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Black midwifery in the United States: Past, present, and future

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Abstract

While sociologists have long explored health and illness, much of it has been androcentric and White-centered. Scholars began to focus more on women's health including pregnancy and birth in the 1970s yet have historically largely ignored Black women's birth experiences. Midwifery in the United States was once the standard practice for prenatal care and birth. However, the vast majority of births have been medicalized and now occur in hospital settings. In this review, I will highlight the role of race in the historical shifts in the provision of care to Black pregnant and birthing women, the marginalization of Black midwives historically and currently, medical racism, outcomes of laws in the 20th century, the voices of Black midwives and mothers, the activism of radical Black birth organizations and finally, how increasing access to midwifery care may help to address current racialized crises in maternal and infant mortality. Midwifery care typically leads to excellent physical and emotional outcomes for low-risk mothers and infants, and reduces reliance on medical interventions. As the United States currently has alarming racialized rates of maternal and infant mortality despite vast medicalization, there is much to consider about increasing access to midwifery care in the United States.

KEYWORDS
birth, birth justice, infant mortality, maternal mortality, medicalization, midwifery, race

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1 | INTRODUCTION

Infant and maternal mortality are often measures the overall health of a society (Reidpath & Allotey, 2003; Sajedinejad, Majdzadeh, Vedadhir, Tabatabaei, & Mohammad, 2015). Birth has long been medicalized in the United States and nearly 99% of births occur in hospitals (MacDorman, Matthews, & Declercq, 2014). Medicalization is when what were previously seen as natural phenomenon come to be defined as medical problems needing medical interventions (Conrad & Schneider, 1992). Conversely, in Sweden, Norway, France, and other European Union countries, midwives provide care to most low-risk women. Thus, while the United States spends more per capita on health care than any other nation (Papanicolas, Woskie, & Jha, 2018), the infant mortality rate[1] is higher than 19 Organization for Economic Cooperation and Development (OECD) countries (Thakrar, Forrest, Maltenfort, & Forrest, 2018) The US infant mortality rate was 5.8 per 1000 live births in 2017 (Murphy, Xu, Kochanek, & Arias, 2018).

There are stark racial disparities in infant mortality rates. Data from 2016 show that Black infant mortality is 11.4 per 1000 births which is similar to rates in 1915. The infant mortality rates for American-Indian/Alaska Natives are 9.4 and 7.4 for Native Hawaiians or other Pacific Islanders. Latinx, non-Hispanic White, and Asian-American infant mortality rates are all under 5 per 1000 (Goode & Rothman, 2017; Murphy et al., 2018). Overall, 10% of babies are born preterm and 8.28% of babies are born with low birth weight which are two causes of infant mortality in the United States (Centers for Disease Control and Prevention, 2019; Hamilton, Martin, Osterman, & Rossen, 2020). Again, these rates are also racialized and disproportionately affect infants of color.

Concomitantly, maternal mortality rates have increased since the late 1980s from roughly 7%–17% while maternal mortality has decreased in most OECD countries (Centers for Disease Control and Prevention, 2019; Lu, 2018) Black women in the United States are three to four times more likely to die from a pregnancy-related death than White women (Howell, 2018). These trends have increased over the last decade. Social conditions as a fundamental cause of disease are a classic theoretical explanation for health outcomes with an emphasis on access to resources (Link & Phelan, 1995). Thus, it is important to assess the racialized history and current landscape of midwifery care as increasing access for Black women may help to address disturbing birth outcomes in the United States.

2 | THE SHIFT FROM GRAND MIDWIVES TO OBSTETRICAL CARE

In order to understand how midwifery can help to address racialized birth outcomes in the 21st century, we need to address the history of Black midwives in the United States. During the colonial era and the antebellum period in the United States, all women practiced "social childbirth." Female relatives and friends supported birthing women and for White women of wealth, often included a hired midwife (for a comprehensive review of the history of midwifery in the United States see Wertz & Wertz, 1977). In the Deep South, African women who were enslaved attended births of not only other enslaved women but plantation mistresses as well (Goode & Rothman, 2017). They brought traditions from West Africa that led to a "new world healing culture" that gave a sense of community and humanity (Hays, 2016). These women were often older and deeply respected in their communities and frequently served as healers (Guerra-Reyes & Hamilton, 2016). While many had a spiritual "calling" to midwifery, they had to be accepted in slave quarters by demonstration of not only a calling but skills (Goode & Rothman, 2017). Due to their esteemed roles in their communities, many also participated in abolitionist activities suggesting Black midwifery has long been a means of social justice (Bonaparte, 2015, 2016). While these midwives have come to be known as "granny midwives," Goode and Rothman (2017) suggest the term "grand midwives" as granny does not reflect the vast knowledge of these midwives. Grand midwives served in the Deep South from the 1600s to the mid-1900s despite the professionalization of physicians (Yoder & Hardy, 2018).

With the emergence of the specialty of obstetrics in the 19th century and the growing power of the American Medical Association (AMA), White men vied for control of birth and began to push out midwives from practicing (Bonaparte, 2016; Reissman, 1983). Though most had little to no experience with birth, they brought a new social definition of childbirth as potentially dangerous and in need of technological intervention for “difficult” or “abnormal” births thus effectively medicalizing childbirth (Rothman, 2007). Much of the rhetoric about midwives was steeped in sexism, racism, and classism positing that women's intellect was inferior (Ehrenreich & English, 2010). Racist and classist campaigns portrayed midwives as dirty, ignorant, and symbolic of the “old ways” of countries of origin (Bonaparte, 2015; Rothman, 2007). The process of medicalizing childbirth by physicians had different consequences for White midwives versus grand midwives, in part due to beliefs about African-American people's health.

Medical science has long been steeped in racism (Hill, 2016). Discourse which was largely accepted for centuries, and arguably still today, purported that Black people were mentally and physically inferior to White people (Bridges, 2011). Conversely, enslaved women were thought to be “obstetrically hardy” and resilient which were effective theories to support slavery (Hill, 2016). Enslaved women were seen as able to handle pain better (Goode & Rothman, 2017; Weitz, 2010). Dr. Marion Sims, the “father of gynecology,” routinely performed vaginal surgeries without anesthesia on enslaved women for experiment (Hill, 2016). Grand midwives were seen as a necessary evil to provide care to rural Black and White women (Davis-Floyd, 2018). The continued rise of physicians' dominance of birth was further supported by emerging public health campaigns and legislation having consequences for grand midwives.

In the late 19th century, reformers, including White, middle class women, and progressive ideologies brought attention to infant and maternal health (Davis, 2019; Goode & Rothman, 2017). This movement led to the creation of the US Children's Bureau with the aim to “save babies.” State governments created social welfare programs and agencies to assist. However, Black babies were never truly a focus in the South. Indeed, many of these early reformers believed that grand midwives were incompetent (Goode & Rothman, 2017).

This movement led to the passage in 1921 of the Sheppard–Towner Maternity and Infancy Protection Act (STA) which further alienated grand midwives (Davis, 2019). This act provided states with federal monies to institute maternal and infant health programs. Among other components, the Act required midwives to be licensed and trained by nurses disenfranchising grand midwives especially. Mostly White public health nurses and nurse midwives supervised “lay” midwives, often grand midwives, especially in the rural South, where physicians had little interest (Craven & Glatzel, 2010; Goode & Rothman, 2017). These interactions were steeped in racism. Rural Black women and midwives were portrayed as infectious agents of disease. Whites nurses purported that midwives must be “clean and tidy” clearly connected to stereotypes about Black women (Goode & Rothman, 2017). Due to racist components of training under the STA as well as racialized discourse published in medical journals in the early 20th century about grand midwives, Black women and midwives were further marginalized (Bonaparte, 2015).

Several other factors contributed to the disenfranchisement of grand midwives and increasing rates of hospital births for Black women. Prominent organizations such as the National Association for the Advancement of Colored People did not defend midwifery and the sociologist and public figure, W.E. DuBois, supported hospital birth for Black mothers (Goode & Rothman, 2017). Increasingly, middle class Black women sought out hospital births as a symbol of their class privilege (Goode & Rothman, 2017). The passage of the Hill–Burton Act in 1946 also contributed to this shift to hospital births. The Hill–Burton Act provided funds to build hospitals and health clinics for the underserved but “separate but equal” facilities (Hill, 2016). The South received a preponderance of monies which led to more segregated facilities including in rural areas. As a result, more and more Black women in the South began birthing in hospitals by the 1940s and 1950s leading to the further demise of grand midwives.

While the presence of grand midwives waned in the 1940s and 1950s and many Black women birthed in hospitals, some White women were disenchanted with the medical model of managing birth especially due to experiences with anesthesia (twilight sleep) and emerging ideologies supportive of “natural childbirth,” such as the Lamaze method (Rothman, 2007; Wertz & Wertz, 1977). Tenets of the Lamaze method were the autonomy of

birthing women which especially appealed to middle class White women and the growing Women's rights movement that emphasized reclaiming the body.

In response to the re-emergence of a largely White midwifery community in the 1970s and early 1980s, some states (Arizona, Texas, and California) began to license midwives or revise older licensure laws, though these battles were often fraught (DeVries, 1996). Obstacles to the practice in Arizona included qualifying examinations written and graded by Certified Nurse Midwives (CNM) and often testing knowledge based on a medical model of birth (Sullivan & Weitz, 1984). Licensed midwives had to have backup care with a cooperative physician which was incredibly difficult to fulfill as most physicians had antagonism toward lay midwives and believed home birth was dangerous; beliefs continuing from the 19th century and still affecting midwives today, especially Black midwives. Shafia Monroe, a well-known Black midwife practicing since the 1970s, relayed an experience she had in the early 1990s while trying to establish backup care with a Black obstetrician. The doctor was not receptive: “Are you crazy? I'm against it. You know how long we fought to get in a hospital and now you're going to try to take us back out?” (quoted in Hays, 2016, p. 175). Her view harkens back to middle class Black women's desire to shift to hospital birth in the 1940s as a sign of equality and having “won the fight” for hospital births (Hays, 2016).

Concurrently, due to growing professionalism, midwives began to reject the label “lay midwifery” and embraced the more professional term, “direct entry” (Davis-Floyd, 2018). The American College of Nurse Midwives encouraged lay midwives to develop a formal organization. This dialogue led to the development of the Midwives Alliance of North America (MANA) and more formal tenets of the midwifery model (Davis-Floyd, 2018). MANA members began to organize for a voluntary national accreditation credential though there was concern about how this would affect their ability to practice the midwifery model of care. In 1994, the North American Registry of Midwives was formed and led to the credential called the Certified Professional Midwife (CPM; Davis-Floyd, 2018). Education requirements, written tests, attendance at a required amount of births, and conferences all helped establish legitimacy for CPMs and helped legislative efforts. However, not all midwives embraced these organizations. Many Black midwives felt alienated: “So often we come to these spaces and we don't have a space in which to share how we feel” (quoted in Davis, 2019, p. 173). Some midwives, regardless of race, also eschewed these organizations as they were disinterested in professionalism, commodification, and wanted to preserve their communities' beliefs and customs with birth (Davis-Floyd, 2006).

3 | CONTEMPORARY BLACK MIDWIFERY

Women choose to enter midwifery for myriad reasons which often cross racial and ethnic lines. Some midwives embrace a somewhat essentialist notion of women's bodies and speak of women's natural abilities to birth and as inherently nurturing caregivers. Others discuss their interest in midwifery due to feminism and conceptualizing medicine as patriarchal (Simonds, 2007). Black midwives especially focus on preserving longstanding African cultural traditions of birth within their community (Guerra-Reyes & Hamilton, 2016). Some express how dissatisfaction with their own births led to midwifery and they wanted to honor a woman-centered model of birth.

For Black midwives, this motivation is specifically grounded in racialized negative experiences with a medicalized model of birth (Davis, 2019). Many describe their interest in midwifery as their calling which is religious for some and more spiritual for others (Daviss, 2006; Guerra-Reyes & Hamilton, 2016; Simonds, 2007). Daviss (2006) suggests that whatever the motivating factors to enter midwifery, they all “stand with women.” Ultimately, “the essential career of the modern North American midwife is first and foremost that of social activist” (Daviss, 2006, p. 414). Likewise, while not all midwives identify as feminists, Simonds (2007, p. 127) states that “midwifery is, ideally, activist work.” For example, Cara, a Black midwife, interviewed by Davis (2019, p. 189) relays her views about her practice:

> When we think about medical care and race, we have to think about the relationship to the profit-driven medical industry. We have to think about the construct of race within a medical industry that is rooted in the preservation of cis, white, male, straight, able-bodied Christian concepts of wellness and existence.

Many Black midwives often explicitly mention a history of medical racism, their involvement in activism, and reproductive justice (Etienne, 2016; Guerra-Reyes & Hamilton, 2016).

When midwifery became professionalized in the late 20th and national organizations emerged, Black midwives often did not feel included in organizations such as MANA as there was not a focus on racial/ethnic reproductive justice (Daviss, 2006). Reproductive justice is, “a movement, reproductive justice seeks to identify racism and disparity where they exist and affect change” (Davis, 2019). Radical Black birth workers were and are actively engaged in work to address reproductive justice in Black communities (Davis, 2019). For example, in 1997, 16 women of color organizations founded the SisterSong Women of Color Reproductive Health Collective. This organization emerged from discussions amongst various women of color (WOC) activists who recognized the need to address reproductive health for women of color (Strickler & Simpson, 2017). SisterSong incorporates a human rights framework influence by Global Southern women. A plethora of other organizations exist including the Birthing Project, National Black Midwives Alliance, National Association to Advance Black Birth, National Birth Equity Collaborative, Sista Midwives Productions and the Sista Midwife Directory, Black Mamas Matter Alliance, Mama Glow, and more. These organizations often have similar goals: to raise awareness about health disparities in Black communities, to raise awareness about an array of birth options and support for these mothers, to fight racialized medicalization of Black women's bodies, to grow future Black midwives including financial support for students, to support legislative efforts, and to remember and celebrate the traditions of grand midwives. The discourse of these organizations, to decolonize birth for Black women, can be explored through accounts of the lived experiences of Black midwives in the 21st century (Davis, 2019). The voices of women of color doulas, people who offer labor support to birthing women, will also be included as there is overlap in ideology.

Black birth workers ground their work in a commitment to Black women, children, and communities (Etienne, 2016; Guerra-Reyes & Hamilton, 2016; Nash, 2019) Websites of self-described Black midwives include a sense of “urgency” in extending access to midwifery care to address racialized disparities in infant and maternal morbidity and mortality. Likewise, WOC doulas in Chicago interviewed by Nash (2019) also expressed a “pro-Black” orientation and when possible, chose to work with WOC clients. Both groups of birth workers focus on disseminating information geared toward Black/WOC mothers. Likewise, both doulas and midwives in these studies promote various birth options for women but embrace physiological also known as unmedicated birth (Guerra-Reyes & Hamilton, 2016; Nash, 2019). The midwives particularly try to destigmatize homebirth in the Black community. Nash (2019) notes how some of the WOC doulas encourage clients to birth at home to have autonomy and avoid medical racism. The WOC doulas she interviewed saw unmedicated birth as a way to “remake Black mothers and communities” (Nash, 2019, p. 43). While there are similar beliefs amongst Black midwives and WOC doulas, the setting of work affects their experiences.

While this review focuses on out of hospital birth, some Black CNM work in hospital settings. Etienne (2016) describes working in a large urban hospital serving mostly WOC. Similar to a large, urban hospital in New York, a few women going to these types of hospitals are aware of and seek midwifery care provided by CNM, however, many do not know that is an option (Bridges, 2011). Both Etienne (2016) and Bridges (2011) discuss the racialization of Black's women bodies as endemic relying on tropes of “high risk, wily, unruly, and yet also ignorant.” Etienne addresses the difficulty in balancing the hospital's high volume practice and offering low intervention birthing. She manages to still form long-lasting relationships and ties with these mothers despite the institutional constraints challenging pervasive stereotypes about Black women. While midwifery care privileges unmedicated birth, Etienne (2016), similar to the WOC doulas, supports mothers in making informed and autonomous choices about their births though some doulas describe medicalized birth as racialized obstetric violence (Nash, 2019).

WOC doulas may work for a doula agency or do solo WOC doula practice. Doulas who work in agencies have less choice, if any, about their clients. They often work with White privileged women. However, agency work provides steadier income. Solo practice allows for more intimate relationships with clients and meshes with the ideological view of transforming Black women's birth experiences (Nash, 2019). A young doula, Elfe, said, "People are not paying attention or concerned with young Black doulas and what we are doing. But I feel like we are shifting birth work" (Davis, 2019, p. 184.) Due to lack of institutional and public recognition and support, doulas often have to have other employment to make ends meet. Many WOC doulas work in community doula programs. Doulas often do not have livable wages working in community doula programs and are often seen as "volunteers." However, they like working with communities of color and women who would not likely have access to doula care. The experiences of these mothers must also be addressed.

There is more research about Black mothers' experiences in hospitals than out of hospital birth (Guerra-Reyes & Hamilton, 2016; Yoder & Hardy, 2018). We know that Black women suffer from higher abuse and racial discrimination in obstetrical care than White women (Rosenthal & Lobel, 2011; West & Bartkowski, 2019). Mothers may experience higher rates of coercion for interventions and lack of informed consent, yet may also wait longer to receive epidurals (West, 2019). Some Black women, including middle class women, are afraid to birth in hospitals. A mother interviewed by West and Bartkowski (2019, p. 9) said, "I know that for Black moms, you will never be treated like your White friends." Some women also see home birth as institutional resistance yet do not have this option (Bridges, 2011; West & Bartkowski, 2019). Low income WOC in the Bronx did say that some hospital staff were caring and empathetic but most reported feeling that they were seen as incompetent (Esposito, 1999).

Research with low income Black teen mothers found that most teens accept and welcomed formal obstetric care (Brubaker, 2007). For them, they felt engaging in this care was a means to decrease stigma of being a teen mom and show they were "good girls" to fight stereotypes about hypersexualization of Black women. Some enjoyed the access to ultrasounds, availability of pain management, and the support of a doctor's expertise in decision-making. However, these teen mothers were also subversive and not passive. Some report not following the prescribed diet or taking prenatal vitamins because they made them feel sick. Others were skeptical of epidurals and reported following their bodily intuition (Brubaker, 2007). It is important to consider then how offering midwifery services and out of hospital birth options may be perceived by teen girls.

Black mothers are not a homogenous group nor are Black midwives. Mothers describe varied, though mostly positive experiences with midwives. Black mothers from research in the Bronx as well as research in San Antonio compared their hospital experiences with midwives or obstetricians to out of hospital experiences at a birthing center or home (Esposito, 1999; West & Bartkowski, 2019). They especially appreciated the shorter wait time for appointments, the longer time spent with midwives, the inviting atmosphere, and feeling valued. Tara, a mother who had two out of hospital births described her relationship with midwives: "I feel like I almost have fallen in love with my midwives. They brought me my babies safely and they make sure to check up on me" (West & Bartkowski, 2019, p. 13). Women in both studies all said their out of hospital birthing experience was more enjoyable and private than their hospital births.

The mothers in the Bronx also liked the camaraderie with other mothers while socializing at the birthing center before and after appointments. Yoder and Hardy (2018) reviewed research about a program, Centering Pregnancy, a prenatal care model started in 1993, that gave women group care for those with close due dates. Similar to the mothers mentioned above, most Black women reported satisfaction with these program in terms of camaraderie, more information, less waiting time than at clinics, better relationships with providers, and improved healthy practices (Yoder & Hardy, 2018). However, Sharon Rising, the CNM who started the program, acknowledges that some Black women are guarded in group settings (Davis, 2019). Interestingly, the mothers in diverse age groups tended to be more engaged. The teens that participated in the program had higher rates of breastfeeding and use of birth control postpartum.

Another program via the Birthing Project, an organization started over 30 years ago, asks mentors to connect with young pregnant mentors and be her "sister" throughout pregnancy and the first year after birth (Davis, 2019).

The founder of the program, Kathryn Hall-Trujillo, describes the goals of the program to "make family" reflecting a collective history of Black community mutual aid and "other mothering" (Collins, 2000; Murphy-Geiss, Rosenfeld, & Foley, 2010). The program has been implemented in more than 100 communities across the globe. The mentorship of trained "big sisters" has shown to decrease preterm and low weight birth (Davis, 2019).

While midwifery care is often portrayed as diametrically opposed to obstetric care, there are still power dynamics at play. Some Black mothers discuss how their midwife did interventions such as amniotomies (artificial rupture of membranes) and even pushed one woman to have an unplanned home birth (West & Bartkowski, 2019). Another reported experiencing a traumatic cesarean section while under the care of CNM in a hospital. Some suggest that midwives operating in a hospital setting are more constrained in their practice due to institutional and structural limitations. It is worth noting that CNM make a good deal more money and have more regular hours than out of hospital midwives (Davis-Floyd, 2006; West & Bartkowski, 2019). West (2019) suggests that midwives do exert covert power with mothers though the mothers do contest and subvert power through methods such as sharing information about "bad" midwives with other Black women. However, most mothers interviewed greatly preferred midwifery care and experienced more pleasant birthing experiences. It is important to understand the tenets of midwifery care as well as birth outcomes to contextualize why some Black mothers prefer this type of care.

4 | SAFETY OUTCOMES OF MIDWIFERY CARE

The midwifery model or "wholistic" model of birth does not separate the mother and infant but sees them as an interdependent whole (Davis-Floyd, 2004). Pregnancy and birth are natural processes and intimate events and the mother decides her environment. Mothers are respected as having intuitive knowledge of their bodies and babies. Mothers are ideally the active agents in pregnancy and birth; midwives are there to nurture and empower the mother via technical skills and knowledge of birth (Davis-Floyd, 2004). Midwives "catch" babies versus "delivering" babies as they are the "professional guardians of natural birth" (Murphy-Geiss et al., 2010). Labor can take as long as it needs and pain is seen as acceptable and normal. Labor support via a "high touch" versus a "high tech" approach is the norm. If clients desire interventions, such as oxygen or herbs, or more high technology interventions at the hospital, informed consent is typically respected as it is a key tenet of woman-centered care (Davis-Floyd, 2006). Women are allowed movement, food, and position of birth. In short, the wholistic model is in many ways fundamentally at odds with the medical model which some see as hierarchical and authoritarian with a supervaluation of science and technology facilitating aggressive interventions. However, many physicians and midwives do not strictly endorse one model to the exclusion of the other (Davis-Floyd, 2004).

Unfortunately, much of the public and medical professionals believe that midwife attended home births are dangerous; methodologically sound empirical data suggest otherwise. While the American College of Obstetrics and Gynecology (ACOG) oppose home births, the American Public Health Association acknowledges home births as an option for low-risk mothers (Johnson & Daviss, 2005). Studying home birth is challenging as only 1.36% of births occur outside of hospitals, though this is the highest rate since 1975, yet not all are planned home births (MacDorman et al., 2014). Thus, research importantly must include only planned home births with a trained midwife as some studies include nonplanned homebirths, unskilled attendants, and high-risk women skewing results (Cheyney et al., 2014). The most recent study based on nearly 17,000 homebirths recorded by 432 CPM in the MANA database is illustrative. A majority paid for their care out of pocket. Over 93% of mothers had spontaneous vaginal births. The remaining births were 1.2% forceps/vacuum assisted births and 5.2% cesarean sections both occurring after hospital transfers. Ninety-two percent of newborns were full term and fewer than 1% were low birth weight (Cheyney et al., 2014). The rate of transfer to hospital was 10.9%, the majority of which were for failure to progress or desire for pain relief. Postpartum maternal transfers were 1.5%, and neonatal transfers were less than 1%. Intrapartum fetal death was 1.3 per 1000 including fatal congenital

anomalies. Mothers also had high rates of breastfeeding with 97% of newborns at least partially breastfeed at 6 weeks postpartum. In summary, low-risk home birth mothers have excellent outcomes with few transfers and low rates of technological intervention (Cheyney et al., 2014). However, the majority of mothers in the sample were White, middle class, college educated, and married which is a great limitation (Cheyney et al., 2014). Future research must assess safety outcomes specifically for Black mothers who have home births to address the limitation of this study.

In contrast, in 2017, 31.9% of all women in hospitals in the United States birthed via a cesarean section though importantly this includes low- and high-risk pregnancies; there are slight racial differences (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018). The World Health Organization posits that only 10%–15% of cesarean sections are medically necessary (World Health Organization, 2018). There are substantial risks associated with cesarean sections including risks for children such as asthma and obesity and risks for mothers especially regarding future pregnancies (Keag, Norman, & Stock, 2018). Seventy-one percent of women in hospitals use epidural analgesics during birth which increases the rate of cesarean sections by 2.5 compared to epidural use at less than 5% for home birth mothers (Butwick, Wong, & Guo, 2018; Cheyney et al., 2014; Goer, 2015). Thus, women who birth in hospitals have a much larger chance of experiencing technological interventions even for those who desire a physiological birth and this is exacerbated for Black mothers (Block, 2008; West & Bartkowski, 2019).

5 | CONCLUSION AND THE FUTURE

Black midwifery care provides an alternative to standardized, medicalized, and racialized hospital births. International health organizations, such as the World Health Organization, support increased access to midwifery care as does the American Public Health Association to improve infant and maternal outcomes, reduce use of unnecessary interventions, and for cost savings (Vedam et al., 2018). There are numerous explanations for racial discrepancies in infant and maternal morbidity and mortality including a lifetime of racial discrimination, wages, housing, and neighborhood contexts (Rosenthal & Lobel, 2011; Vedam et al., 2018). Black midwifery may be one solution for addressing health outcomes Black mothers and babies. There are several obstacles to increasing midwifery care by Black women for Black women including the continued medicalization of birth and opposition from medicine, the long history of discrimination toward grand midwives still affecting Black midwives today, medical racism, effects of legal decisions, and lack of strong institutional support for increased access via the state. There are several possible means to address some of these issues moving forward.

The ACOG issued a committee opinion regarding interventions in birth. They suggest delaying admission into hospital in early labor, allowing freedom of movement, emotional support, no coached pushing, and not timing labor (American College of Obstetrics and Gynecologists, 2019). This opinion lends some support to demedicalization of birth though institutional pressures and hospital culture may impede this (Block, 2008). However, it has the potential for change in obstetricians' beliefs about midwives and homebirths as some of the suggestions are tenets of the midwifery model which may facilitate friendlier relationships and collaboration with midwives.

The AMA has started to acknowledge the history of racism within the organization. They published a commentary based on the work of a writing group acknowledging the long history of discrimination toward Black physicians, "acknowledging our painful legacy" (Baker et al., 2008). There are conversations occurring in medicine about how to change curriculum in medical schools to address medical racism and social justice, "these curricula should involve giving students space and opportunities to examine personal bias critically in an effort to help close health disparities based on race" (Bakke et al., 2014, p. 443). In the wake of numerous events of police brutality and protests in the spring of 2020, the Board of Trustees of the AMA issued a pledge to address racism, "the AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care" (American Medical Association, 2020). They have committed to actively working to address racism in medicine. If this

discourse is incorporated into medical school and embraced by medical professionals, it could potentially start to mitigate medical racism toward Black midwives and mothers.

Addressing the privilege to choose home birth must be addressed. White women are two to four times more likely to have a home birth than women of color (MacDorman et al., 2014). In fact, 90%–95% of women who have homebirths in the United States are White (Johnson & Daviss, 2005). Considering the stark racial differences in infant and maternal morbidity and mortality, it appears that those who are most at risk have little access to midwifery care reflecting lack of resources and options as determinants of health outcomes (Link & Phelan, 1995).

One factor may be regional differences. Higher scores for integration of midwives in state care are associated with higher rates of physiological birth, significantly lower rates of interventions, lower preterm and low birth weight infants, lower neonatal mortality, and lower race specific neonatal mortality (Vedam et al., 2018). Midwives in states with low integration have less autonomy, less mothers using midwives, and more hostile relationships with the state and physicians. Low integration of midwives is linked to higher rates of neonatal death amongst all racial and ethnic groups (Vedam et al., 2018). Integration is lowest in states with a higher proportion of Black mothers which may be due to the long-term effects of the STA and the Hill–Burton Act, a history of discrimination toward Black midwives, medical racism, and lack of access to midwifery education. Institutional support by the state and acceptance from physicians could increase prevalence and integration of Black midwives in these areas.

Black mothers may have less access due to the ability to pay for their midwifery care. Out of hospital births are 50% self-pay, 29.4% private insurance, and 16.4% Medicaid (Vedam et al., 2018). Washington state has the highest integration of midwives and North Carolina the lowest (Vedam et al., 2018). Practicing midwifery is still illegal in North Carolina. It is not surprising Washington state has the highest levels of midwifery integration as Medicaid covers homebirth there. Strong consumer demand, changing state policies, and professional mobilization by midwives led to Medicaid coverage in the early 2000s (Hartley & Gasbarro, 2002). It should be noted that WA has less than 4% Blacks. In the South, only Arkansas and Florida provide Medicaid coverage for homebirths. Thus, fighting for Medicaid coverage in low integration states with large Black populations will prove challenging and will need mobilized consumer demand and institutional support from medicine and the state.

In conclusion, this review has demonstrated the vast changes in the shift from midwifery to obstetrical care, discrimination toward grand midwives, continued effects of medical racism, the consequences of laws, marginalization of Black midwives in some midwifery organizations, the prevalence and activism of radical black birth organizations, experiences of Black midwives and mothers, and the improved birth and maternal outcomes from midwifery care. The public, politicians, and physicians must listen to radical Black birth workers and mothers, first and foremost, about their lived experiences. Radical Black birth organizations' goals include raising awareness of various birth options for Black mothers, addressing the history of medical racism, increasing and supporting Black woman becoming midwives, and activism with medicine and especially the state. Society can increase support for birth justice by supporting and centering radical Black birth organizations. Some ways to do this can be via public pressure toward the health care industry and the state to implement changes for increased access to care via Medicaid and private insurance, increased funding for more Black midwives via local and state grants to Black birth organizations, and more broadly, actively demanding and working to change racism in the United States.

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ENDNOTE

[1] Infant mortality is defined as death before 1 year old.

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