated that pain is often undertreated in black patients. One black woman shared that her mother "basically had to scream at the doctors to give [her] the proper pain meds."²⁹⁹ This often results in medical practitioners completing procedures such as episiotomies or cesarean sections that might otherwise not be performed as readily on white women due to pain levels and longer healing times.

Discrimination in the healthcare system also takes the form of assumed hypersexuality and irresponsibility. Black women are more likely to be repeatedly tested for STDs throughout their pregnancies, suggesting them to be sexually gluttonous and unable to refrain from sexual activity.³⁰⁰ Assumptions of hypersexuality are reflected in the high hysterectomy rates of black women during the cesarean section surgery process, often forced and non-consensual.³⁰¹ Rather than holding a conversation about safe contraception and family planning options, practitioners force compliance with the medical system's methods, ripping reproductive autonomy from black women's bodies.

This discrimination and breach of autonomy is also present in the non-consensual drug testing that occurs at higher rates for black women in hospitals following delivery, though the

same is hardly done for white women clearly abusing substances.³⁰² As one study proved, there is very little difference in the prevalence of substance abuse by pregnant women among racial lines, with positive results for white women even being slightly higher (15.4%) than those for black women (14.1%). Nonetheless, black women are ten times more likely to be reported to government authorities for drug abuse.³⁰³ Lastly, black families are much more likely to have social services called on them in the hospitals,³⁰⁴ severely disrupting family structure, support, and thereby health outcomes.

These different forms of discrimination have significant effects on health indicators during childbirth. Studies have shown positive relationships between perceptions of racial discrimination and preterm birth, low birth weight, and very low birth weight.³⁰⁵ Even when controlling for gestational age, spontaneous labor, parents' educational level, and medical risk, perceived racism is correlated with lower birthweight for black mothers' babies, though not for white mothers'.³⁰⁶ This is exacerbated when correlated with younger maternal age and lower educational status.³⁰⁷

However, the meaning of these statistics can often get lost in the numbers, particularly for people who have not embodied these lived experiences and are removed from their implications. Regardless, each of these statistics tell the stories of real women. One NPR article describes these stories:

There was the new mother in Nebraska with a history of hypertension who couldn't get her doctors to believe she was having a heart attack until she had another one. The young Florida mother-to-be whose breathing problems were blamed on obesity when in fact her lungs were filling with fluid and her heart was failing. The Arizona mother whose anesthesiologist assumed she smoked marijuana because of the way she did her hair. The Chicago-area businesswoman with a high-risk pregnancy who was so upset at her doctor's attitude that she changed OB/GYN in her seventh month, only to suffer a fatal postpartum stroke.³⁰⁸

As a result of black motherhood's devaluation, black women's stories are not being heard. Anthropologist Khiara Bridges says the following, "Black mothers are seen to corrupt the reproduction process at every stage... they damage their babies in the womb through bad habits during pregnancy. Then they impart a deviant lifestyle to their children through their example."³⁰⁹ White reproduction, in contrast, is rarely subjected to discourse implying "censure and condemnation," instead being considered a relatively beneficial activity, bringing joy and a sense of flourishing to the nation.³¹⁰ There is a double standard of discrimination within healthcare.

Lastly, negative health outcomes for black women during pregnancy and delivery are likely perpetuated by stress reactions in response to constant systemic racism. Racism, operationalized as personal discrimination or stress experienced after witnessing discrimination toward members of one's racial ethnic group,³¹¹ has been conceptualized as a large contributor to both chronic prenatal and lifetime stress, leading to preterm birth and low birth weight. Stress can easily trigger biological processes that affect health, and black communities tend to experience this stress at significantly higher levels than white communities. Fleda Mask Jackson, a researcher focusing on birth outcomes for middle-class black women, says:

It's chronic stress that just happens all the time – there is never a period where there's rest from it. It's everywhere; it's in the air; it's just affecting everything. It's the experience of having to work harder than anybody else just to get equal pay and equal respect. It's being followed around when you're shopping at a nice store, or being stopped by the police when you're driving in a nice neighborhood.³¹²

The experiences of stress may be minute individually but aggregate tremendously over a lifetime. Even women with higher educational or professional status experience this stress, as they often operate in social environments that are underpopulated by people of color, and thus have contact with people less likely to understand the dangers of microaggressions. Black women often experience discrimination in interviewing, hiring, job placement, and salary

negotiations. Once hired, they are often forced to work harder and have more qualifications than their white counterparts to maintain their professional positions.³¹³ This is likely compounded when pregnant, a time during which stereotypes of sexuality and motherhood may infiltrate and produce anxiety regarding others' perceptions of them as less capable.³¹⁴ An awareness of society's racism surely worsens this stress, particularly during an era of extreme police brutality and hatred against black and brown people. One CPM communicated this sentiment:

I just had this woman today. Pregnant with a black boy. [long pause, deep breath] I can't imagine. Look at the state of black boys in this area. You know what I am talking about...jail, discrimination, violence, no father, bad schools. And her high blood pressure is through the roof. No wonder. It's more than just diet and exercise. We are bad at that but that is another problem. It's...you know...something at our core. In our cells. In our genes. Her mama had these kinds of worries in the womb, too. And her mama. And her mama. This goes way back. From our ancestors. I believe that.³¹⁵

Fear exists not only for themselves, but for their unborn children, in entering a racist society bound to spout discrimination.

This conceptualization of stress stemming from racism was termed in the early 1990s by public health scholar Arline Geronimus as the “weathering” hypothesis, positing that the “stress inherent in living in a race-conscious society that stigmatizes and disadvantages blacks may cause disproportionate physiological deterioration.”³¹⁶ This theory expands from neuroendocrinologist Bruce McEwen's theoretical framework of allostatic load, which understands allostasis to be “achieving stability through change.”³¹⁷ McEwen claims that even through stress, organisms are able to adjust dynamically to both expected and unexpected events, and that physiologic systems interact to protect the body from stressors. However, the ultimate physiologic result from constant response to these stressors in the sympathetic and parasympathetic nervous systems creates a disequilibrium. This imbalance is known as the allostatic load, otherwise understood as the “wear and tear” on the body following a chronic period of stress.³¹⁸ Following this principle, it has been determined that even when controlling

for socioeconomic and educational status, black women have the highest allostatic load scores in comparison to white women and black men.³¹⁹ This “gendered racism” is uniquely inhabited by black women oppressed by both their gendered and racial identities, and stimulates a larger intensity of psychological distress than encountered from inhabiting simply one of these identities.³²⁰

The weathering of black women’s bodies causes susceptibility to poor health, with impacts seen explicitly in biological changes.³²¹ Geronimus’ research even indicates that weathering accelerates aging at the molecular level. Telomeres, which are chromosomal markers of aging, were shown to be 7.5 years older for black women in their 40s and 50s than for white women of the same ages.³²² As shortening during cell division occurs until a point of instability is reached and the cell dies, telomeres indicate age in the sense that their length is inversely related to age – the older the person, the shorter their telomeres. However, because DNA helix tears caused by oxidative stress are not easily repaired in telomeres, oxidative stress has become a predictor for telomere shortening.³²³ Stress biomarkers such as cortisol, epinephrine, and norepinephrine have also been found to be associated with shorter telomeres, as have several chronic diseases such as hypertension, diabetes, atherosclerosis, and cirrhosis, as well as mortality.³²⁴ This indicates that although a woman’s 20s and 30s have previously been conceptualized as the “prime” childbearing years, the weathering that black women experience present a risk to even younger childbearing ages because their bodies operate as if they were 7.5 years older. One researcher posits that “as women get older, birth outcomes get worse. If that happens in the 40s for white women, it actually starts to happen for African-American women in their 30s.”³²⁵ With higher risks of pre-eclampsia and pregnancy-induced hypertension, for example, this can be incredibly dangerous.

The stress black women experience is recognizable in other biological processes as well. Research has shown that frequent anxiety, insecurity, and lack of control over environment is correlated to increased blood glucocorticosteroid levels and blood pressure, leading to cardiac and immune effects.³²⁶ The primary response system is designed to handle stress by activating the sympathetic nervous system and the “fight-or-flight” response. Cortisol levels increase as a result of hypothalamic-pituitary-adrenal (HPA) axis activation, “reigning in” these actions.³²⁷ However, after constant activation of these systems due to chronic stress, the body’s responses become inefficient. An increase in inflammation and oxidative stress in turn exacerbates future risk of cardiovascular, immune, and metabolic dysfunction. Women with higher levels of stress hormones corticotrophin-releasing hormone (CRH), adrenocorticotropin hormone (ACTH), and cortisol are at highest risk for preterm birth.³²⁸ At high levels, these hormones can even affect fetal development, growth, and the timing of birth.³²⁹ The allostatic load accelerates biological processes that would typically take place over an extended period of time, instead concentrating bodily deterioration during prime childbearing time for black women.

Additionally, these impacts of stress due to discrimination and systemic racism are not limited solely to black women of lower socioeconomic class. Just a year and a half ago, world tennis star Serena Williams gave birth to her first child via cesarean section, though not without complications. The day after the surgery, Williams experienced a pulmonary embolism – a blood clot was blocking an artery in her lung. Although she and her medical team were aware of her history of this disorder, she said that her medical practitioners ignored her symptomatic concerns. Even though she had urged her physicians to monitor her condition, she received treatment, last-minute only, later to enter a coughing fit induced by the embolism, causing her cesarean wound to rupture. Upon this second surgery, her physicians found a large hematoma, or

pool of blood, in her abdomen. For the first six weeks of her newborn's life, she was bedridden in recovery.³³⁰ Even one of the most well-known, most economically stable black women failed to receive quality healthcare during her delivery.

Avoiding Biopower and Instating Womanly Autonomy

The control that contemporary hospitalized birthing practices wield over vulnerable laboring women aligns with the notion of biopower, a term conceptualized by philosopher Michel Foucault. Defined as the domination an establishment holds over another's body in order to define, control, and subjugate populations,³³¹ Foucault suggests that the technological surveillance which processes mortality rates, reproduction rates, longevity, and the fertility of a population, for example, is often used to control biology and target particular populations. The overmedicalization of reproductive life transforms natural aspects of procreation into abnormal medical conditions that require utmost attention. It is "essentially a right of seizure: of things, time, bodies, and ultimately life itself,"³³² says Foucault, operating through prohibition, repression, and taking life away.

In the US, these patterns of biopower originated in early America practically as soon as the first enslaved people arrived. In fact, the "Father of American Gynecology," Marion J. Sims, profited solely from black women's bodies. The medical bondage of enslaved women in the mid-19th century enabled him to repeatedly operate on 12 enslaved women, even performing surgery on a single woman a total of 29 times.³³³ Meanwhile, he refused to conduct surgical experiments on his white clients. This was not simply an anomaly of one physician's wrongdoings, however. Physicians Paul Eve and Charles Meigs, for example, removed an enslaved woman's uterus without her consent and failed to explain the repercussion, eventually putting the organ on display even after her death.³³⁴ Ephraim McDowell (the Father of the Ovariectomy), John Peter

Mettauer (the first American physician to perform a successful plastic surgery), and François Marie Prevost (the Father of the Cesarean Section) also earned their fame by profiting off the non-consensual use of black women's bodies.³³⁵ As enslaved people, these women did not own their bodies, were not able to leave at will, and could not seek medical treatment after surgical complications. They were often subjected to more painful procedures and were placed in more vulnerable positions than white women of the time would have ever endured. For example, by openly and publicly operating on nude black women, physicians made it clear that the white male gaze fell on these bodies as objects. By subjecting these women to countless procedures that compromised their health, physicians asserted the existence of a "medical superboddy"³³⁶ that relegated black women as "other" and able to withstand the brutal effects of pain. Anthropologist Gertrude Fraser says:

Black women of the time came to represent a repugnant anomaly, a kind of woman who shared the basic biology of white women but who, by virtue of her lower position on the evolutionary scale, was coarse, immoral, lacking in intellect, sexually promiscuous, and well-suited for hard and intensive physical labor.³³⁷

Thus, while their bodies were framed as the models for pioneering gynecological techniques that essentially were to benefit white women's health, conflicting messages about their character and intelligence defined them as inferior.³³⁸ While white physicians gained respect and recognition from their "accomplishments," the enslaved patients were not acknowledged for their contributions. They continued their plantation work without the presence of fathers, nursing their babies while healing their scars born throughout experimentation. As legal scholar Dorothy Roberts says in her book *Killing the Black Body*, "Black women's activism always lied in the struggle to control their own bodies."³³⁹ This necessity began during slavery and continues today.

Although the biopower held over black women's bodies began during initial colonization of the US, it continued in various forms throughout American history. The sexual abuse of women during slavery,³⁴⁰ the involuntary sterilizations that were conducted in the deep south during the 1920s and 1930s,³⁴¹ the non-consensual removal of Henrietta Lacks' cancer cells for the purpose of profitable medical research in the 1950s,³⁴² the regulation of black births via coercive dispensation of birth control in the 1980s,³⁴³ and the recent federal funding cuts to Planned Parenthood – which serves significant numbers of lower-income women³⁴⁴ – are all examples of this.

Perhaps most horrifically direct and currently ongoing, this biopower can be seen in the horrendous amounts of non-consensual sterilizations performed on black women. Sterilization became the most rapidly growing method of birth control in America in the 1970s, increasing from 200,000 cases to more than 700,000 within a ten-year span. Teaching hospitals performed hysterectomies on poor black women to both earn larger incomes (a hysterectomy provided \$800 in revenue in 1975, compared to \$250 for a tubal ligation) and practice their medical technique skills.³⁴⁵ In 1970, approximately one fifth of all black American women were sterilized, and by 1983, black women in the US constituted 43% of all American women sterilized by federally funded programs.³⁴⁶ This violation of bodily autonomy became regular among American physicians; Foucault's concept of biopower was ravaging medical establishments in order to wield control and serve a single interest – their own. Black women had every right to fear subjugating their bodies to a medical system that did not have their best interests at hand.

The exertion of this biopower can be seen today as well. Physicians tend to see themselves as the ones in control rather than practicing shared decision-making with expectant mothers. This holds true even more so for women on Medicaid, which “manages an intrusion

into women's private lives and produces pregnancy as an opportunity for state supervision, management, and regulation of poor, otherwise uninsured women."³⁴⁷ Women on Medicaid are often required to undergo many more tests and procedures than those with private insurance. For example, Medicaid demands urine testing for glucose and albumin at each visit, a Group B streptococcus culture at 35-37 weeks, weight checks at every visit, an internal ultrasound between 12 and 24 weeks to identify all fetal anatomy and amniotic fluid levels, vaccinations against Hepatitis B and screening for Tuberculosis, and repeat STD testing.³⁴⁸ Though purported as helpful, this medicalization of poverty teaches women that they are the possessors of "unruly bodies"³⁴⁹ over which they have minimal control. With all decisions are made by the medical establishment, women are unable to assert their preferences. Though arguably less extreme, this mirrors the lack of bodily autonomy experienced by enslaved women and women of color throughout American history. Moving forward, caution must be taken to ensure that bodily autonomy is returned to birthing women, especially to black birthing women whose bodies have historically been manipulated.

Technological Transformation

This concept of biopower can also be applied when considering how the technologization of birth has undermined bodily independence, autonomy, and self-awareness. Prior to the introduction of technology that enabled rapid diagnosis and constant monitoring, pregnancy and the knowledge of its arrival existed purely from sensation. Now, it can only be confirmed by a professional; a woman's sense of pregnancy is typically not solidified until the physician-administered pregnancy test comes back as positive.³⁵⁰ Similarly, the excitement gathered over ultrasound images brings joy despite knowledge that the fetus has been present the entire time – a physical depiction produced by technology often holds more meaning than sensation itself.

Birthing women have largely conformed to the ways of technology, but several also note the discomfort that has accompanied the disconnect from their bodies. One woman shared this:

The first time we heard the heartbeat I wasn't as excited as my husband, and I couldn't figure out why I wasn't excited, and then I finally realized that the reason I wasn't is because my doctor gave me the heartbeat. It's like he took it away from me because he said, "here's the heartbeat." I mean, he is the one who arranged that I could hear it, and I sort of felt like, well, this is my baby's heartbeat, but I can't hear it unless he does it for me. Maybe I'm a real independent person or something, but I felt funny that we had to rely on him. I wanted to do it by myself.³⁵¹

Though she wanted to connect with her baby, she felt unsettled that technology was the only way in which she could do so. Other women describe similar disconnects when delivering their babies as well:

I asked for an epidural, not knowing that I was actually in transition and nearly fully dilated. At six o'clock I was ready to push, but with the epidural I couldn't feel the urge; we had to watch the monitor to know when to push.³⁵²

As soon as I got hooked up to the monitor, all everyone did was stare at it. The nurses didn't even look at me anymore when they came into the room -- they went straight to the monitor. I got the weirdest feeling that *it* was having the baby, not me.³⁵³

The culture of medicalized and technologized birth does not consider the body to be necessarily involved, but rather prioritizes the insight technology can lend to biological processes. The mother becomes conceptually separated from her baby and is forced to allow technology to intercept. Though resistance to this is possible, the ability to resist and decline technological intervention is, of course, challenged by race and class. As this chapter has emphasized, the resistance against authorities of power, and thereby intervention, is multifold for black women, particularly for those of lower socioeconomic status.

This can be framed within the concept of technological determinism, which posits that a society's technology determines the development of its cultural values and social structure. Childbirth has existed for as long as humanity has existed, but only recently has it become medicalized and technology-driven. This is true for America's history as well, as exemplified

throughout the first chapter of this thesis. The contemporary practice of giving birth in a hospital surrounded by the possibility of technological intervention has led us to what political theorist Langdon Winner terms “technological somnambulism;”³⁵⁴ we have failed to question the motivation and necessity of innovative solutions and instead take their presence for granted without examining their true origin and use. Winner suggests that technology is embedded with artefacts and politics, and that its market-driven nature alters our own interactions within society. There is no linear description of these interactions, but rather an original motive that causes unintended consequences that impact society.

For example, technology in the birthing world was primarily introduced to benefit mothers and babies by addressing the exorbitant mortality rates that could have been otherwise unavoidable. This began with forceps, hemorrhaging medication, and the development of cesarean section techniques. However, as physicians recognized that this technology was their key into the obstetrical world, the technological options expanded, providing methods by which doctors could promote health while furthering their reputations and earning generous salaries. Hospitals quickly grew to adopt business models, and large-scale professional organizations provided institutional support. This expanded until hospital birthing rates reached 99% and cesarean rates reached 33%, proving technologized birth to be the expectation.

The misconception that technology can automatically produce a better humanity³⁵⁵ hides the power dynamics growing from a history embedded in politics hoping to best serve men’s education, subjugate women’s bodies, and uplift medical institutions. Although the technology was designed with a beneficial motive in mind, it has surely evolved and extended to cause unintended consequences reinforcing the very problems it was created to avoid.

Today, those harmed most by this technology in conjunction with the systemic racism of our society are black women. Their pain and voices cannot be side swept in these discussions, and it must be recognized that the immediate needs and interests of this technology's creation have been transformed due to deeper cultural, intellectual, and economic origins. The culture of power and dependency must be shifted in order to best serve pregnant black mothers and support them through a time in which they can regain their agency while improving health measures. The following and final chapter will explore how the utilization of midwifery can return political power to black women and best support their needs.

Chapter Five: Changing Movements to Promote Equity in Midwifery

The lack of diverse racial representation in midwifery points to the myriad issues carried forward from the Sheppard-Towner time period. The changes necessary to overcome the norms engrained in American birth culture originating from this era prove to be enormous, but not insurmountable. While the previous chapters focused on the root causes for lack of racial diversity among midwifery clientele, this final chapter aims to highlight the possibility for transformation of clientele demographics to best serve black women and families. I choose to conclude with this chapter purposefully – academia far too often victimizes black women, warping their stories into ones centering pain and oppression. Although these facets are part of their experiences, it does little justice to make them central to black women’s narratives. Rather, justice can be reached by placing a focus on what black women have done for themselves and how their everlasting strength and growth are key to self-empowerment. Reflecting this, chapter five both examines recommended paths to success and shares accomplishments by women of color groups that have promoted equity in midwifery. Though this in no way discounts the devastating consequences of racist atrocities committed against black women, it foregrounds black women’s activism.

Support for Midwives of Color: Funding, Scholarships, and Safe Spaces

In order to address the lack of black women working in midwifery circles, financial programs can be established to support their enrollment in professional schools. Such funding via loan repayment programs and scholarships can ease the financial burden on students unable to pay tuition, thereby opening up opportunities for less affluent individuals. This financial aid can be extended to support training programs, local organizations, and the needs of black midwifery groups.

One such group, The Birth Justice Fund, has developed initiatives to finance individuals, organizations, and communities working to address disparities in birthing care.³⁵⁶ Partnered with over 25 organizations, The Birth Justice Fund especially supports efforts utilizing the midwifery model of care. For example, Ancient Song Doula Services (ASDS) received \$25,000 in 2018, which they utilized to continue their Doula Training Program that provides prenatal, postpartum, lactation support and counseling to incarcerated parents in Rikers Island – the second largest jail in the US.³⁵⁷ Focusing specifically on women of color, trans, and gender non-conforming people of color, ASDS trained 80 new doulas, 25 of which received full scholarships. This amount of funding also enables parents to access low-cost services both in and out of hospitals. Similarly, the International Center for Traditional Childbearing (ICTC) received \$35,000 in 2018, with which it bolstered its organizational development, infrastructure, and board development, as well as supported midwives and doulas of color.³⁵⁸ Mamatoto Village is another such organization that received \$30,000 through The Birth Justice Fund to provide perinatal community health worker trainings supporting free and low-cost maternity services for families of color throughout the first year of a newborn's life. Finally, funding was also granted to Sista Midwife Productions and Uzazi Village to promote doula trainings specifically for black birth workers, as well as to provide individualized support for local women of color striving to fulfil their roles as maternity navigators for those on Medicaid.

Loan repayment programs also cushion the financial burden midwives often experience following completion of their degree. Certified Professional Midwives (CPMs), in particular, have little access to loan repayment programs, consequently barring midwives without financial means from participating in out-of-hospital births. Conversely, CNMs are eligible to receive \$30,000-\$50,000 toward loan repayment in exchange for a two-year service commitment to

underprivileged communities through the National Health Service Corps (NHSC) program.³⁵⁹

This financial advantage is in part responsible for the disproportionate draw of birth workers to CNM schooling rather than CPM schooling. Extending loan repayment programs to CPMs would undoubtedly diversify the demographics of midwives attending to home birth, birth center delivery, and postpartum care.

The creation of “safe spaces” for black midwives may also foster supportive working environments that promote the day-to-day inherently revolutionary work necessary to prioritize communities of color. This might look like encouraging apprenticeships among black midwives and black midwifery students, centering the importance of traditional African traditions, or holding affinity space trainings specifically for black women and families. Additionally, encouraging a variety of birth work professionals such as lactation consultants, doulas, and postpartum workers to join forces within these spaces may prove to be beneficial. Together, these initiatives could significantly improve accessibility to out-of-hospital birth work for black midwives.

Promoting a Comfortable Environment for Black Clients

In addition to encouraging black women to enter the midwifery work sphere, the harm historically perpetuated against black midwives must be addressed. As previously explored, the persecution of grand midwives has contributed to the lack of racial diversity in the profession today, and the first step in overcoming this harm is to explicitly address its effects. It must be acknowledged that midwives today stand on the shoulders of black women from the past – those who first practiced midwifery, as well as those who fought for reproductive justice as we know it today.

A myth-history of midwifery's background is often told in predominantly white circles; these narratives are infuriatingly easy to slip into and necessary to avoid. This became starkly obvious to me when I attended the Midwives Alliance of North America (MANA) annual conference in 2018. Held in Portland, Maine, the conference's attendees were predominantly white, and few workshops explicitly addressed the racial disparities in health outcomes for black women. For me, the conference culminated when Jill Breen – a middle-aged white woman – was called on stage to accept her Sage Femme award designating her as a beacon of inspiration. As she accepted her award, however, she referred to herself as a grand midwife without acknowledging the history and accomplishments of her predecessors – despite her white identity. Because I had been researching the persecution of grand midwives at the time, my understanding of this statement's weight was enormous, and I looked around the full room to read other people's reactions: while some reacted with disappointment, the audience was largely indifferent. Though Breen was able to conclude her speech, a white audience member stood up before she could step off the stage. "This is *not* okay, one of my students just ran out of the room crying," she exclaimed. This became the start of a two-hour long moderated conversation that explored emotional reactions and the necessity for mitigating harm in these circles. Although making space for this conversation was uncomfortable for some and painful for others, it ultimately fostered a sense of community and signaled strongly that justice work needs to be pursued relentlessly.

If black families are to be equitably and appropriately cared for, the creation of a comfortable patient environment is integral. Because an understanding of implicit biases cannot develop overnight, midwives must be willing to devote their time and energy to this work. Through a series of trainings, workshops, and conferences, birth workers can become engaged in

acknowledging how their identities influence interactions with families of different identities. Online sources from Harvard and Beyond Whiteness, for example, provide people with opportunities to test their own implicit bias tendencies and watch videos to understand how to overcome them.³⁶⁰ More specific training can be acquired through the Speaking Race to Power Fellowship, which supports organizations who wish to “develop generative ways of breaking through the current bottlenecks of race and power in the reproductive health, rights, and justice movement,”³⁶¹ or through trainings from other women of color-centered organizations such as SisterSong.³⁶² Lastly, the horrendous health disparities between women giving birth must be recognized. Without an awareness of the facts, there can be no action. Hosting conferences and distributing educational material within predominantly white midwifery circles may help to address some of these concerns.

Policy Changes: Mortality Review Boards and Insurance Accessibility

In addition to these aforementioned shifts in midwifery spheres, the implementation of policy is necessary to produce structural and systemic change. Many activists have advocated for changes in the law to protect black birthing women, with Charles Johnson being perhaps the latest accomplished activist contributing to this work. His wife, Kyira “Kira” Dixon Johnson, passed away after a preventable series of events unfolded while multiple physicians ignored the urgency of her postpartum hemorrhaging.³⁶³ Heartbroken after this outrageous experience, Johnson advocated for legislation supporting the expansion of mortality review boards; in 2017, H.R.1318 passed, directing the Department of Health and Human Services (HHS) to establish a program monitoring pregnancy-related deaths.³⁶⁴ Under this legislation, cases of maternal mortality are thoroughly investigated to understand root causes and thereby develop comprehensive strategies to avoid future deaths.³⁶⁵ Strategies aim to utilize research specific to

racial and ethnic health disparities by taking a location-specific lens. Though individual states have previously taken this successful approach in preventing morbidity and mortality,³⁶⁶ this nation-wide approach has been significantly more far-reaching.

Several other initiatives have moved along with similar ideals and progress. *The Uncesarean* and the International Cesarean Awareness Network have been powerful advocates for policies enabling women to refuse cesareans, while Black Women DO VBAC! has engaged in activism to let black women know their rights in advocating for vaginal birth after cesarean section.³⁶⁷ With lobbying and legislative effort, ICTC and the Oregon Coalition to Improve Birth Outcomes passed an Oregon bill that allowed Medicaid reimbursement for doula care. Although the US generally lacks a sufficient legal framework protecting black women in healthcare,³⁶⁸ these efforts have shown significant decreases in disparities. The key to change is working towards a human rights-based organizing approach, and away from an individualistic approach that overlooks the multitudinous social, sexual, economic, and cultural rights reflecting community needs. Through community involvement via letter-writing and postcard campaigns, rallies, legislative briefings, voter education, and voter registration, we can begin to move towards large-scale change that engages community members on both a personal and wide-reaching level.³⁶⁹

Lastly, legislative policy must expand to include the fight for comprehensive insurance accessibility. Governments must ensure that, after becoming pregnant, women covered by Medicaid have access to their plans while their applications are still pending, as well as during the post-partum period. These restrictions should be lifted immediately to better serve families unable to access equitable care. If out-of-hospital birth is to become a viable option for families, it must be financially affordable. Not only would an expansion of insurance accessibility

improve health outcomes, it would also be economically beneficial; in Washington State, one of the first states to reimburse CPMs under Medicaid, Medicaid saved \$3.1 million.³⁷⁰

Integration Among Healthcare Providers: Public Awareness & a Middle Ground

The final recommendation presented in this chapter encourages the integration of woman-centered care among all types of healthcare providers. More productive collaboration between midwives and OB/GYNs, in particular, may significantly improve birth outcomes for black women. Studies have shown that high-quality maternity care requires interprofessional teamwork.³⁷¹ Coordinating care allows the transition to be seamless among different providers, leaving no gaps in understanding if an emergency arises. Rather, poor communication, disagreement, and lack of clarity concerning provider roles have been documented as leading factors in poor birth outcomes.³⁷² Although midwives and OB/GYNs alike strive for the same outcome – a healthy mother and baby – differences in schooling often lead to contrasting definitions of risk. Collaboration, however, particularly when transferring from an out-of-hospital setting to a hospital, can be largely beneficial. For example, if a midwife can facilitate access to specialized hospital equipment, medications, or providers, her client has much more positive health indicators such as higher rates of physiologic birth, less obstetric intervention, and fewer adverse neonatal outcomes.³⁷³ Studies have shown this to be even more true for black mothers.³⁷⁴

This collaboration could take the form of apprenticeships or shadowing days, in which each provider could have the opportunity to learn the roles and knowledge of the other, promoting mutual respect and opening conversation for future partnership. Expansion of CPM credentials and legality in all 50 states would also encourage collaboration, as midwives would not experience the pressure and stigmatization that prevent them from asking for help. However, the expansion of CPM work can only occur once midwives are widely considered skilled and

valid maternity care providers. Therefore, an increase in research publications outside of midwifery journals (public health and social science journals, for example) may encourage public awareness and believability in the midwifery model of care.

Finally, this integration and collaborative support can take the form of finding a safe and comfortable middle-ground birthing location. Although perhaps not all physicians will agree with home birth, birth centers may be prime locations in which black birthing mothers can find a serene environment without the threat of intervention, while still having medical assistance if necessary. With this middle ground established, physicians might support midwives, thereby allowing a growth of clientele base through referrals rather than word-of-mouth “advertisements” on which midwifery practices typically rely. Undoubtedly, this professional support may allow for a more diversified clientele.

Models That Worked: The JJ Way, Other Success Stories, and More Recommendations

This last portion of this thesis examines models implemented by black midwives that have brought impactful change to their communities. These models have been successful by working directly with women of color to understand the critical issues needing attention. By practicing active listening and checking in with what was needed through community surveys, dialogues, and conferences, these groups excelled in centering the most marginalized.

The JJ Way

Perhaps the most spectacular model explicitly founded to address maternity health disparities for black women is Jennie Joseph’s Common Sense Childbirth Inc.³⁷⁵ Florida-based and British-trained midwife Jennie Joseph extended an arm of this non-profit organization by creating the National Perinatal Task Force (NPTF). A group of organizations and agencies

collaborating to improve maternal and infant health outcomes across the US with a grassroots model, the NPTF

fosters community-led initiatives that improve access to quality culturally-congruent health care and support services, connects women and families to practical resources, shares knowledge of best practices while supporting informed choice, empowers each pregnant person to have agency in all of their decisions regarding their self and their baby's health, and strengthens local community efforts to advance social and racial justice and create equity.³⁷⁶

By developing several Perinatal Safe Spots (PSS) across the country, this model has encouraged a network of virtual, geographic, and physical locations that provide judgement-free access to care and contact to resources. With over 31 PSS in the NPTF, many regions now have equitable healthcare options.

Most notable of the NPTF is a particular model of care developed by Jennie Joseph to improve maternal health disparities and identify specific areas of need. Termed “The JJ Way,” this model centers increased social and community support as a means of mitigating detrimental effects of racism-induced stress.³⁷⁷ Established with core principles in mind, the JJ Way has become well-known in midwifery circles aiming to center women and families of color, particularly black families. Freedom of choice, self-reliance, easy access, a team approach, connection creations, gap management, and education are listed as the model's key tenets, and specific tactics to produce change are outlined within each category.³⁷⁸ For example, the JJ Way encourages women to be involved in their own healthcare by carrying a mini health chart that ensures a continuity of care among various providers. The model also recognizes that every woman should be greeted warmly from the moment she enters the clinic; no person is turned away, regardless of financial situation or proximity to due date. Each staff member is involved in the continuity of care, from the receptionist greeting the women by name, to the office manager knowing each family's background – everyone is kept informed about the clients' situations.

Family members and friends are also included each step of the way, and peer educators share educational messages tailored to clients' specific understanding.

These techniques have enabled increased vigilance for risk factors, as well as better compliance with instructions and appointments, all while significantly reducing health disparities. Clients under the JJ Way benefit enormously from this model of care, as clarified in published statistical outcomes. Impressively concluded in a comprehensive study, clients' average gestation was shown to be 38.9 weeks, and over 95% of all births were of normal weight (above 5lbs. 8 oz.), with an average birthweight of 7 lbs. 7 oz.³⁷⁹ The JJ Way clients had a 25% cesarean section rate in this study, compared to a 37% rate for Orange County. Among black clients enrolled in one study, the preterm birth rate was lower for those receiving care the JJ Way (8.6%) than it was for other black clients in Orange County (13%), Florida (13.3%), and the nation (13%), as well as lower than the rates of their white counterparts in Orange County, Florida, and the nation (9%).³⁸⁰ These statistics display an erasure of racial disparity for preterm birth rates. Additionally, this model achieved a breastfeeding rate of 81% for black women. Even postpartum, 69% reported breastfeeding and 63% were using a form of birth control.³⁸¹ 98% said they would recommend this model to others, and the numbers speak for themselves. Lastly, it is essential to note that these outcomes all exist with over 48% of clients on Medicaid and over 42% with no insurance at all.³⁸² With great success, the JJ Way has uplifted the very communities that medical institutions tend to depress.

Other Success Stories

Although the JJ Way is one of the more far-reaching and established initiatives to decrease racial maternal health disparities, other organizations have contributed to the effort as well. The Groundswell Fund, for example, has played a large role in raising money for women of

color providers, organizers, and leaders advancing birth justice in America. Their establishment of the Birth Justice Fund mentioned earlier in this chapter has provided opportunities to the most holistic, empowered, interconnected, and community-based organizations. Ancient Song Doula Services, for example, provides free or low-cost perinatal care for communities with the highest levels of infant and maternal mortality while advocating for clients in hospital settings.³⁸³ The Birth Place Lab overlooks multi-disciplinary research and community-based participatory research that supports midwifery-based care. Headed by midwife Saraswathi Vedam, this organization coordinates evidentiary outcomes of racism on health disparities with policy-driven information dissemination.³⁸⁴ The National Association of Birth Centers and Clinics of Color (NABCCC) provides logistical and practical support to practitioners of color while providing mentoring, peer review, professional development training, and malpractice training so that communities of color have access to providers that look like them.³⁸⁵ Another community-based program by the name of One Hundred Intentional Acts of Kindness Toward a Pregnant Woman was developed by the Healthy African-American Families Project to encourage families, friends, and strangers to emotionally support local pregnant women.³⁸⁶ Other organizations such as the National Black Women's Health Project (NBWHP) and African American Women Evolving (AAWE) have strived to partner with historically black colleges and universities to introduce emotional wellness into health-related conversations.³⁸⁷

In addition to these visionary solutions spearheaded by women of color, national professional midwifery organizations such as MANA are also committed to addressing systemic issues within their own work. Though this effort should have existed since the conception of these organizations, their decision to become involved now shows growth. Recognizing the need for an Access and Equity Committee, MANA partnered with Elephant Circle – a grassroots,

consumer-based, non-profit group aimed at establishing a more diverse political grounding.³⁸⁸ Elephant Circle has concluded that because clients are most positively mobilized by their midwives, nurturing an alliance between providers and clients is necessary for political strength, loyalty, and passion. Nonetheless, though there is value in building inclusive community, activists of color often describe frustration while working within white spaces. Many organizations centering women of color have emphasized that perhaps working in the black community is, in itself, a large enough task. Several activists have expressed that rather than trying to make mainstream groups be more inclusive, efforts should be focused with an emphasis on coalition building amongst various identities.³⁸⁹

Lastly, although this chapter focuses on the work of larger organizations and efforts, it is essential to acknowledge that change happens on the smaller scale, too. The work carried out by black midwives across America is enormous, and each individual's work amounts to the changes that will gradually shift the birth culture of this nation. For example, Afua Hassan, the only black midwife in the greater Houston metro area, is one such midwife instilling great change in her community even without the backing of large-scale organizations. I briefly highlight her story as a beacon that serves to represent the magnificent work countless other women of color do individually. One client says about Afua:

She doesn't just ask the pregnant mom how often she's pooping—and she does do that, every damned time—she asks if the mom and dad are having sex, whether Grandma is on board with a home birth, how the divorce in the family is going, what the older sister thinks about all this.³⁹⁰

This communal approach engages her clients with a sense of family, ensuring that their comfort comes first and foremost. This is radical for black women, and Afua, along with many others, have made it their mission to continue providing welcoming spaces for self-empowerment.

More Recommendations

While the strategies proposed throughout this chapter may hold the most weight in broadening midwifery clientele demographics to better serve black women, there are countless other suggestions posed by a variety of policy-makers and organizations. CNM Kim J. Cox outlines a myriad of such recommendations, which I include in the appendix to serve as a comprehensive guide. As made clear from this list that highlights psychosocial, environmental, and community-level interventions, preventative care must be prioritized with effective solutions planned ahead of time. Nonetheless, it is essential to emphasize that no change can be made if the needs of the community at hand are not adequately considered. Checking in with context-specific demands while centering those most severely affected through community dialogues, surveys, and conferences ensures that appropriate needs will be met.

Conclusion

Grand midwives' legacy in the United States is one perceived in stark contrast to that of white midwives responsible for the profession's revival in the 1960s and 1970s. Though the roots of American midwifery are attributable to grand midwives, the legislative initiatives instated by the Sheppard-Towner Act effectively erased this narrative by rewriting grand midwives' efforts as inadequate and incomparable to the services of uprising physicians. The condescending training courses, race-specific propaganda targeting appearance for the sake of cleanliness, and birth registration rules tracking black families and eliminating non-literate midwives portray the differential treatment faced by black birthing providers of the Antebellum period.

Second-wave feminists advocating for midwifery's resurgence, on the other hand, saw attention and recognition at a national level. As this contrast became emphasized when several publications backed their fight with legitimacy, when boards and organizations supported their endeavors, and when funding met their financial needs, midwives of the counterculture effectively reconstructed American midwifery's narrative. The resurgence led primarily by white middle-class and wealthy women arguably shifted clientele demographics, failing to prioritize the needs of black birthing women. Barriers to racial diversity have been maintained since, due largely to prohibitive economic barriers, lack of midwife visibility, social norms, and a lack of midwives of color stemming from the regulation of grand midwives.

This lack of access, along with the disproportionate health disparities black women experience during pregnancy, birth, and the postpartum period, is becoming increasingly detrimental. However, because hospitalized, medicalized, and technologized birth does not necessarily support birthing women holistically, the technocratic model of care posits midwifery

as an empowering alternative. In order to increase access to this care while addressing rising maternal mortality rates, the numerous obstacles faced by black families must be acknowledged. With efforts to support midwives of color via funding and safe spaces, initiatives to create comfortable environments for black clients, legislation to address policies for mortality review boards and insurance accessibility, campaigns to increase integration among healthcare providers, and establishment of out-of-hospital options, this change can begin. The advocacy promoted by several women of color over the past decades has shown to be successful in these ways, and such initiatives must continue to flourish if black birthing women and their families are to flourish.

Furthermore, the midwifery model of care need not look exactly as it is presented in this thesis, but can take on a variety of forms that work best realistically for each given situation. For example, by incorporating a holistic approach to maternity care, providers such as OB/GYNs, doulas, nurses, lactation consultants, pediatricians, and community health workers can support birthing women under the midwifery model without necessarily being a midwife. Additionally, because a majority of women realistically give birth in hospitals, it is crucial that midwifery be incorporated into hospital settings in whatever way possible. Even those requiring severe medical intervention deserve the holistic components of midwifery-based care. Lastly, although this thesis presents the midwifery model of care as beneficial specifically for black women, it can similarly benefit other marginalized groups experiencing healthcare disparities such as trans men, indigenous women, and survivors of sexual assault, for example. Nonetheless, upon this model's extension, it is integral to recognize its roots and honor grand midwives' contributions originally in black communities.

Finally, I would like to close this thesis by acknowledging that a sense of sisterhood and social support drives this activism forward; none of it can be meaningful without love and care for one another. As African diaspora anthropologist and birth worker Haile Eshe Cole says about the movements she has been a part of:

at the root of this work was/is love. It was an attempt to create the just and loving world that we imagined, centered on self-care, healthy communities, self-determination, agency, empowerment, and autonomy. We acknowledged the significance and power of self-love and care. Our work centered on giving care, love, and support to one another while encouraging other women, a community of women, to empower themselves to do the same.³⁹¹

The strength stemming from community can be multiplied tenfold when people recognize just how many other women and families identify with their experiences. In sharing personal stories and making space for testimony, the dominant narrative of birth culture in the US – the white, middle class, hospitalized birth – gets turned upside down. Testimony of personal experience offers a full, unapologetic view of the speaker’s thoughts, identity, and lived experiences, allowing for the emergence of broader connections and truths to inform battles against systemic oppressions. Testimony offers expression for complexities, for multiplicities of identity and experience, thereby combating the erasure of difference that is all too common in modern dialogue.³⁹² The gaps between reality and academia become bridged for individuals who are traditionally excluded and marginalized from those spaces, allowing visibility and sustained conversation of these voices in unison.

With the creation of space for testimony comes the opportunity to imagine new models of community within birthing work. Imagination is the possibility to create alternative realities other than what we’ve been taught to be true, the chance to understand the inevitability for change and ponder what embodiments these futures might have. It’s the revelation that fighting for the future is necessary, and that sometimes this requires us to “get experimental.”³⁹³

Imagination for alternative models can be radical, operating most successfully in collaboration and in practice, rather than in theory. Although commonly perceived as abstract, imagination can also be precise – we *must* be more precise, delving “inch wide mile deep”³⁹⁴ into new possibilities for how this activism can be advanced. This comes with daily practice on a personal level as well as on a structural level; respect must be granted to the small shifting changes as well as the large ones, because change cannot happen overnight.

I will leave you with one last testimony from Kimberlee, a Certified Nurse Midwife who has attended to birth for the past 25 years. She says:

It's a beautiful and amazing experience. There is none like it...for a woman – not me, not a doctor – just her...to see her push whether in the hospital, at home or a center, to see her be the very first person to touch, hold and love on her baby...it's amazing and it is power. We, we black women, simply do not have many opportunities for power in in this world. You can have all the education in the world, but your power is not the same as a white woman's. But I have to believe, and my women tell me, that feeling, that sense of power in birth gives them a feeling of power they will have for the rest of their lives. And...it's an achievement, a unique experience for black women in our society. It's such an honor to bear witness to this.³⁹⁵

We are invited to celebrate the small victories, to gradually understand that there is no one correct path on which to move forward, but that chaos and uncertainty may be the only way to acknowledge that we can start where we are. Though modern midwifery is far from perfect, thriving in the chaos of it all and inching forward with progress while uplifting those most in need is the first step to change. As Kimberlee says, “It's such an honor to bear witness to this.”³⁹⁶

Appendix

Recommendations for Practice Interventions to Reduce Inequalities in Health³⁹⁷

Reducing Psychosocial Stress

- Ask the women in your practice what THEY think would most meet their needs
- Employ support staff from the neighborhood and/or cultural group
- Insist on face-to-face female interpreters
- Begin group prenatal care in your practice
- Address high stress levels by teaching simple relaxation techniques
- Inquire about sexual orientation, financial situation, housing, and significant relationships
- Assure that the mother has a support person for the birth
- Before the birth, discuss the need for a minimum of two postpartum visits
- Decorate the office setting with art and posters that match the population served
- Develop culturally relevant educational materials that suit the literacy level of the population

Environmental Interventions

- Inquire about working conditions, rest breaks, and leave time
- Be proactive about documenting the need for medical leave when appropriate
- Determine if the woman is exposed to household, workplace, or agricultural chemicals
- Provide testing for chemical exposures through the state environmental lab
- Educate all women about environmental chemical exposure
- Conduct a thorough nutritional assessment at the initial visit
- Provide culturally-specific dietary advice
- Encourage label-reading of food products
- Discourage fast foods by suggesting cheap, easy, at-home alternatives
- Inquire about cooking skills—many young women do not know how to cook!
- Know the resource groups in your location, such as shelters, emergency food sources, etc.

Community-Level Interventions

- Open a birth center in an underserved community
- Consider volunteering your services on a weekly or monthly basis
- Give a free talk in the community on a timely women's health issue
- Organize a new moms' support group at your health center
- Encourage women who successfully breastfeed to help women in their community
- Recruit a community leader to teach a culturally relevant cooking class

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