April 12, 2021

Disparities in maternal deaths persist, what role can midwives play in reducing deaths and disparities?

by Tara Britton in Blog, Maternal mortality and morbidity, Ohio, Racial Equity

For the last several years, The Center for Community Solutions has focused much of our research and advocacy on understanding and reducing the maternal mortality and morbidity rates for Ohio's women. **Despite bringing more attention to the issue of maternal mortality over the last several years**, the United States remains one of the most dangerous places to give birth, especially for Black women. The most recent data available from the Centers for Disease Control and Prevention (CDC) (released in the fall of 2019) tells us that these disparities persist, and persist at staggering levels. The overall pregnancy-related[1] mortality ratio (PRMR) is 15.0 to 17.0 maternal deaths per 100,000 births.[2] For Black women, the PRMR is 40.8 deaths per 100,000 births, for white women it's 12.7 deaths per 100,000 births. For American Indian/Alaska Native women, the ratio is 29.7 deaths per 100,000 births. Disparities increase even further for Black and American Indian/Alaska Native women older than age 30. The PRMR for both groups older than 30 is four to five times higher than white women in this age range.

> The United States remains one of the most dangerous places to give birth, especially for Black women.

At the end of 2019, the Ohio Department of Health (ODH) released a report on pregnancy-related deaths. The overall rate of deaths from 2008 through 2016 (14.7 per 100,000 births) is similar to the national rate.[3] Black mothers in Ohio are similarly dying at a higher overall rate, 29.5 deaths per 100,000 live births compared to 11.5 deaths per 100,000 live births of white women.

> The introduction of midwives and doulas is just one component of a robust strategy that should be explored to reverse and eliminate maternal deaths.

Both CDC and ODH reports state the majority of these pregnancy-related deaths are *preventable.* And both reports identify the need to understand the disparities that exist and encourage implementing ways to address those problems. The CDC report states that "significant racial/ethnic disparities in pregnancy-related mortality need to be addressed. **Further identification and evaluation of factors that contribute to racial/ethnic disparities are crucial to inform and implement prevention strategies** that will effectively reduce disparities in pregnancy-related mortality." One such strategy employed throughout the world is making midwives and doulas more widely accessible. These are professionals who are part of a spectrum of individuals who are better equipped to provide culturally-informed care for pregnant women across many backgrounds. **In the coming weeks, Community Solutions will explore, through a series of research pieces, background on midwives**, what access to midwifery services looks like and outcomes for women and babies with midwife-assisted deliveries. The introduction of midwives and doulas is just one component of a robust strategy that should be explored to reverse and eliminate maternal deaths, and the disparities in those deaths.

Pregnancy-related deaths are defined as the death of women as a result of pregnancy or delivery within one year of giving birth.

Emily E. Petersen, MD; Nicole L. Davis, PhD; David Goodman, PhD; Shanna Cox, MSPH; Carla Syverson, MSN; Kristi Seed; Carre Shapiro-Mendoza, PhD; William M. Callaghan, MD; Wanda Barfield, MD. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016, *Weekly* / September 6, 2019 / 68(35);762–765

[3] A Report on Pregnancy-Associated Deaths in Ohio 2008-2016 The Ohio Department of Health 2019

April 19, 2021

What is a midwife?

by Hope Lane in Blog, Health, Infant Mortality, Maternal mortality and morbidity

For the past several years, Community Solutions has raised awareness of poor maternal and infant health outcomes by advocating for policy changes that would increase the availability of data; eliminate racism, discrimination and prejudice in the health care system; and to increase insurance access for low-income mothers. Recently, however, we have identified that **for favorable birth outcomes, women need more than *access* to care, they need a combination of clinical skills and relationship-based care.** For this reason, we have supported doulas, non-clinical birth support professionals, as well as midwives as key parts of a pregnant woman's support team. While midwives are known for delivering babies for low-risk women, many midwives in the United States are highly trained health care professionals who offer a range of services for women at all stages of life. These services may include:

- General health care services
- Annual gynecologic exams
- Family planning needs
- Treatment of sexually transmitted infections
- Care for pregnancy, labor and birth
- Menopause care

> Many studies, both retrospective and systematic, have produced the same results: women who initiated care with a midwife demonstrated better results compared to those whose care was led by or initiated by a physician.

Midwives do, however, specialize in the normal process of pregnancy, birth and the post-partum period. **They are able to manage many common obstetric scenarios and complications without obstetrician oversight, although many midwives do work in collaboration with hospitals and/or physicians.** A midwife usually seeks to eliminate or minimize the institutionalization of birth and therefore strays away from unnecessary technological interventions, centering pregnancy and birth as normal life processes. Similar to doulas, midwives provide support to mothers throughout pregnancy including emotional support, advice on nutrition, monitoring gestational progress and suggesting strategies to help ease labor.

Historic overview of midwifery in the United States

As compared with many other wealthy and industrialized countries, the United States has an incredibly complex history with birth work, midwifery, childbirth and general maternity care. **For most of Colonial America and well into the 19th century, all births occurred in the home, an overwhelming majority of which were attended by midwives who also provided most medical care for the entire family.** British

women, whose skills were passed down informally and largely rooted in experience and spiritual healing, were quickly able to adapt their practices once they arrived in the American colonies. West African midwives, who in addition to experience and spiritual healing had extensive knowledge of herbs, came to America as slaves and had to attend the births of both Black and white women on plantations. **Slave midwives served an incredibly important role in the slave community from sharing and thus preserving African culture and traditions, passing on general health care advice and serving as community conduits.** Slave midwives were more mobile than field hands as they were able to care for pregnant women and deliver children on surrounding plantations who did not have midwifes, therefore facilitating communication between many friends and families who had been broken up in slave trades.[1] Because of this crucial role, many Black women continued providing midwifery services to poor women throughout the rural South after emancipation.

> Despite the increase in hospital deliveries between 1915 and 1930, maternal mortality remained steady and the number of infant deaths from birth injuries increased between 40 and 50 percent.

As medicine became professionalized in the United States, births became more institutionalized. **In 1900, fewer than 5 percent of women gave birth in hospitals but by the early 1920s up to 50 percent of women gave birth in hospitals.**[2] The idea of anesthetics and medical advances such as twilight sleep during labor and childbirth became very popular among women of reproductive age who previously faced birth with dread about pain and the fear of death.[3] Many of these innovations, however, could only be used in a hospital setting under the care of a physician. Physicians, all of whom were male and many of whom now received formal education and training from medical schools, viewed midwifery as competition and were uninterested in having who they perceived as uneducated women working alongside them in a hospital setting. Thus, midwifery care was reserved almost exclusively for those who were unable to afford hospital births and those who were excluded from hospitals because of their skin color. While few Black hospitals did exist, they were notorious for poor care. Midwives not only charged significantly less than physicians for their services but also provided a variety of services which neither hospitals nor physicians could offer such as cleaning the house, preparing meals and looking after other children.[4]

By the mid-1930s, while the number of physicians attending births had climbed exponentially since the turn of the century, this seemed to negatively impact birth outcomes. A 1933 report issued by The White House Conference on Child Health and Protection found that despite the increase in hospital deliveries between 1915 and 1930, maternal mortality remained steady and the number of infant deaths from birth injuries increased by between 40 and 50 percent.[5]

In spite of this and the fact that trade associations began to pick up steam, obstetricians and gynecologists continued to seek respect for their specialties by blaming poor outcomes on "the midwife problem." Addressing this problem, of Black midwives in particular, consisted of attacking them based on intelligence, character and hygiene.[6] Dr. Thomas Darlington, a former Commissioner of Health for New York City was one of the first to define the extent of the *problem*. In 1911, he published an article in the *American Journal of Obstetrics and Diseases in Women and Children* titled "The Present Status of the Midwife" where he stated:

> "We know in general that the midwife is commonly employed in this country by the negro and alien populations as well as by many native-born of foreign parentage… Reports upon midwifery investigations made in several of our large cities, together with observations from those who confront the problem in the rural districts, prove conclusively that the midwife, with very few exceptions the country over, is dirty, ignorant and totally unfit to discharge the duties which she assumes." [7]

Meanwhile Black midwives, sometimes known as "Granny" midwives, continued to be the center of health and social support in the Black community through the mid-1900s, delivering approximately 90 percent of Black women's babies in the South.[8] While midwifery schools and formal training programs had emerged by this point, in part because of the passage of the Sheppard-Towner Act [9], many

Black women had limited education or were illiterate as a result of racial discrimination and poverty and thus practiced in secret, relying on the teachings of their ancestors and deep religious beliefs for their practices which often occurred without monetary compensation. These women, known as lay midwives, were not incorporated into a national system of public health and had no national professional organizations to defend their existence within the field of medicine unlike in other industrialized countries such as Japan, Germany and England.

Although the demand for midwifery services, especially among white families, continued to fall in the early 1900s, physician-led campaigns against "the midwife problem" waged on. Many physicians, however, began to concede that abolition of midwifery was unattainable and instead advocated for the licensing and increased supervision of midwives instead.[10] Between licensing requirements, which varied considerably across states and intended to prohibit lay midwives, and the Sheppard-Towner Act which enforced stricter guidelines and certification requirements for midwife training programs, Black "Granny" midwives were systematically ousted from practicing.[11]

Midwife use began a slow rebirth in the mid-1900s as attitudes about childbearing and hospital care began to shift thanks to a rise in the use of Caesarean sections, many Black midwives remained boxed out of the profession as Certified Nurse Midwives (CNMs) were preferred to lay midwives.[12] **CNMs are Registered Nurses (RNs) with an additional training in midwifery.** This along with help of their professional organization, the American College of Nurse-Midwives, allowed them to quickly be recognized as primary health care providers which in turn allowed them to gain reimbursement from private insurance companies, Medicare, Tricare and Medicaid, and also gave them prescriptive authority in all states.[13] **While CNMs are able to practice in all birth settings including private homes, clinics, birth centers, physicians' offices and hospitals, a majority choose to primarily attend births in a hospital setting.**

Along with CNMs, today the most commonly practicing midwives in the United States are Certified Midwives (CMs), Certified Professional Midwives (CPMs) and Direct-Entry Midwives (DEM). Generally, CMs graduate from a master's level midwifery education program and have similar training to CNMs but are not required to have the nursing component, therefore not all states license them. On the other hand, CPMs are often required to complete a certification and accreditation process through the North American Registry of Midwives (NARM) to receive a credential. While NARM is a national organization, licenses are issued by states and not all states recognize the CPM in midwife licensure. Many CPMs choose to not work alongside physicians and thus they generally work in private homes or birth centers. While any non-nurse midwife can be referred to as a DEM, a lay midwife (LM) entered the profession with no certification, licensure or any formal education. Often these midwives began by engaging as an apprentice to a practicing midwife.

> Having a midwife is a common practice in most developed countries because of the positive birth outcomes associated with their presence.

Most midwives in the United States are CNMs who along with CMs attended more than 350,000 births, which represented 85 percent of all midwife-attended births and 9.1 percent of total United States births in 2017. Of these CNM/CM attended births, 94.1 percent occurred in hospitals, 3.2 percent in freestanding birth centers and 2.6 percent in homes. While midwives are most known for attending births, 53.3 percent of CNMs/CMs identify reproductive care as their main responsibility and 33.1 percent identified primary care as the main responsibility in their full-time positions. This includes performing annual exams, prescribing birth control and contraceptive care, parenting education, nutrition counseling, etc.[14]

Having a midwife is a common practice in most developed countries because of the positive birth outcomes associated with their presence.[15] **Many studies, both retrospective and systematic, have produced the same results: women who initiated care with a midwife demonstrated better results compared to those whose care was led by or initiated by a physician.** A large, continuously updated systematic Cochrane

review[16] of small-scale research studies in midwifery-led care has shown favorable birth outcomes for women with low-risk pregnancies. Women who experienced midwife-led care were less likely to have regional anesthesia for pain management or experience operative vaginal deliveries, episiotomies or preterm births before 37 weeks. A similar systematic review found midwife care to be associated with lower rates of Cesarean deliveries, lower rates of third and fourth-degree lacerations, and higher rates of initiation of breastfeeding among women delivered by CNMs.[17]

[1] Varney, Helen. Thompson, Joyce. (2015). *A History of Midwifery in the United States.* Springer Publishing Company.

[2] **https://midwiferytoday.com/web-article/history-midwifery-childbirth-america-time-line/**

[3] Goode, K. (2014). *Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism* [Doctoral dissertation, The City University of New York]. Academic Works, CUNY.

[4] Litoff, J. (1978). Forgotten Women: American Midwives at the Turn of the Twentieth Century. *The Historian, 40*(2), 235-251.

[5] *Ibid*

[6] Sano, Y. (2019). "Protect the Mother and Baby": Mississippi Lay Midwives and Public Health. *Agricultural History, 93*(3), 393-411. doi:10.3098/ah.2019.093.3.393

[7] Darlington, T. (1911) The Present Status of the Midwife. *The American Journal of Obstetrics and Diseases of Women and Children, Volume 63.*

[8] *Ibid*

[9] Passed by Congress and signed by President Harding in 1921, the Sheppard-Towner Act, also known as the National Maternity and Infancy Protection Act provided federal funds to states to establish programs to educate people about prenatal health and infant welfare

[10] Anderson, D. et al. (2016). *The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality.* National Bureau of Economic Research.

[11] Hoffman, C. Diaz-Camacho, V. (2020). Birthing Battle The Struggle for Equity in Maternal Health Care. Flatland.

[12] Wolf, J. 2018. American women are having too many caesareans, at too much risk. Los Angeles Times.

[13] *Ibid*

[14] American College of Nurse-Midwives Fact Sheet: **https://www.nber.org/system/files/working_papers/w22456/w22456.pdf**

[15] Tikkanen, R. et al. (2020). Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries. The Commonwealth Fund.

[16] A Cochrane Review on continuity of midwife care was first published in 2004, and most recently updated in 2016. As more trials have been added to the Review, uncertainties in the original finds have been reduced. Both the World Health Organization and the United Kingdom's Department of Health have identified this Cochrane Review as a priority topic for updating.

[17] Moore, J. et al. (2020). *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid*. Institute of Medicaid Innovation.

THE CENTER FOR COMMUNITY SOLUTIONS EST. 1913

April 26, 2021

How are midwives regulated in Ohio?

by Loren Anthes in Blog, Maternal mortality and morbidity, Ohio

Currently, only Certified Nurse Midwives (CNM) are the only legally-enabled professional midwife type who can practice in Ohio. As established in Ohio Revised Code (ORC) Section 4723.41, there are several requirements for CNMs, including licensure as an advanced practice nurse and an application to practice in the specialty and pay a license fee.[1] Also, as a provider designated in Ohio's state Medicaid plan, CNMs are eligible for Medicaid reimbursement.

> Certified Nurse Midwives are eligible for Medicaid reimbursement.

Under Ohio Administrative Code (OAC) Section 3701-83-33 to 42, which outlines the regulatory definitions for the establishment of freestanding birth centers, the following represent the other categories of midwives in Ohio.[2]

TABLE 1: Midwife Definitions in Ohio Law

TYPE	DEFINITION
Apprentice Midwife	An individual who is currently serving an apprenticeship under a practicing midwife
Certified Professional Midwife	An independent practitioner who has met the standards for certification set by the North American registry of midwives
Lay/Traditional Midwife	An individual who has entered the profession as an apprentice to a practicing midwife rather than a formal school or certification program

Unlike other states, Ohio notably does not define a Certified Midwife (CM). Developed in 1994 by the American College of Nurse-Midwives, the CM credential expands access to midwifery through multiple educational pathways. The CM pathway includes a graduate degree in midwifery (where Certified Professional Midwife (CPM) does not) and has many of the same regulatory requirements as CNMs, only lacking the nursing credential.[3] Additionally, Ohio CNMs have limited prescriptive authority; do not have autonomous practice and risk assessment authority (i.e. physician oversight is required and CNMs do not have the ability to practice independently); do not have a stand-alone regulatory board; and are functionally unable to petition consultation and referrals outside of institutional settings (i.e. freestanding birth centers and home-based deliveries). Beyond CNMs, then, the de facto professionalization of CMs and CPMs does not exist in Ohio. As such, **legal midwifery is thereby under the functional authority of hospitals**,

meaning deliveries are compelled into institutional settings versus community-based or home-based settings.

How are freestanding birth centers regulated in Ohio?

Given the role freestanding birth centers have as a regulatory source for midwifery, looking into Ohio's laws regarding these facilities is worthwhile. OAC sections 3701-83-33 to 42 outline how freestanding birth centers are regulated. It should be noted that freestanding birth centers are called freestanding because hospitals commonly describe maternity wards' birthing suites as "birthing centers" though they are not the same thing. These, instead, are hospital facilities that are licensed under the auspices of the hospital. For freestanding birth centers, there are requirements regarding the definition of risk, professional types, reporting, facility requirements, and medical oversight in each section. Key to these standards are the requirements to establish physicians as medical directors and consulting physicians, and additional requirements for transfer agreements must be in place with hospitals.

> Ohio's current delivery landscape appears to be more institutional than collaborative.

According to the American Association of Birth Centers, **these requirements mean birth centers "frequently operate in a needlessly restrictive regulatory environment which is often exacerbated by hostile or exclusionary practices on the part of dominant provider groups**, health plans and other payers and professional liability insurers."[4] The argument the association outlines is that licensure does not provide a pathway to the establishment, but rather medical oversight becomes a tool to create barriers of entry for community-based providers, thus preventing centers from existing meaningfully. In other words, physicians and hospitals can refuse to collaborate with centers. There are also concerns for potentially interested physicians that liability insurance is too expensive. With the increase of physicians employed by hospitals, hospitals prevent physicians from overseeing deliveries in locations outside of the hospital as a matter of contract. Even though there is evidence from the American College of Obstetricians and Gynecologists that improved collaboration produces better outcomes and that independent midwives in clinical decision making do not adversely impact results, Ohio's current delivery landscape appears to be more institutional than collaborative.[5],[6]

Comparative analysis

Depending on the state, the scope of practice for CPMs varies widely.[7] Registrations, accreditation bodies, educational requirements, a regulatory board's presence, and testing requirements are all variables in a given state's regulatory approach. Notably, **21 states provide CPMs some ability to administer medications**, though the type of medications they can prescribe and the potential for oversight also varies widely. Given this broad variability, it's important to gauge the relationship between a given state's regulatory structure of midwives and the outcomes associated with deliveries, generally.

In 2018, a multidisciplinary team of maternal and infant clinical experts produced a study called the Access and Integration Maternity Care Mapping (AIMM) Study. The point of AIMM was to evaluate the statistical relationship between the including midwives in the delivery process and assess the impact. Through this work, the group developed the Midwifery Integration Scoring System (MISS), where higher scores indicate greater integration of midwives across all settings. Using reliable indicators in the Centers for Disease Control and Prevention's Vital Statistics Database, the MISS identifies the correlation coefficients between scores and maternal-newborn outcomes by state. While no state achieved a perfect score of "100" (the highest was Washington state at 61), **Ohio ranked 46th out of 50 states with a score of 20**. The tool breaks down the score into four main areas:

- **Options for the birth site** (16 measures, 25 points)
- **Reporting and data collection** (1 measure, 1 point)

Vaginal Birth After Cesarean (VBAC) allowed for licensed midwives (1 measure, 3 points)

Professional standards for CNPs, CPMs and CMs[8] (For each: 11 measures, 24 points)

Regulation & Medicaid reimbursement (3 measures, 8 points)

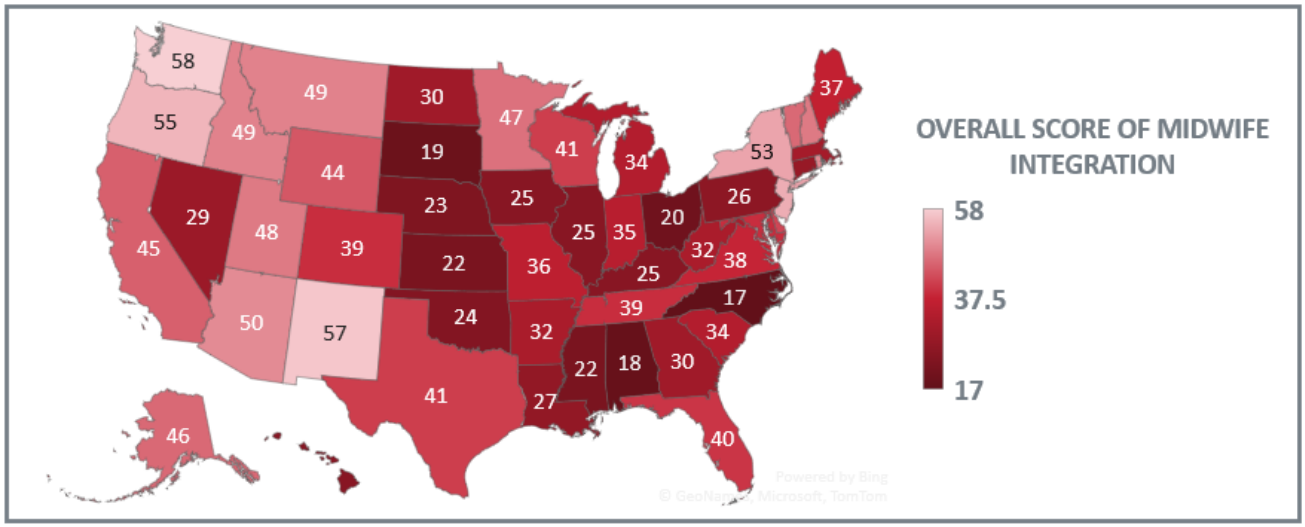
Autonomous practice & risk assessment (3 measures, 7 points)

Scope of practice (2 measures, 2 points)

Medication administration authority (2 measures, 5 points)

Is representation on the regulatory board required (1 measure, 2 points)

FIGURE 1: Relative Integration MISS Score



Shading based on total achievement, not possible score.

TABLE 2: MISS Score By Category

MISS SCORE COMPARISON	OPTIMAL	NATIONAL AVERAGE	OHIO
Options for Birth Site	25	8	7
Reporting and Data Collection	1	0.02	0
VBAC	3	0.94	0
CNM	24	18.24	13
CPM	24	8.24	0
CM	23	1.25	0

As the MISS indicates, Ohio lags the country in midwife integration across many measures. Notably, for **Ohio, CPMs and CMs are not integrated at all and, even for CNMs, the biggest areas of deficiency are in midwife autonomy**. This deficiency is represented in the requirements for CNMs to have physician oversight, a consultation agreement (which is particularly difficult to achieve in home or center settings), access to medications and prescription-writing authority.

> Ohio lags the country in midwife integration across many measures.

Cost benefit

Beyond the benefit in outcomes, cost savings are apparent when midwife legalization is made possible in de-institutionalized settings. Currently, expenses associated with normal delivery and Caesarean sections vary widely in Ohio and across the United States, especially when compared to other industrialized nations.

This variance is difficult to explain in concrete terms, but the expense generally is driven by an institutional approach to delivery.

As complex medical facilities, tertiary medical centers like hospitals have high fixed costs with high salaried practitioners, complex equipment and large campuses with significant infrastructure. While there is certainly an advantage to this for high-risk medical interventions, it's important to realize that the entirety of a hospital's resources are not always necessary for effective, efficient delivery. This supposition is borne out in the data as well, which suggests services for low-risk births are significantly less expensive when performed by a midwife. For example, in a 2019 University of Massachusetts study, researchers found that **childbirth costs for low-risk women with midwife-led care were, on average, $2,262 less than births for low-risk women cared for by obstetricians**.[10] Similarly, in a 2019 study from the American Journal of Managed Care, data from 2010 indicated average facility charges for freestanding birth centers were $2,277, while hospitals charged an average facility fee of $10,166 for an uncomplicated vaginal birth – an 87.7 percent difference. In Ohio, the average price for normal delivery is $16,106.

[9] This variance is difficult to explain in concrete terms, but the expense generally is driven by an

[1] Requirements for practicing nurse-midwifery or other specialty. Ohio Revised Code §4723.41 (2018). https://codes.ohio.gov/orc/4723.41v1

[2] Definitions – exempt freestanding birthing centers. Ohio Administrative Code §3701-83-33 to 42 (2016).

[3] Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S. (2017, October). Retrieved March 11, 2021, from https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf

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[7] Schleiter, K., JD, LLM. (2016). State law chart: Certified Professional Midwife Scope of Practice. Retrieved March 11, 2021, from https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/specialty%20group/arc/direct-entry-midwife-state-chart-practice-information-2016.pdf

[8] For CMs, the MISS only has 1 measure with 23 total points possible.

[9] Anthes, L. (2020, August 25). At what Cost: Price and common procedures in OHIO'S HOSPITALS. Retrieved March 12, 2021, from https://www.communitysolutions.com/research/cost-price-common-procedures-ohios-hospitals/

[10] Attanasio, L. B., Alarid, E. F., & Kozhimannil, K. B. (2020). Midwife-led care and obstetrician-led care for low-risk pregnancies: A cost comparison. Birth: Issues in Perinatal Care, 47(1), 57–66. https://doi-org.proxy.library.ohio.edu/10.1111/birt.12464

THE CENTER FOR COMMUNITY SOLUTIONS EST.1913

May 3, 2021

Midwives can help to address inconsistent access to maternity care and disparities in maternal and infant health outcomes

by Tara Britton in Blog, Maternal mortality and morbidity, Ohio

The United States is one of the most dangerous places to give birth in the industrialized world, as the maternal mortality rate has increased over the last several decades. With that as context, it is important to understand the connection between access to care and overall outcomes. There are significant racial disparities in maternal health outcomes. Overall, Black women die from pregnancy or childbirth at a rate two to three times that of white women. These disparities also exist for infant health outcomes. We know that by improving access to care, including to a spectrum of providers such as midwives and doulas, disparities are reduced and better maternal health outcomes are achieved.

> In 2020, the March of Dimes found that 1,095 counties in the United States lack maternity care.

Despite what appears to be a robust health care system, in 2020, the March of Dimes found that 1,095 counties in the United States lack maternity care (no hospital offering obstetric care, no birth center and no obstetric provider).[1] This includes 14 counties in Ohio.[2] There are more than 2.2 million women of childbearing age living in these counties and in 2017, nearly 150,000 babies were born to women living in these counties. These maternity care deserts span urban and rural areas of the country. A report from the federal Centers for Medicare and Medicaid Services (CMS) found that **counties with greater proportions of Black and Hispanic populations and those with an overall lower median income were more likely to lack a hospital with obstetric services**.[3]

While there are myriad factors contributing to lack of maternity care access and just as many potential ways to make improvements, one recommendation in particular is to increase access to midwifery services. We have explored the role of midwives, the history of midwives in this country and how a devaluation of their role as birth professionals, based in racist and sexist stereotypes, lead to their inconsistent integration into the current health care system. **Midwives seek to normalize pregnancy and childbirth as routine parts of a woman's life course and care**. Midwives also play an important role in deinstitutionalizing childbirth and bringing community-based support to hospital-based deliveries, which is key to reducing disparities resulting from health care institutions that often provide care influenced by bias and racism. We have also explored[4] the different classifications of midwives and how there is a wide range in the level of integration into the health care system dependent on the state in which you reside. State policies play a significant role in overall access to midwives and the Midwifery Integration Scoring System (MISS) shows that Ohio ranks on the low end of states for integrating midwifery services.

> Low-risk births attended by midwives in rural areas were shown to have just as good or better outcomes and higher satisfaction than those with physicians.

Policy changes across the country, and in Ohio, are needed to support increased access to a range of midwifery services. Low-risk births attended by midwives in rural areas were shown to have just as good or better outcomes and higher satisfaction than those with physicians.[5] This is key in filling the gaps identified across urban and rural areas in overall maternity care. Certified midwives, who are often more closely connected to the communities they serve, can locate their services more easily, compared to hospitals and physician practices, in maternity care deserts. CMS identifies a "multidisciplinary workforce" as one strategy to improve access to maternity services in rural areas.[6] Policymakers in Ohio should closely examine the MISS, as these are seen as key steps to increasing access to midwifery services. One scoring factor in the MISS is whether there is certification in that state for certified midwives (CM). Ohio does not have a formal certification for CMs. And of course, certification plays a role in whether CMs can be reimbursed through Medicaid and other insurance. In the last few years, Alabama, a state with the second to lowest MISS score as well as the fewest maternity care providers per capita and the highest infant mortality rate, passed a law for certifications of lay midwives.[7] Steps like these can help to build trust in midwifery services and position them as extenders of maternity care where there is limited availability.

[1] https://www.marchofdimes.org/materials/2020-Maternity-Care-Report-eng.pdf

[2] Carroll, Champaign, Fayette, Hardin, Jackson, Lawrence, Meigs, Monroe, Morrow, Noble, Paulding, Perry, Putnam, and Vinton

[3] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

[4] https://www.communitysolutions.com/midwives-regulated-ohio/

[5] http://ruralhealthquarterly.com/home/2018/07/09/might-midwives-help-fill-rural-maternity-care-gaps/

[6] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

[7] http://ruralhealthquarterly.com/home/2018/07/09/might-midwives-help-fill-rural-maternity-care-gaps/

May 10, 2021

How midwives help outcomes for women and babies

by Natasha Takyi-Micah
in Blog, Health, Infant Mortality, Maternal mortality and morbidity, Strengthening the HHS Safety Net

The United States experiences unprecedentedly high rates of maternal deaths. In a study that compares the United States to 10 other developed countries, women in the United States had the highest ratio of maternal deaths. **For example, there were 17.7 maternal deaths per 100,000 live births in the United States compared to 1.7 maternal deaths per 100,000 live births in New Zealand** and 3.0 maternal deaths per 100,000 live births in the Netherlands.[1] Further, there are racial disparities in maternal deaths in both the United States and Ohio as Black women are more likely to die from maternal or pregnancy-related deaths compared to white women. Midwives can help reduce the chances of maternal and infant deaths, but unfortunately, compared to the other developed nations in the study, the United States and Canada use the fewest midwives, with four midwives for every 1,000 live births.[2] Moreover, midwives can prevent the use of hospital interventions during labor and produce positive health results. Thus, an analysis on the positive outcomes of using midwives is worthwhile to explore.

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One of the advantages of using midwives is the reduced chance of performing birthing interventions/procedures. One study shows that **women who received midwifery services experienced a lower chance of epidural usage, episiotomy and the use of forceps/vacuum** – also known as "instrumental vaginal birth."[3] In another study, researchers examined the different birthing interventions when women received care from either midwives or obstetricians. After examining the responses from 2,539 women in a California survey, those who obtained help from midwives compared to obstetricians were less likely to receive any pain relief medication (71.6 percent with midwife assistance and 81.7 percent with obstetrician assistance) and synthetic oxytocin (37.5 percent with midwife assistance and 42.3 percent with obstetrician assistance).[4] Also, women who received assistance from midwives were more likely to use nonpharmacologic comfort interventions during labor such as walking, hot/cold compresses and a shower or tub.[5] Based on the results of these studies, midwives seem to assist low-risk women go through natural births with minor use of medical procedures.

Midwives also produce positive health outcomes for mothers and babies. Some of the positive health results include a reduced chance of losing babies under 24 weeks of gestation [3] and higher breastfeeding rates. [6] Locally, researchers examined neonatal outcomes and birth interventions among low-risk pregnant women who received prenatal care from either midwives or physicians at The Ohio State University Wexner Medical Center.[7] After completing this study, women who obtained prenatal care from midwives had a 42 percent lower risk of experiencing preterm births.

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Another study observed whether there would be a possible reduction of fetal, neonatal and maternal deaths if there was an increase in midwifery coverage in 78 low to middle-income nations.[8] The nations were classified into three categories based on the Human Development Index (HDI) – a statistic comprised of education, life expectancy and income indexes – and the estimated number of prevented deaths. Group A consisted of the lowest HDI countries, group B included low-to-moderate HDI countries and group C involved moderate-to-high HDI countries. After grouping the countries into three categories and making projections, **if there was a modest increase, 10 percent for every five years, in midwifery coverage, then maternal deaths could be reduced** by:

- 4 percent for group A
- 9 percent for group B
- 7 percent for group C

Moreover, if there was universal midwife coverage for maternal and newborn health interventions for countries only listed in group A, then "60.9 percent of all maternal, fetal, and neonatal deaths could be prevented."[9] Although the United States was not a part of this study, similar results could happen here if there was more midwifery coverage.

Overall, midwives can create encouraging outcomes for both women and children. Pregnant women could have more freedom to choose whether or not they want hospital interventions during labor. In addition, women and babies could yield positive health benefits, including a decreased chance of death. Due to this research supporting the benefit of expanded midwifery on maternal and infant outcomes, legislators in Ohio should consider policies that will allow more midwives to become certified and practice. Furthermore, there should be more awareness about midwives in the public so women can decide whether or not they want to receive such services during pregnancy and birth. Midwives can help save the lives of mothers and babies in Ohio which could help resolve this public health issue.

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