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Mitigating Maternal Mortality in Maryland
Integrating Midwives into State Medical System to Reduce Racial Disparity

This writing sample is my abbreviated version of a final 15-page graduate-level policy memo I wrote as a culmination of the Fall 2021 semester. Most relevant to ASPA NCAC's theme of social equity, the subject matter of this paper outlines the need for an expanded midwifery model of care to combat maternal mortality and its associated racial disparities in Maryland, as well as a reform plan providing incentives for a more diverse midwifery workforce through targeted recruitment initiatives.

To: Professor Mark Croatti
PLCY688E - Governance: Normative & Political Dimensions
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Part A: Problem Statement

More women die in the United States from pregnancy and childbirth-related causes than in any other developed country[1], despite the US spending more money per capita for maternity care than all other developed nations.[2]

Particularly troublesome is that at the state level, Maryland's maternal mortality ratio (MMR) has consistently exceeded the national average and demonstrated significant racial disparity.[3] MMR is measured by the number of maternal deaths per 100,000 live births, of which Maryland ranks 22nd in the nation for highest maternal mortality.[4] Maternal mortality is also an issue because of the large-scale preventability of lives lost. 80% of pregnancy-related deaths in Maryland were found to be preventable or potentially preventable if given more comprehensive care.[5]

Although Maryland has seen decreased MMR in the past few years compared to 2008-2012, a 2019 report by the state Department of Health revealed that this general decrease is actually the effect of decreased MMR among Whites, while Black MMR rose by 11.9%[6]—underscoring that the issue of maternal mortality in Maryland is distinct for its significant racial disparity. The average MMR for Black Marylanders was found to be four times that of White Marylanders.[7] This racial disparity endures even when controlled for income, level of education, and socioeconomic status.[8] Upper-class Black women with advanced degrees continue to be more likely to die from pregnancy-related causes than white women without a high school

diploma.[9] The persistence of preventable, racially disproportionate maternal mortality is hence a pervasive threat to African-American mothers and their families all over Maryland.

Contributing factors to the high MMR can be tracked to several other issues in Maryland's healthcare system. Cesarean births (or C-Sections), for instance, expose women to unnecessary surgical risks and increase risk of birth complications when they are either ordered for non-life-saving measures or when hospitals lack the infrastructure to conduct them safely.[10] In Maryland, C-sections make up a third of all births[11], a rate that is more than triple what is recommended by the WHO.[12] In fact, states like Maryland that exceed a 33% cesarean birth rate are actually at a 21% higher risk of maternal mortality.[13] While C-sections can be a necessary life-saving procedure for certain high-risk pregnancies, a 33% cesarean rate far surpasses a global standard level of necessity, which may be a result of pressure to undertake the procedure by medical providers, as 13% of surveyed mothers reported.[14]

The midwifery model of care has been proven to reduce C-section rates due to its emphasis on low-intervention deliveries, developing relationships with patients, and empowering pregnant women to understand and fully participate in their own healthcare.[15] A prevalent factor of successful deliveries throughout developed European countries is collaboration between physicians and maternity care clinicians, such as midwives and nurse-midwives, who are involved in all aspects of patients' maternity care.[16] Conversely, lack of midwife integration in the US has been linked to higher rates of adverse birth outcomes, like unnecessary C-sections and other types of SMM that lead to maternal mortality.[17]

Maryland, however, suffers from a large shortage of Certified Nurse-Midwives (CNMs) and virtually no Certified Midwives (CMs) due to state restrictions on their practices and a long history of culture clashes between midwifery practices and professional medicine.[19] Given that childbearing women and newborns make up a quarter of all hospital admissions[19], it is essential to safe birthing that midwives are integrated into Maryland hospital systems where the majority of deliveries happen.

Part B: History and Normative Dimensions

Maryland currently faces a shortage of midwives.[20] The lack of midwife involvement in Maryland's birthing landscape is rooted in a long history of anti-midwife sentiment ingrained in American medical culture. Until the late nineteenth century, the majority of babies in the US were delivered by lay midwives--most of whom were BIPOC and/or immigrant women taught through apprenticeships with local physicians or generations of knowledge passed down from experienced midwives.[21] However, as childbirth became more medicalized in the early twentieth century, physicians became America's chief birth attendants, and birthing shifted from the home to hospital settings.[22] In the early 1900s, midwives delivered almost 50% of all newborns in the United States; by 1930, that number had decreased to 15%.[23] Key to the cultural shift towards hospital births was the developing notion among medical professionals that childbirth was hazardous and necessitated constant vigilance for medical intervention by hospital physicians and new technology.[24] Physicians of the era, however, had little experience in labor and delivery than midwives and were rarely trained specifically in childbirth.[25]

As maternal mortality rates soared with the incline in poorly-trained, predominantly White physician-attended deliveries, so did accusatory propaganda blaming lay midwives of color for the alarming national trends in maternal deaths. Despite evidence from multiple studies at the time indicating midwife-assisted births result in fewer maternal deaths than those attended by general physicians, the work of BIPOC lay midwives became racialized and labeled as unsanitary, dangerous practices propagated by foreigners.[26] Consequently, traditional midwifery became the subject of several campaigns led by white-dominated professional medical associations, namely the American Medical Association and the American College of Obstetrics and Gynecology, to eliminate their culture-rooted practices.[27]

The anti-midwife lobbying extended to national discourse, leading to Congress' passage of the Sheppard-Towner Act of 1921 to combat the high rates of maternal and infant deaths.[28] Administered by the US Children's Bureau, the law provided federal matching funds to states for the establishment of midwifery training and licensure standards, which effectively required lay midwives to submit to medical authority for supervision and subsequently forced thousands out of their practices for incongruence with medical professional standards and/or fear of prosecution.[29] Lay midwives who opted to continue with the new state-established midwifery classes were met with culturally-insensitive and flawed curricula taught by public health nurses, many of whom had far less experience delivering newborns and sought to convince the midwives to reject their "superstitious" practices for the sake of preserving the medical establishment and Sheppard-Towner approved protocols.[30] The state's efforts to professionalize midwifery ignored the value of traditional practices and folk healing, thereby advancing the medicalization of childbirth and disdain for lay midwifery practices of women of color.[31]

Despite the intentions of the Sheppard-Towner Act to improve maternal health for mothers of all backgrounds in the US, the Sheppard-Towner Act's decentralized administration preserved discrimination by allowing southern governments to deliver inadequate services to Black areas.[32] Because Black nurses in Maryland were already prohibited from accessing the same transportation as white nurses, they were unable to reach patients in rural areas and prevented from effectively administering child health clinics and midwife programs for Black women.[33] These years of systemic exclusion have perpetuated the legacy of both medical racism and the diminution of culturally-relevant maternal healthcare providers that continue to result in such wide racial disparities in maternal mortality.

Although the aftermath of Sheppard-Towner may have led physicians to improve obstetrical training in medical schools due to the public's demand for preventive care and safer births, lay midwives of color never recovered from the medical establishment-driven policy's expulsion and shaming of their practices.[34] This history points to a longstanding tension between physicians and midwives that continues to harm maternal health outcomes today.

There remains a culture of distrust in the medical world among physicians towards midwives that have kept them from being better-integrated into hospital systems and helping mothers deliver their babies comfortably. Studies have revealed that the increasing medicalization of birth in American society has fostered a common organizational imperative in hospitals to "process' women admitted into in labor, creating a depersonalized environment of institutionalization that negates midwifery's tenets of empowered patient-centered care, low-intervention deliveries and fostering trusting relationships with women.[35] Because of the institutional culture to "get through the work," physician supervisors often meet coworking midwives with tension, resulting in poor communication detrimental to treatment.[36]

The ideological wedge between hospital physicians and midwives is especially evident with the contemporary issue of C-section overutilization. As mentioned in this memo's Part A, Maryland's C-section birth rate is more than triple the necessary rate, meaning the majority of the state's C-section births are medically non-indicated (or unnecessary) and put Maryland at a 21% higher risk of maternal mortality. Despite common knowledge among the medical community that C-sections carry more hazards than vaginal births—greater blood loss, more future pregnancy complications, higher risk of infection, blood clots, and mortality—hospital physicians tend to take on C-section deliveries as a precaution when inconveniences arise, such as long labor time, rather than for actual medical emergencies.[37] Since labor rooms are scarce and hospitals, by their nature, impose pressures that may influence birth decisions for the sake of being risk-averse, physicians—and subsequently their patients—often face both implicit and explicit pressure to not "take too long", opting for C-sections instead of letting labor continue.[38]

Midwives, on the other hand, have an understanding of the main medical rationales for C-sections that differ dramatically from what is extensively practiced in modern hospitals.[39] The midwifery model of care observes the hospital-induced pressures behind C-section decisions and understands that many women feel tempted to receive them due to pseudo-problems deriving from easily preventable issues and challenges that could have been addressed through less drastic measures than major surgery.[40]

Part C: Reform Plan

In other developed nations, including most of Europe, midwife-led maternity care is the standard. Midwives, for example, are the leading attendants for over half of all births in England.[41] Maryland midwives, in comparison, attend only 8% of the state's births with the Maryland General Assembly's Midwives Workgroup pointing to a drastic shortage of midwives.[42] Furthermore, 90% of Maryland's certified midwives are White, meaning many mothers of color may not be receiving care that is culturally responsive.[43]

To provide a sufficient workforce of diverse maternity care providers in the coming years, incentivized midwifery education programs must be developed, particularly in areas of the nation where accredited programs are currently unavailable. These programs would also create additional entry points into the profession and midwife certifications, making the midwife-led model of care available to more women, particularly those in Maryland's underprivileged communities.[44] Increased and diverse numbers of midwives is essential to the maternal care of Maryland's rural and underserved communities of color; the framework with which Black and other midwives of color operate is founded upon reproductive justice as an integral part of their care practices.[45] Midwives educate clients on the delivery process and their alternatives, with bodily autonomy and agency being a key priority. A crucial element of their duty is to advocate for racial justice and reproductive health on behalf of their clients in order to reform social policies, with equity and justice being the ultimate goals of their service.[46]

Adopting the reform based on California's passage of the 2021 "Midwifery Workforce Training Act", this memo therefore proposes that the State of Maryland create a fund to support

the expansion of midwifery workforce and certification training programs that prioritize admitting students from underrepresented groups into the field or placing its graduates into Maryland's maternity care deserts.[47] In order to maximize the delivery of high-quality maternal care services to areas where there is an unmet need, this program is designed to increase the number of students receiving accredited education and training who, as eventually practicing midwives, can care for these target populations at a reduced cost compared to hospital physicians.[48] Predominantly midwife-led models of care have been shown to save states' hospitals and Medicaid systems more than $2,000 per birth when they received care from midwives–partly because midwives reduce the occurrence of expensive, medically unnecessary C-Sections as well.[49]

In this proposal, MDH would establish a program to address the state's limited access to reproductive care and the shortage of certified midwives by contracting with state midwife training programs/schools that hold dedicated multi-year initiatives to recruit and train midwifery students from medically underserved communities, such as lower-income, multicultural and rural communities, or prepare current students to service those specific communities. Example recruitment initiatives may include targeted outreach and travel to Maryland's Historically Black Colleges and Universities (HBCUs) and community colleges in historically marginalized and predominantly rural and/or Black counties.

Following California's example, the reform's implementing agency, Maryland's Department of Health (MDH), is permitted to adopt their own standards and regulations necessary to meet the program's goal requirements.[50] When MDH considers the fund's eligibility

standards for midwife training programs, they may accept the educational standards set by the Maryland Board of Nursing (MBON), the state's licensing and regulatory body for certified midwives.[51]

Appropriated funds from this reform that are awarded to eligible midwife training programs must be used to either to develop new multi-year initiatives or curriculum or expand current ones related to diversity and inclusion of underrepresented groups, which may include programs to provide tuition assistance for students, recruit diverse preceptors, or sustain training sites for students. Eligible training programs will apply for the appropriated funds by submitting a grant application to the MDH Office of Minority Health and Health Disparities (OMHHD) that presents an itemized budget with proof of their proposed diversity and inclusion initiatives, as well as comprehensive justification of where they will direct the funds. Upon submission of the grant application, MDH's OMHHD will award the grant pending approval and verification of the diversity recruitment initiatives. In order to cover the expenses of innovative special projects or programs, OMHHD may also pay contracted programs in an amount calculated based on a single per-student capitation formula or other MDH-suggested formulas, a replication of California's proposal.[52] OMHHD will also be tasked with devising alternate funding streams aside from the set-aside state funds to ensure the long-term viability, and expansion of, this reform, such as through funding from private foundations.[53]

Evaluation metrics of the program's success include training programs' provision of data outlining changes in enrollment admission from each type of underrepresented groups above (based on socioeconomic, geographic, or racial underrepresentation). Monitoring of compliance

and appropriate funding expenditures of the awardee training programs will be held annually by the Maternal and Child Health Bureau within MDH's OMHHD. Lack of increased diversity in candidates may result in withholding of the following years' grant funding until evidence of improved performance is sent by the training program to MDH.

Midwifery has long both been linked to better maternal health outcomes, but low-income women of color are frequently unable to access these types of care because of barriers in midwife shortages, transportation, cost, and general unawareness.[54] Holistic pre- and post-natal care provided by community-based midwives can offer the kind of equitable, person-centered care that Black women do not receive in typical white-dominated maternity care and/or hospital settings.[55] Closing the racially disproportionate gap of maternal mortality thus requires expanding access to midwifery services for low-income Black mothers.[56]

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