Why Have You Chosen the Path of Midwifery?

The United States has the highest maternal mortality rate among industrialized (developed) countries. In 2020, the maternal mortality rate in the U.S. was 24 deaths per 100,000 live births — more than three times the rate in most other high-income countries. (In 2019 – 20 deaths; In 2018 – 17 deaths)

Birth is a gift. To share in the normal process of birth is a privilege. After many years assisting families with breastfeeding support and childbirth education, I was introduced to birth doula work. As I have supported women through the journey of pregnancy, birth, and the postpartum period, I have come to understand that there is so much more to caring for women than what we read in books. The most intuitive education is gained from watching the miracle of birth and all that comes with it in action. I regularly witness women not receiving accurate information or sound maternity care. Many women put sole trust in their doctors who, while they might be great physicians and surgeons, often have never seen a birth without medication or at least one intervention. This is a sad phenomenon, as the holistic care of women should be the very core of obstetrics.

Without false idealism, I realize much of the maternity care system is governed by commercialism; it is a business, and there are some levels of change I will not be capable of attaining. With the knowledge gained through midwifery studies and training however, I will touch as many lives as possible. I want to help families, and then communities see birth as wellness, not illness; a transitional period of growth in a woman's life that should be embraced, not suppressed or manipulated with drugs and unnecessary processes.

I do not see women in color; I see women as women. Our current, common medical model of birth fails many women regardless of race or nationality, but the numbers don't lie. Black women and babies are dying at higher rates than any other national group or race, and as modern medicine improves, the numbers decline year over year. We must accept that we live in a society where race, socioeconomic status, and other defining lines govern the care women receive, as well as their own perception of what that care should look like. As a Black woman, I have the opportunity to talk to women of my same race and similar nationalities on a level that they might not welcome others on. The statistics also support the fact that there are disparities in care among women of different races and nationalities. I chose midwifery because the numbers ***can*** be improved with good care, beginning long before birth. I hope to engage these affected women in the cause of improving outcomes for themselves – to actually ***participate*** in their care, not just act as passive recipients. I take pride in being a voice, an advocate, an example and support system for them.

CDC STATS on ethnic disparities:

Maternal Mortality (deaths per 100,000 women)

2018	***2019***	***2020***
White – 14.9	White – 17.9	White – 19.1
Hispanic – 11.8	Hispanic – 12.6	Hispanic – 18.2
Black – 37.3	Black – 44	Black – 55.3

1. Give brief history of African American midwives.

a. For African American Midwives, this role is a part of our heritage, a culture of our ancestors of hundreds of generations from across oceans, which survived the passage of slave trading, bringing with it the knowledge of birth and natural medicinal skills. In many African villages there was not just one specific woman who was known as the Midwife of her village. That is why it is difficult to find an African translation to the word midwife. Birthing was looked on as being women's work and older women who had given birth before assisted another during labor. Oftentimes it would simply be the birthing woman's mother or grandmother and other women to help. Only if there was difficulty would someone else be called in, usually the medicine man. Other than him, it was considered taboo for a man to be in the hut of a birthing mother (including the father). It wasn't until slavery around the 17th century, on the plantations, that women were appointed as midwives based on their knowledge and familiarity of woman craft. Even as recently as the mid-20th century, African-American midwives were caring for birthing families in Southern communities and receiving as little as $2 or $3 as payment; or sometimes just a chicken. With healthcare reforms in the early to mid 1900s, such as the Sheppard-Towner Act, many lay midwives of color were forced to stop providing these crucial services to their communities due to lack of access to, and money for the newly required medical schooling. Despite evidence that demonstrated better outcomes when midwives of color cared for women, traditional midwifery began to wane in the 1920s with the advent of obstetrics. Fast forward to recent years, and fortunately we are seeing an increase in midwifery among women of color from so many backgrounds and nationalities.

2. How can we and healthcare professionals implement changes to address socioeconomic and cultural barriers that contribute to the healthcare disparities in African Americans and other underserved populations?

a. We have to begin by closing the gap. Increase the level of cultural sensitivity among healthcare providers; recognize unfavorable socioeconomic and cultural barriers as a preexisting condition; improve the community surrounding African Americans & other patients of color; and increase the number of healthcare workers of color, i.e. midwives. Hugely important, we need to encourage more birth workers of color. The sad reality is that we live in a world where racism still thrives and affects birth outcomes and so much more. We can reach more women if more felt understood and as if their caregivers could intimately relate to their personal struggles and uniqueness.

New research findings from Boston Medical Center (BMC) show that women born in the United States have an increased risk of experiencing adverse perinatal outcomes. But among those giving birth who were born in the U.S., Black patients experienced a 22% higher prevalence of hypertensive disorders, 28% higher prevalence of preterm birth, and 83% increased prevalence of early preterm birth compared to White patients. To quote the National Partnership for Women and Families: Science is catching up to the truth communities of color have known for generations: that experiencing racism throughout one's life course damages one's long-term health.

3. What private and/or government funded programs are available to assist and educate women of color?

In researching, I came across several that are going strong such as:

a. National Birth Equity Collaborative – focused on removing barriers to reproductive justice

b. Sista Midwife Productions – based in New Orleans, they provide education, training and consultations for communities, birth workers and organizations that work with child bearing families

c. Black Mamas Matter Alliance - a Black women-led alliance that centered on advocacy, driving research, and shifting culture for Black maternal health, rights, and justice

These are wonderful initiatives, but I am concerned that right here in our own back yard, it seems that we are letting women down. I can only speak from my own personal experiences and firsthand accounts, but in the past 2 weeks alone I have witnessed or heard stories of women being given half truths about their care in order to be coerced into unnecessary inductions; or doctors who are too busy with heavy surgical schedules to give attention to women who have late pregnancy concerns. Concerns such as a breech baby that has a chance to be turned if only there exists a physician to perform the procedure. Concerns such as a pregnant woman escaping an abusive relationship who needs big-picture care; not just typical check-a-box care. Concerns such as a newly pregnant woman with a history of miscarriage who cannot find a doctor willing to see her before 14 weeks into her pregnancy because of tight schedules. Doctors are too busy, and women fall through the cracks. Concerns such as insurance that does not value midwifery and the right of a woman to choose how she gives birth. I could go on and on. Collaborative care between OBs and Midwives could solve many of these issues.

I was invited to be a guest on the panel of the Black Maternal Community Call to Action in May of 2022. There was an impressive line-up of community leaders as speakers who hold high positions in our city. However, the prevailing theme was moving in faster to fix the problems that black women face once they are in the hospital to give birth. It was as if we all have to accept that we are just sick, and thank goodness there are people dedicated to talking about it and maybe one day fixing it. There was zero focus on preventing the problems and supporting from a holistic, emotional, and mental level first; zero focus on us not being the "problem" in the first place, but rather the care and lack thereof is the root of the problem. It is just a fact that a woman's mental and emotional well-being plays a huge role in the health of her pregnancy. Prejudices exist within our race, and the poor outcomes can often be attributed to care from a caregiver of the same race. We need a proactive rather than reactive approach to care in our community. It is about autonomy and genuine freedom of choice.

4. Do you know of any Houston based community programs that support better birth outcomes in the Black community?

a. March of Dimes

b. University of Houston Healthy Start

5. Why do you feel discrimination is at the root of the problem?

a. Research suggests that stress induced by this discrimination plays a significant role in maternal and infant mortality. According to the CDC, data published in 2018 states the following: Per 100,000 deaths in the US, from the All Mothers group, 14 will die, White mothers, 12 will die, and from Black mothers, 43 will die.

b. Poverty and low socio-economic status is not the reason why. Racism is the reason why. We cannot stop the deaths until we have caregivers who can understand the needs of women who are subjected to this sad reality, and we need the women being cared for to truly feel understood – not just that their caregiver is not racist – they need to feel understood at a very basic, human level. Non-Hispanic Other Pacific Islanders, American Indian/Alaska Native women, Black women – all of these groups are 4 or more times more likely to not begin prenatal care until the 3rd trimester. We have to ask why. According to research, such as that done in part by University of Pennsylvania, patients report higher satisfaction from being able to choose caregivers of their same race and nationality. There is just a comfort level there, and even more notable when a woman is in the vulnerable state of pregnancy, and even MORE notable among women who are still to this day subjected to intimidation and misconstrued ideas about the care of our own bodies.

Characteristics of Mother

African American mothers were 2.3 times more likely than non-Hispanic white mothers to begin prenatal care in the 3rd trimester, or not receive prenatal care at all.

Percentage of mothers who received prenatal care (first trimester), 2019

Black	White	Black / White Ratio
67.6	82.8	0.8

Percentage of mothers who received late or no prenatal care, 2019

Black	White	Black / White Ratio
9.6	4.5	2.1

Percentage of mothers who smoked during pregnancy, 2019

Black	White	Black / White Ratio
4.8	8.8	0.5

6. How is maternal care impacting newborns?

While we have seen some minor improvement in the statistics, the numbers are still sad regarding infant mortality. The mortality rate for non-Hispanic black infants remains more than twice that of non-Hispanic white infants. Newborns whose mothers had no prenatal care are almost five times more likely to die than babies born to mothers who had early prenatal care. Often prenatal care is beyond the reach of many women because of lack of insurance, insurance restrictions, or other financial and educational barriers.

Infant Mortality (deaths per 1,000) – March of Dimes stats – ***BETTER NUMBERS***

2018	***2020***
White – 4.7	White – 4.4
Hispanic – 5.2	Hispanic – 4.7
Black – 10.9	Black – 10.4
Asian / Pacific Islander – 3.9	Asian / Pacific Islander – 3.1
American Indian / Alaska Native – 8.6	American Indian / Alaska Native – 7.7

Extra notes:

In 2011, The maternal mortality rate among non-Hispanic Black women (28.4 per 100,000 live births) was roughly 3 times the rates among non-Hispanic White and Hispanic women (10.5 and 8.9 per 100,000, respectively).

The U.S. maternal mortality rate has been on the rise since 2000 and has spiked in recent years. The COVID-19 pandemic challenged health systems across the world and may have played a role in limiting women's access to health care. Consistent with this finding, when looking at countries where maternal mortality data are available since 2018, we find the U.S. is not alone. The maternal death rate increased in six of the nine countries shown. It is yet to be seen whether this trend in maternal deaths continued throughout the pandemic.

The maternal mortality rate dropped in Australia, Japan, and the Netherlands, although there is currently insufficient research to understand which policy levers may have caused these decreases. ***Research has shown that in the Netherlands there was an increase in home births and vaginal deliveries and a decrease in cesarean sections (both planned and emergency) during the pandemic. These practices may have contributed to lowering maternal deaths.***

https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison#:~:text=In%202020%2C%20the%20maternal%20mortality,exceptionally%20high%20for%20Black%20women.

https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/