Maternal Mortality, Medicaid, and Midwifery Care: Community Praxis Research to Benefit Low-Income Texas Women

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Abstract

Texas is experiencing a maternal mortality crisis that particularly impacts low-income women. These women face challenges in accessing and using their Medicaid benefits to obtain adequate and timely prenatal care from hospital-based providers. Geographic challenges and the limitations of Texas pregnancy Medicaid preclude them from obtaining care from Texas licensed midwives for a community-based birth (home or birth center). As the most vulnerable population to maternal mortality from assorted causes, low-income women deserve access to the protective midwifery model of care. With the COVID-19 crisis setting further limitations on birthing choice in hospital settings and making midwifery care less available, some women are taking charge of their pregnancies independently. The proposed feminist-grounded study both supports these women's endeavors and qualitatively investigates their attitudes and practices around community birth.

Keywords: childbirth, midwifery, unassisted birth, community birth, maternal mortality, Medicaid, low-income, feminist research, healthcare

Introduction

According to many sources, the state of Texas is experiencing a maternal mortality crisis that particularly impacts low-income Texas women. Intimidated by the behemoth that is Texas pregnancy Medicaid, ignored and abused by providers, or eliminated from the safety net by the state's stringent requirements, many mothers forego essential prenatal and postpartum care that could prevent complications and even save their lives. Furthermore, in the era of COVID-19, increasing numbers of birthing women have begun to seek out-of-hospital alternatives, either to avoid exposure to the virus or to avoid hospital restrictions that force them to give birth isolated from their partner and family. Community-based birthing typically takes place in a freestanding birth center or at home with a midwife. Since Texas Medicaid offers limited coverage for midwifery care, low-income women who want a community birth must choose between paying out of pocket for a midwife they can't afford and going without care.[1] Medicaid limitations impact both urban and rural service areas, but likely have the greatest impact in West Texas, a vast swathe of the state served (with the exception of El Paso and the Lubbock-Amarillo corridor) by MRSA-West ("Texas Managed Care Service Areas"), where rural non-obstetric hospitals outnumber those with an obstetric wing ("Texas Rural Hospital Obstetrical Access") and where fewer than 10 licensed freestanding birth centers (located primarily in metropolitan service areas) are available to serve a total area of more than 100 counties.[2]

The National Academies of Science, Engineering, and Medicine recognize that women have the right to choose where to give birth and that, "to exercise that choice, they must have access to options" (National Academies News Release). Nevertheless, the "power struggles associated with the medical domination of childbirth continue to marginalise [sic] homebirth and prevent women from accessing the care they want and need" (Rigg, Schmied, Peters, and Dahlen, 2015, n.p.). The same combination

[1]Full-scope care (pregnancy, birth, and postpartum) from a Texas licensed midwife typically starts at $3,000. Prenatal care from a physician costs about $2,000 out of pocket for an uncomplicated pregnancy.

[2]The single licensed birth center in the Permian Basin, Midland-based Motherly Way Birthing Center, closed in June 2019, leaving a service gap that extends from El Paso to San Angelo and from Lubbock to Eagle Pass.

of factors that, as found by Rigg, Schmied, Peters, and Dahlen (2017), drive Australian women to hire unregistered birth workers (lack of insurance coverage, restricted eligibility for publicly funded options, lack of geographic access to registered midwives, excessive interventions in hospital birth, and increasingly tight regulatory restrictions on midwives) seems to be driving American women to make a similar choice: hire an underground birth attendant or birth at home unassisted (see Jenkinson, Kruske, & Kildea, 2017, citing Dahlen et al., 2011, and Ireland et al., 2011).[3] Texas has around 700 registered midwives to serve 28 million residents, including 286 licensed midwives ("Direct Entry Midwives, 2019"). The replacement rate for midwives is low because, although Texas licenses midwives, the state poorly integrates them into the health care system, making it an unattractive state to practice in ("In Poland, midwives play a significant role in childbirth. In Texas? Not so much"). Based on the available literature as well as ongoing participant-observation research with birthing families, I suggest there is an invisible demographic of low-income mothers (in Texas and other states) who are turning to unfunded birth alternatives, including self-directed prenatal care and unassisted home birth, because Medicaid and the conventional medical system simply are not meeting their needs for care.

Problem, Purpose, and Significance

In the words of Mann, Hudman, Salganicoff, and Folsom's recommendation (2002, p. 16): "Both public and private efforts will be necessary to improve coverage for poor women with children." This paper proposes an innovative policy-as-praxis intervention to address the lack of community birthing options for low-income women. The purpose of the proposed study is to gather data in support of broad policy changes benefiting low-income Texas women by increasing access to midwifery care in order to reduce maternal mortality (defined as "the death of a woman while pregnant or within 42 days of the end of pregnancy, regardless of duration and site of the pregnancy, from any cause related to or

[3]The primary voices discussing the underground or autonomous birth movement in the United States reflect the experiences of middle-class, educated, culturally white women who are married or successfully partnered (see Barrett, 2019). The childbirth experiences and choices of low-income and Medicaid-eligible women, however, intersect with diverse demographics such as working-class, urban and rural poor, low-educated, single mothers, immigrants, and women of color.

aggravated by pregnancy or its management, but not from accidental or incidental causes," Baeva et al., 2018, p. 762). It is the first proposed study in a multi-part investigation similar to that conducted by Rigg, Schmied, Peters, and Dahlen (2017, 2018, 2019) that will explore the intertwined impacts of factors such as rural geography, income, education, insurance coverage, race and ethnicity, obstetric bias and the "culture of experts" (see Barrett, 2019), and state midwifery licensing regulations on women's freedom to obtain the maternity care of their choice. The midwifery model of care improves the birth experience for mothers (Dahlen, 2016, citing a Cochrane Systematic Review by Sandall et al., 2015), making it both an attractive option for women and a means to reduce common causes of maternal mortality and morbidity.

Review of the Literature

Home birth rates soared by 41% between 2004 and 2010 (Cheyney et al., 2014), partly because women want fewer obstetric interventions (*Birth Settings in America: Outcomes, Quality, Access, and Choice*, 2020, cited in National Academies of Sciences, Engineering, and Medicine News Release). Despite critics' concerns "that women would be pushed into 'cheaper births, not safer ones' (Donnelly, 2016)," not only are midwife-led care and community-based birth significantly cheaper (Dahlen, 2016), but they are equally safe as (or, by some measures, safer than) birthing in the hospital system (see Cheyney et al., 2014's summation of the 2004 MANA Statistics Project; Janssen et al., 2009; Johnson & Daviss, 2005; Hutton et al., 2016; and the three population-based cohort studies from 2009 evaluated by Cheyney et al., 2014). Nevertheless, the total number of women choosing community birth remains at less than 2%, primarily due to lack of access to midwifery care in underserved areas (*Birth Settings*, 2020, in National Academies News Release). The American Public Health Association called for increased access and integration of midwifery services in the United States as early as 2002 ("Public Comments - American Association of Birth Centers"), but "consistent U.S. standards for regulation, scope of practice, and access to reimbursement for midwives are still lacking, resulting in a fragmented system of care" (Vedam et al., 2018). A 2020 report from the National Academies of Sciences, Engi-

neering, and Medicine, *Birth Settings in America: Outcomes, Quality, Access, and Choice*, highlights the uneven distribution of local perinatal services – whether obstetric or midwifery-led – in underserved areas as a major contributor to poor birth outcomes and suggests that ensuring that home birth and birth center providers are paid adequately by Medicaid is "critical to improving access" (National Academies News Release).

The Canary in the Coal Mine

Pregnant and postpartum mothers and their infants are the most vulnerable of society. Low-income mothers and their children represent the front lines of risk. Mothers at risk of intrapartum death should, and rightly do, move society and lawmakers to improve maternity care, both by setting safeguards and by expanding available options to reach more individuals. Unfortunately, the medical-industrial complex (better called "the techno-patriarchy establishment," Barrett, 2019, p. 6; compare Jenkinson, Kruske, & Kildea, 2017) has constructed childbirth as a disease process in need of expert medical management. The techno-patriarchy narrative excludes community-based, decentralized, person-to-person forms of care in favor of a centralized, compartmentalized, hierarchical system that resembles a Foucaultian prison for sick bodies more than a garden of healing. When women experience adverse outcomes, the system reconstructs these as evidence that "women's bodies [are] flawed" and need "technology and intervention" to function (Jenkinson, Kruske, & Kildea, 2017, p. 8), thus reinforcing the need for the system's specialists to manage outcomes. The canaries crying in the mine are drowned out. In Dahlen's (2016) words: "In maternity care one bad outcome...can move us to ever increasing levels of intervention and surveillance for all" (p. 6). The system addresses the bad by enforcing an increasingly rigid standard of care that limits choices for all women. Maternal mortality is an overlooked leading indicator of the system's sustainability. It shows us how well the system is (not) working for women, especially poor women.

Texas' Medicaid Crisis

From 40% to half of births in the United States, and more than 50% of births in Texas, are covered by Medicaid, which is the most important source of coverage for low-income women. Women are more likely than men to hold part-time or low-wage jobs without benefits, making Medicaid their only source of insurance. Nationally, more than a quarter of Medicaid charges is for services related to the 98.4% of births that occur in hospital settings, and hospital birth itself is the single largest line item on the nation's health care bill. From 8 to 16 percent of Texas women are Medicaid-enrolled, but women of childbearing age may only enroll if pregnant and eligible. For eligible women, pregnancy Medicaid covers prenatal visits, vitamins, and screenings; delivery; and one postpartum visit in the 60 days after birth (with a second visit if medically indicated). (See "Medicaid Coverage and Reimbursement: Issue Summary"; "Medicaid Coverage for Pregnant Women"; "Women and Medicaid in Texas"; "Access in Brief: Pregnant Women and Medicaid"; National Academies News Release; "National Birth Center Study II Fact Sheet.")

Texas' pregnancy Medicaid crisis is reflective of broader national realities for low-income women. The federal implementation of TANF in 1996 reduced the welfare caseload by two-fifths. Although welfare reform resulted in a 6% increase in low-educated, single mothers being added to private insurance, Kaestner and Kaushal (2003, p. 959) found that, in the same demographic, there was a 7-9% decrease in Medicaid coverage and a 2–9% increase in those uninsured. (Notably, due to high deductibles, some women with employer-sponsored insurance still resort to Medicaid for their maternity care, since Medicaid has no cost-sharing; "Medicaid Coverage for Pregnant Women"). Cawley, Schroeder, and Simon (2006) pinpointed an 8.1% increase in the probability that a welfare-eligible woman would be uninsured. Pearlman (1998) states that AFDC eligibility requirements have the effect of limiting Medicaid eligibility and thus "may jeopardize the health of poor women" (p. 217). These findings may partly explain why, in 2014, 28% of Texas women ages 18 to 44, regardless of pregnancy status, were uninsured ("Behind from the start — Part 2") and, in 2018, between 30% and 40% ("The Extraordinary Danger of Being Pregnant and Uninsured in Texas"), affecting their ability to access prenatal care if

pregnant. On the other hand, more recent findings suggest that declines in insurance coverage were smaller than estimated and that negative effects of welfare reform on prenatal care utilization resulted from factors (changes in family disposable income, time available to invest in health care, and stress levels) other than lack of health insurance (Kaestner & Lee, 2005).

Recently, the United States have seen a rising national incidence of low birth weight and pre-term birth (both linked to inadequate prenatal care for mothers) and adverse maternal outcomes (from obstetric intervention, iatrogenic complications, and cesarean delivery to perinatal mortality). Low-income women (Medicaid-enrolled or uninsured) are most likely to experience the above outcomes, for several reasons. They experience more chronic conditions and risk factors that impact pregnancy; the process of enrolling in Medicaid once pregnancy is discovered often delays the initiation of prenatal care until after the first trimester; and fluctuations in eligibility factors (income, household size) during and after pregnancy can change their coverage, interrupting prenatal and postpartum care. The rate for Texas women with no recorded prenatal care was 4.6% in 2013 (more recent estimates suggest close to 10%). A significant number of those pregnancies were under Medicaid, suggesting that Medicaid enrollees either choose not to seek care or face barriers accessing it ("Behind from the start – Part 1").

Texas women "have the latest entry to prenatal care in the country" ("The Extraordinary Danger"), with 21% only beginning care in the second trimester. A 2011 joint report from DSHS and the CDC cited waiting for Medicaid eligibility as the main reason pregnant women in Texas delay initiating prenatal care; additionally, an unplanned pregnancy means the woman may not discover her pregnancy for several months, further delaying her application for the Medicaid enrollment process ("Behind from the start – Part 3"). Entering care beyond 28 weeks (for instance, if her Medicaid approval takes longer than the expected two weeks) increases the chance that a care provider will not accept her as a patient for liability reasons ("The Extraordinary Danger"). Finally, with physician shortages in underserved

areas, women must wait in line to be seen.[4] The subsequent passage of the Affordable Care Act may have made little difference for these women, since the three-month window to enroll in insurance through the federal Marketplace may not coincide with when a woman discovers she is pregnant. Women enrolled in Medicaid are also younger, less likely to be married, less educated, and more likely to be women of color[5] than women enrolled in private insurance; however, even when controlling for these differences, Medicaid enrollees are less likely to obtain adequate and timely care than any group except the uninsured ("Access in Brief: Pregnant Women and Medicaid"). However, Kaestner and Lee (2005) found that, among low-income, unmarried women with low education, having at least a high school diploma was associated with less likelihood of going without prenatal care or having a LBW infant.

Texas' Maternal Mortality Crisis

Dahlen (2016) points out that the United States "spends more on maternity care than any other nation on earth, has a rising maternal death rate (14/100,000) with twice the number of women dying than its neighbour Canada (7/100,000)," and yet continues to substitute outmoded systems of hospital-based "medical surveillance" (p. 7) for the less costly, more protective option of midwife-led care. An estimated 50,000 women per year experience severe intra-pregnancy complications, with delivery complications increasing by a staggering 45% in the decade between 2006 and 2015, and an estimated 700 women die from pregnancy-related causes ("Access in Brief: Pregnant Women and Medicaid"), an unknown (but high) number of them in Texas.[6] Despite recent efforts by Congress to improve the collection and reporting of data on maternal mortality by all states ("2017-2018 Federal Legislative Proposals"), clear statistics for Texas have been notoriously difficult to tease out, due to the state's lacka-

[4]Kelly Beatty, a licensed midwife formerly based in Midland, suggests midwives could fill this need, if allowed: "There's a lot of areas in Texas that have populations that exceed the physician availability, so people are beginning their pregnancy care later and later... there could be midwives who could fill in the gap." For this reason, some Texas midwives have petitioned to be allowed to bill Medicaid. ("In Poland, midwives play a significant role in childbirth").

[5]Being a woman of color, particularly a black woman, is in itself a risk factor for adverse birth outcomes, due to the unique social stresses these women experience in the American context.

daisical efforts to ensure accurate reporting or to establish a maternal mortality review task force to analyze death certificates. (DSHS finally did so for 2017.) "The standard method for identifying maternal death relies on an obstetric cause-of-death code" (Baeva et al., 2018, p. 762), but inconsistent methods for how states handled death certificates historically meant that the rates were likely inaccurate, either too high or too low. Using the standard method, Texas' maternal mortality ratio steeply increased from 2010 to 2012, but then declined from 2012 to 2015. Using an enhanced method of data analysis, Baeva et al. (2018) suggest that the correct 2012 maternal mortality ratio may be less than half of that obtained by the standard method and that the inflated 2012 ratio resulted from women being accidentally coded as pregnant when they were not. DSHS admitted ("Legislative Brief: November 2017") that data (including individual clinical records) was insufficient to confirm accurate death ratios; instead, DSHS sought to establish meaningful trends through a timeline analysis of the confirmed 382 maternal deaths from 2012 to 2015.

47% of deaths were categorized as pregnancy-related, meaning they occurred during pregnancy or within 7 days postpartum or that the cause of death was due to pregnancy complications; the rest were categorized as pregnancy-associated. 21% of deaths occurred during this time frame, with hemorrhage, cardiac event, and embolism as leading causes. Women enrolled in Medicaid at delivery were twice as likely to die as women under private insurance and comprised 57% of total deaths (219 of 382). (The results table combines self-pay and uninsured into one category and does not analyze deaths by income level, giving us no meaningful death ratio for uninsured low-income women.) Women with a high school diploma, no diploma, or an associate's degree (likely primarily students with a vocational degree, as distinct from women with some four-year college attendance) had a noticeably higher ratio, as did unnmarried women compared to married. Women with hypertension had a more than doubled mortality risk; however, the results table does not distinguish between chronic hypertension as a preexisting condition and gestational hypertension (a pregnancy complication typically associated with in-

[6]On the high side, some sources suggest as many as 900 maternal deaths per year nationally and 400 to 500 for Texas.

adequate nutrition). Similarly, women with diabetes had an elevated risk, but the table does not distinguish diabetes as a preexisting comorbidity from gestational diabetes (a co-occurring condition commonly associated with blood volume expansion in pregnancy); therefore, it is difficult to estimate the real impact of these factors on maternal death.

By CDC reckoning, absence of prenatal care increases a woman's mortality risk by three to four times ("Behind from the start — Part 1"). In DSHS results for 2012 to 2015, the mother of a preterm or LBW (low birth weight) infant had an excessively higher mortality risk than the mother of a full-term or normal-weight infant, which may speak to the quality of prenatal care received, since inadequate prenatal care is a predictor of preterm birth and LBW; on the other hand, the timing of when prenatal care was initiated (first, second, or third trimester) was associated with a less pronounced effect, suggesting that the mother's health status (including her motivation to get and stay healthy) has more impact than her attendance at prenatal visits. By region, Regions 9 and 10 (West Texas: Big Bend west to El Paso and Permian Basin eastward) had the second-to-lowest ratio (20.7/100,000), but Region 1 (Panhandle) had the highest ratio overall (34.0/100,000), as well as highest in each category (pregnancy-related versus pregnancy-associated). DSHS intends to look more closely at the link between death and insurance status, with specific attention to those enrolled in Medicaid at time of death ("Legislative Brief: November 2017").

For perspective, compare the Building U.S. Capacity to Review and Prevent Maternal Deaths project, which used a detailed examination of clinical records ("Report from Maternal Mortality Review Committees"). The maternal mortality review committees (MMRCs) of four states participating between 2008 and 2014 found that 44% of pregnancy-related deaths occurred within 42 days postpartum. The most common underlying causes of maternal death were hemorrhage (a risk factor in the immediate postpartum) and heart conditions or heart attack (a risk factor that extends into the year after birth), but leading causes by individual state also included mental health conditions and preeclampsia. Texas comes out with slightly more pregnancy-related deaths, at 47%, but the decision to include only

deaths in the first 7 days postpartum (unless directly related to a pregnancy complication) makes comparison difficult. Texas women may be exposed to mortality risks (such as mental health conditions) in the first 42 days, but after 7 days, that DSHS counts as pregnancy-associated, but other states would count as pregnancy-related. DSHS suggests that prioritizing prevention efforts before 60 days postpartum may prevent nearly 70% of pregnancy-related deaths; after 60 days, pregnancy-related deaths consisted mostly of cardiac events ("Legislative Brief: November 2017").

Midwifery Care and Mortality Risk. Strikingly, women attended by a physician had an elevated risk compared to women attended by a certified nurse-midwife, or CNM ("Legislative Brief: November 2017"); however, the DSHS results table combines CNMs with CMs (certified midwives, a credential not recognized in Texas) and leaves out LMs (licensed midwives), either confusing LMs with CMs or conflating them with the "Other" and "Unknown" categories (which presumably include accidental at-home or away-from-home births as well as planned unattended home births, and which combined have a much higher death ratio than physicians). CNMs attend a very small percentage of home and birth center births compared to LMs. Therefore, Texas maternal mortality data as such does not give us a useful perspective on home or birth center mortalities under midwifery care as compared to hospital care. However, national data suggests women have a reduced mortality risk under midwifery care. In a study of 5,418 planned home births, no mothers died (Johnson & Daviss, 2005). In a study of 15,574 birth center births, no maternal deaths were reported (Stapleton, Osborne, & Illuzzi, 2013[7]). In both studies as well as Cheyney et al. (2014), about 12% of births ended in a hospital transfer (most transfers were nonemergent). The American Association of Birth Centers' Uniform Data Set shows that CPMs (certified professional midwives, a credential accepted for licensure in Texas) in birth centers have outcomes equal to CNMs ("Public Comments - American Association of Birth Centers"). In short, women having a planned community birth attended by a midwife are exposed to significantly fewer

[7]Of note is the fact that a third of births in the study were funded by federal and state programs, including Medicaid and CHIP. For Medicaid enrollees using a birth center under midwifery care, did their risk of mortality decrease?

interventions and adverse outcomes[8] than women birthing in the hospital, whether attended by a nurse-midwife or a physician (Janssen et al., 2009), as well as no apparent increased risk of intrapartum death. Some self-selection is obviously at play; a woman who hires a midwife is likely to be middle-income, educated, housed, and in a stable relationship, with either private insurance or sufficient disposable income and with fewer risk factors for pregnancy complications (e.g., nutrition, lifestyle, stress; unstable household, job, or income), as compared to a Medicaid enrollee seeking hospital-based prenatal care. Also, licensed midwives are required to risk out women who present with certain preexisting conditions. However, given that 85% or more of all US pregnant women are classified as low-risk ("National Birth Center Study II Fact Sheet") and thus eligible for licensed midwifery care, the necessity of expanding maternity care options for low-income women becomes clear.

Midwives and Medicaid

Standard policy solutions for problems like Texas' pregnancy Medicaid crisis include "broadening eligibility for coverage and simplifying the application process" (Mann, Hudman, Salganicoff, and Folsom, 2002, p. 16). While such solutions are practical and immediate, implementing them merely makes the status quo coverage available to a larger demographic; it does nothing to increase access to the personalized maternity care options that women want, need, and deserve. Texas licensed midwives attend more than 80% of home and birth center births (2002 DSHS data), comprising the majority of the 1.5% of Texas births that are community-based (2014 DSHS data, "Texas Midwives Midwife Chart"). Families that choose a home or birth center birth typically do so because they wish explicitly to have a licensed midwife, rather than an obstetrician or CNM, attend them.[9] However, Texas Medi-

[8]Note Melissa Cheyney's insight (quoting Roome et al., 2015) that birth safety in an out-of-hospital context is broader than mere survival of mother and infant, "emphasizing the reduction of potentially harmful interventions and the emotional and psychological safety of the woman and her family" ("Understanding Recent Home Birth Research").

[9]Some families choose community birth by necessity. Women who lose access to hospital-based obstetric care as a result of rural hospital closure become more likely to choose a birth center or home birth (Barclay & Kornelsen, 2016). In rural and urban-adjacent West Texas counties, the absence of birth centers means not only more planned home births, but more unplanned/accidental births, either at home or en route to the hospital.

caid covers only OBs and CNMs (who perform births almost exclusively in hospitals[10]) or licensed midwives in a freestanding birth center. This eliminates the option of home birth with a licensed midwife for Medicaid-enrolled women, as well as all licensed midwifery care for Medicaid-enrolled women who live in areas not served by a birth center. The out-of-pocket fees for licensed midwifery care[11] further eliminate this option for uninsured low-income (and even some middle-income) women. Some LMs offer a cash discount to Medicaid enrollees, but the financial loss makes it unsustainable to accept more than a few Medicaid clients a year. Essentially, the state of Texas is telling pregnant and birthing women that their health care matters, but only if it takes place in an out-of-home setting where they are less likely to receive personalized continuity of care.

Importance of Midwifery Care

The kind of care that is difficult for Medicaid-enrolled women to access is precisely the care they most need. "[T]he evidence is now so strong" that the midwifery model of care improves outcomes for mothers "that one could consider it unethical not to offer all women this model of care and for governments to prioritise funding" toward it (Dahlen, 2016, p. 7). Because the midwifery model "focus[es] on the individual woman, incorporating not just her physical needs, but also her social, emotional, psychological, spiritual and cultural wellbeing (Leap, 2009)" (Jenkinson, Kruske, & Kildea, 2017, p. 6) throughout the childbearing life cycle and not just during pregnancy and delivery, midwives are able to support a woman's pregnancy and especially her postpartum recovery more effectively than the assembly-line medical model. A midwife's appointments typically last 30 to 60 minutes, as opposed to the standard 15 minutes or less. With time to observe a woman closely and build a relationship, a midwife is more likely to notice invisible risk factors, such as mental health conditions (a 2018 British

[10]Nationally, Medicaid is considered "a key payer for midwifery services" for CNMs ("Medicaid Coverage and Reimbursement"). Some states, such as New Mexico, allow Medicaid to cover LMs.

[11]Texas midwives typically charge anywhere from $3,000 to $6,000 per client. While this sounds competitive, it is notably affordable compared with the out-of-pocket costs for medical childbirth options. Across the profession, many midwives barely break even at the end of the year. Many midwives choose not to accept private insurance, due to the cost of retaining a billing specialist.

study published in BMJ *Open* found that midwives were two to three times more likely to document depression in their clients' records), enabling her to "better address the social determinants of health that...affect birth outcomes for vulnerable women" ("Poor women who use midwives"). The study, which controlled for health variables, found that low-income women utilizing a midwife were more than twice as likely to receive adequate and consistent prenatal care than those utilizing a general practitioner or OB, while being significantly less likely to have a LBW infant or preterm birth.

While the midwifery model of care as articulated by midwifery bodies and health journals represents a standardization of pre-modern midwifery traditions, translated into a dialect and format relevant to the modern medical establishment where licensed midwives have had to carve out a professional niche since community-based lay midwifery was stamped out in the 1940s, at its core it reflects the ancient "with-woman" model that birthworker Ynanna Djehuty describes as the "community of supportive women...[e]mpowering women to trust their bodies and innate wisdom" ("Radical Birthwork as an Act of Resistance"). Ultimately, a woman hires a midwife because she is seeking this "with-woman" aspect, which she may articulate as the midwife's support for her autonomy (Jenkinson, Kruske, & Kildea, 2017, p. 8). Autonomy in the literature is associated with the freedom to make independent health care choices, such as to decline an intervention, without being "manipulated," "punished and judged," "badgered," or "assaulted" by a care provider (p. 4). Midwives and women believe midwives are more likely than physicians to safeguard a woman's autonomy. A feminist understanding of autonomy, however, focuses more on wellbeing than on choice:

> By understanding the social and family relationships, context and constraints on woman's decision making, the pregnant woman and fetus retain their status as a single unit, with fetal wellbeing best protected by supporting maternal wellbeing (Harris, 2000; Laufer-Ukeles, 2011). This is reflects feminist understandings of autonomy as a relational, rather than individualistic, construct and underpins a broad, comprehensive and bias- and conflict-aware account of refusal (Laufer-Ukeles, 2011). This relational understanding of autonomy is captured in this study, as understanding the woman's whole context (Jenkinson, Kruske, Kildea, 2017, p. 7).

Unfortunately, midwives who practice under the approval of the political and medical establishment must protect themselves by "practicing 'with institution," rather than 'with woman' (Mander and Melender, 2009)" (p. 8), and end up undermining the woman's autonomy in both senses.[12]

Women giving birth in community settings have lower rates of intervention-related complications, such as iatrogenic (provider-induced) hemorrhage (National Academies News Release). Hemorrhage and preeclampsia have been leading causes of maternal mortality in hospitals since the 1950s ("Why Giving Birth Is Safer in Britain Than in the U.S."), but are "among the most preventable causes of maternal death" ("Legislative Brief: November 2017," p. 6). While hemorrhage can have biological causes (uterine atony, precipitous delivery, or placental abruption), it often results from dangerous interventions, such as cord traction or manual separation of the placenta. Harrowing accounts from 3,100 mothers ("'If You Hemorrhage, Don't Clean Up'") illustrate that physicians often mistrust or misattribute women's self-reported symptoms until the complication becomes a crisis. The maternal mortality review committees in Building U.S. Capacity to Review and Prevent Maternal Deaths found that 58.9% of deaths were preventable, but that patient factors[13] were responsible more frequently than the provider, system of care, or facility ("Report from Maternal Mortality Review Committees"). Yet in a startling revelation, for the two causes of hemorrhage and preeclampsia, the MMRCs found that the provider factor was responsible for from two to three times as many deaths as the patient factor. In other words, physicians made poor judgment calls in managing these complications (in spite of the fact that the recent push to improve training for providers has made available detailed toolkits for hemorrhage and preeclampsia).

As evident from the toolkits, medical systems frame "prevention" of maternal mortality in terms of managing emergent complications with complex surveillance and technological intervention. DSHS

[12]The tension between a midwife's loyalty to women and her obligations to the state motivates the decision of radical midwives to practice with full autonomy instead of submitting to licensure. Radical or grassroots midwives claim legitimacy only from the families they serve, not from an external governing body (Barrett, 2019).

[13]While not listed, these presumably included preexisting comorbidities, as well as the failure to seek appropriate care when

recommends that Texas implement similar maternal safety bundles ("Legislative Brief: November 2017") to prevent deaths from hemorrhage or hypertension (a precursor to preeclampsia) in hospital settings. By contrast, midwives rarely engage in dangerous interventions. Midwife Judy Slome Cohain confirms the absolute opposite stances of the midwifery and medical models: nutritional status (which relies on the intrinsic motivation of the woman) is "a critical factor in homebirth outcomes, while in hospital birth, the interventions used [which rely on the skill, speed, and accurate judgment of the doctor] are the most critical factor" ("Pregnancy Diet"). Empirical knowledge collected by experienced midwives and midwifery-minded obstetricians over decades (and longer) points to low-cost, high-impact strategies for eliminating these two potential complications before they can arise, by emphasizing adequate nutrition in pregnancy in a context of ongoing face-to-face contact with the client. (See, for example, selected articles published in *Midwifery Today*: "Preventing Complications with Nutrition," "Stories to Learn From: Toxemia in Pregnancy," "Hemorrhage in Childbearing," "Preeclampsia and Nutritional Priorities," "Pregnancy Diet," keeping in mind that midwives' stories are not "mere anecdotes, but testimony" that "substantiate[s]" the evidence; Jenkinson, Kruske, & Kildea, 2017, p. 3, quoting Rich, 1995, p. xi.) The evidence suggests that overall dietary quality, a "dynamic and encompassing measure that captures much more than the effects of isolated nutrients," leads to positive pregnancy outcomes for low-income women (Fowles & Gabrielson, 2005, p. 119).[14]

Community-based Programs

Public policy includes not only laws, "but also the subsequent decisions that are intended to enforce or implement" them (Anderson, 2003, p. 3). McGowan, Musicant, Williams, and Niehaus (2015) tell us that community-based "legal and policy innovations or 'experiments'" are effective because they target specific local needs in a "low-cost, but relatively high-impact" way (p. 10). Examin-

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indicated.

[14]Midwives educate women to follow a balanced diet rather than a "magic pill" ("Preventing Complications with Nutrition"). Specifically, hemorrhage prevention involves consuming leafy greens and iron-rich foods to build red blood cells and clotting factors and maintain uterine muscle tone; preeclampsia prevention involves consuming adequate calories, protein,

ing health at the local, granular level leads to a surprising insight: "Counties with the strongest health care systems and resources are often not the healthiest overall" (p. 10). In other words, propping up a giant, modern, heavily-funded hospital system is less effective in the 21st century than maintaining agile, diverse, accessible options across the geographic and financial spectrum. In fact, clinical care (both access to care and the quality of care) constitutes only 20% of the factors that support health in a community. In addition to the health behaviors of community members (30%) and the physical environment (10%), the largest contributor is social & economic factors (family, social support, education, income, community safety), which make up 40% of the success of a public health intervention. Therefore, we should begin "addressing health by focusing not solely on health care access and quality, but the wider environment" (p. 11), including combined efforts from multiple stakeholders, a broad distribution of resources, and clear measurement of outcomes. The growth of community birthing practices not only offers an example of targeting local needs, but suggests possibilities for "go[ing] beyond traditional health care approaches and work[ing] with new partners and sectors" (p. 10) including the private and for-profit sectors. In some countries, private and for-profit entities contribute 60% of health products and services ("New statement champions the role the private sector can play").

COVID-19

While the foregoing discussion would, in any other year, lead naturally into a discussion of policy strategies for integrating midwives firmly into the Texas maternity care system as a strategy for reducing the mortality risk of low-income women, in 2020 the landscape looks far different. With hospitals overloaded and families scrambling for alternatives, midwives "are experiencing a 'surge in demand.' But there are not enough midwives to go around" ("Covid-19 exposes the need for midwives"). Families with the disposable income and foresight to change plans mid-pregnancy have booked up the available midwives, while those with less fortuitous timing "find that their insurance won't cover out of hospital births, or that they are unable to transfer care because there are simply not enough birth centers

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and salt to maintain blood volume expansion and perfusion.

or homebirth providers" ("What We Can Learn From Hospital Restrictions"). In some jurisdictions, authorities canceled all home births that were scheduled with registered midwives ("Nova Scotia suspends home births"). Thus, families that might have successfully sought out midwifery care in a "normal" year are barred by circumstance in 2020. Meanwhile, women (especially black women) birthing in hospitals that ban doulas and partners from attending births, with no one to advocate for them in labor, bear an increased risk of death from harmful interventions and overlooked complications ("COVID-19 Is No Reason to Abandon Pregnant People").

What is the answer? While some minds might jump immediately to a policy solution such as emergency stopgap funding (a successor to the CARES Act?), others are finding ways to maneuver around the crisis without directly engaging with a system (medical and political) that has failed them in the past.[15] In addition to the obstetric violence and dangerous interventions commonly leveled against women in hospitals, low-income mothers are likely to experience discriminatory treatment from Medicaid providers as well as substandard prenatal education. They also experience more factors (such as high BMI) that cause the medical community to label them as "high-risk." The universal adoption of COVID policies for labor and delivery is the tipping point that caused them to see hospitals as not just a bad birthing experience, but a system built on coercion and dehumanization. My observations suggest that at least some families, including low-income families unable to hire a midwife, are so dedicated to avoiding the hospital experience in 2020 and beyond that they will have a planned unassisted home birth, with no outside prenatal care. This includes those who seek out resources to educate themselves about topics like nutrition, pregnancy complications, and emergency transfer, but also those without the awareness, motivation, or self-efficacy to do so. Both groups are at a slightly elevated risk of maternal mortality compared to midwife-attended births, making prenatal education on nutrition for the preven-

[15]My observations parallel other authors' findings that women "make the choice to birth outside of the medical system to avoid patriarchal systems of power and medical management" (Rigg, Schmied, Peters, & Dahlen, 2018, p. 2).

tion of complications highly beneficial for this population.[16] In general (prior to 2020), ethnograpic observations have led me to conclude that many women who birth unassisted make the choice more or less reluctantly, out of inability to find a midwife they are comfortable with[17] or can afford. They would prefer a midwife for the "with-woman" aspect. Without one, they fill the gap by deliberately creating or joining a "community of supportive women" (in Ynanna Djehuty's words), both on social media and in person. In response to the innovation and individualism shown by these families, our commitment to reducing maternal risk should drive us to reach them in innovative, individual ways. This requires conducting a study grounded in community-based praxis: first, to widen the circle of awareness about community birth through outreach, and, second, to allow women to identify, in their own voices, what options in midwifery care they desire going forward.

Research Questions

RQ1: Will making licensed midwifery care more accessible in Texas improve birth outcomes for low-income women?

RQ2: Will validating (rather than persecuting) the practice of unregistered midwives make the midwifery model of care accessible for more low-income women in underserved areas of the state?[18]

RQ3: Will offering community-based free prenatal nutrition classes or circles increase low-income women's awareness of and interest in midwifery care?

RQ4: Will offering community-based free prenatal education or circles increase the confidence and self-efficacy of low-income or low-educated women who are directing their own prenatal care?

[16]Minimal research on the statistical risks of unassisted birthing exists, but extrapolation from existing home birth data is possible. See Barrett, 2015. Rixa Freeze (rixarixa.blogspot.com) is the current academic authority on the attitudes and practices of women who choose unassisted birthing.

[17]Some women deliberately choose unlicensed midwives, better called radical, underground, or autonomous midwives (see Barrett, 2019), to avoid being bound by restrictions on their care (such as the Texas rule that licensed midwives must either find a collaborating physician or transfer care of a client whose pregnancy continues past 42 weeks).

[18]Rigg, Schmied, Peters, and Dahlen (2019) found that if unregistered birth workers were formally outlawed by Australian state governments, most would continue practicing, and at least two thirds of women would continue to hire them rather than return to mainstream care. To paraphrase Melissa Cheyney ("Understanding Recent Homebirth Research"): "[Autonomous] birth isn't going to go away," so we will serve women better by adapting to what they intend to do.

RQ5: Will equipping women with resources and community support for directing their own prenatal care lead to improved maternal outcomes and increased satisfaction with their birth experience?

Hypotheses:

H1: Offering community-based free prenatal education on nutrition and lifestyle will improve birth outcomes for low-income women who would prefer, but are currently unable, to hire a midwife.

H2: Low-income women who are currently directing their own prenatal care out of a desire to avoid the hospital-based medical model will continue to desire the midwifery model of care, whether or not they contract with a licensed midwife in the future.

Theory and Methodology

Praxis methodologies maintain that activism must begin in, and in turn be shaped by, the communities the activist hopes to affect. In keeping with the recommendations of McGowan, Musicant, Williams, and Niehaus (2015), the study will take place in the context of an outreach that is granular and local rather than sweeping or global. The outreach will be neighborhood-based. To address Bexar County's abysmal rates of low or no prenatal care utilization, Dr. Robert Ferrer suggests using *promotoras* (community health workers) to implement a "community-based solution where you go out to the neighborhoods [i.e., place flyers in grocery stores] and you have programs to educate women and help find women who are newly pregnant" and get them enrolled in Medicaid earlier so they can start going to appointments ("Behind from the start — Part 3"). While not focused on Medicaid enrollment or utilization of the medical system, the outreach follows a similar model of inviting women to join a neighborhood class or discussion circle held in a church, home, community center, or natural wellness practice. Unlike doctor visits that must take place during business hours, the group will meet in the evenings to accommodate working mothers (or at another time by agreement). An important consideration will be the provision of child care. The initial proposed location for an outreach to low-income women in south Midland (generally considered a lower-income area) is in a natural wellness practice below downtown. Women in this area have reasonably close access (up to 25 minutes) to Midland Memorial

Hospital, but less access to other options (the prominent midwife and doula agency in the city maintain their offices on the northwest side of town in a fairly prosperous area).

Circles will be small (5-10 members) to facilitate personal connection and equal time, and will be guided by a mother/sister figure who fills the role of "holding space" (i.e., maintaining a sense of psychological safety) that would be filled by a midwife in the midwifery model of care. To create a welcoming atmosphere, nourishing food may be provided, based on the "village prenatal" model created by Cherokee midwife Sister Morningstar. Since "[t]he degree to which a woman feels that she has the ability to control her own health may lead her to engage in healthy behaviors, such as healthy eating" (Fowles & Gabrielson, 2005, p. 120), the facilitator will focus on building a culture of intrinsic motivation and self-efficacy among participants.[19] The intention of the outreach is not to suggest to women that they should choose one method of prenatal care over another (i.e., midwife-led over medical or self-directed over midwife-led), but to expose them to their entire range of options while imparting tools and information they can use to take charge of their pregnancy, a decision that will look different for every woman (one mother may decide to manage her nutrition within the "community of supportive women" while seeing a Medicaid provider for routine prenatal screenings; another mother may find incentive to strategize financially with her partner, family, and friends so that she can hire a midwife).

The praxis approach "focuses on ritual as political practice (Nash, 2007; Paulson, 2006; Robins, 2006)" (Cheyney, 2010, p. 42). Ina May Gaskin describes home birth as both a private family ritual and a constitutional right "among those unenumerated rights [of the Ninth Amendment] which are to be retained by the people" (1975, p. 12). When "the people" exit the medical system to birth on their own terms, they are engaging in a political act. Gathering with a group of women to connect over the shared

[19]Unfortunately, financial assistance programs like WIC typically supply dairy products, fortified cereals and juices, and legumes but not meats, whole grains, vegetables, and fruits (Fowles & Gabrielson, 2005), leaving low-income people to fill the unsatisfied need for nutrient-dense whole foods with cheap but empty calories (e.g., chips). Given the limitations low-income women may be working with, it will be essential to offer nutritional strategies that are practical for them.

experience of pregnancy and birth outside of the patriarchal medical system is, likewise, a political act. Unlike policy activism that leads from the front to shift regulations and make external change from the top down (an energetically masculine approach), this form of community-based praxis leads from behind and below, seeking to shift what is inside ourselves (an energetically feminine approach). A radical autonomous model of birth inverts the medical hierarchy (see Cheyney, 2010, in Barrett, 2019), centering the mother as the true expert on her own body. Recognizing "that women's stories '[are] never mere anecdotes, but testimony through which the neglect and abuse of women by the health care system [can] be substantiated' and change wrought (Rich, 1995, p. xi)" (Jenkinson, Kruske, & Kildea, 2017, p. 3), the study engages the ritual of storytelling, both to validate the mother's role as expert and to offer her the "with-woman" attention that safeguards her sense of autonomy.

Sampling, Recruitment, and Procedures

Inspired by previous feminist-grounded studies such as Jenkinson, Kruske, and Kildea (2017) and Rigg, Schmied, Peters, and Dahlen (2018), and building on my prior investigation into the attitudes of radical midwives (Barrett, 2019), the study uses a combination of unstructured ethnographic participant-observation with in-depth semi-structured interviews. The approach is grounded in narrative inquiry, the "close study of the particular within individual stories as a means to illuminate universals" (Bruce, Beuthin, Sheilds, Molzahn, & Schick-Makaroff, 2016, p. 2). The study uses a convenience sampling strategy of placing posters or pamphlets in strategic locations in the neighborhood, as well as offering pamphlets to local Medicaid providers such as pediatricians and CNMs in private (not hospital-based) practice, since they have contact with the target demographic of mothers even when not pregnant (e.g., for well-child visits or contraceptive services). For the ethnographic observations portion, the sample will consist of all women who attend the circles. For the interview portion, motivated participants will be recruited through one-on-one conversation from among those attending. They will receive more detailed information about the study, plus an informed consent form and confidentiality statement. Following the interviews, the data will be analyzed using thematic analysis and compared

against ethnographic field notes for a full understanding. For a woman who has used or is currently using a Medicaid provider, how difficult was it for her to initiate prenatal care? How does she experience care within the system? Does the provider meet her needs for personalized education and support? Is her pregnancy normalized or pathologized? For a woman directing her own prenatal care, what motivated her choice? What complications does she prepare for? How does she educate herself? What resources or supplies does she obtain, and how does she budget for them? What gaps in available prenatal education has she noticed?

Limitations

Study limitations include the inability to predict or control the number of circle participants and the demographics they represent. For example, a woman may be Medicaid-enrolled because of her current income or employment status, yet hold a college degree. Another may live in a low-income neighborhood by choice (for example, to care for aging family members), yet have a secure job with full benefits. Still another makes too much as self-employed to qualify for government assistance, but not enough to afford to purchase her own coverage. This limitation makes it difficult to be certain of recruiting participants who fall into the Medicaid-eligible category, unless they self-select by volunteering that information.

Two other limitations offer more of a challenge or growth opportunity: first, the facilitator's semi-shared background with participants (college-educated, never pregnant, but also having experienced income and housing instability) and, second, the need for the facilitator to maintain explicit boundaries and communicate clearly that the information shared is educational in nature, not medical advice. A final limitation is the lack of funding to cover the meeting space, flyers, handouts, childcare, food, and the facilitator's time. Possibilities include applying for public and private grants and seeking donations or assistance from a local nonprofit.

Discussion

The personal is political. The childbearing choices of women are personal; that is, they pertain to unique and self-determining persons, and they are bound up with bodies and relationships, not technology and transactions. Policy solutions that honor women's autonomy should do more than expand access within the existing system by, for instance, simply widening the income net for eligible patients. A system-focused policy overhaul could offer many progressive solutions, such as to authorize all licensed providers (including licensed midwives) to bill Medicaid at 100% of physician rates, enabling them to serve all clients in a financially sustainable way; to give CNMs autonomy of practice and place LMs under the purview of a midwife-run board (instead of Texas Department of Licensing and Regulation) for peer accountability; to allow freestanding birth centers run by LMs (with or without an autonomous CNM as consulting provider) to qualify as Rural Health Clinics; to reimburse nonlicensed providers such as doulas, lactation consultants, and childbirth educators for auxiliary services offered under the umbrella of a midwifery practice; to increase grants for health nonprofits to provide services like prenatal nutrition education; and to provide individual health grants for low-income and rural women to use for the maternity care of their choice instead of being restricted to Medicaid providers. On the other hand, these solutions all fall within the system and, at some level or another, constrain the choices of the recipients and care providers, whether in terms of qualifying for financial support or of being obligated to conform to rules of the medical and political establishment. A truly progressive approach would be to return to the bedrock of autonomy in its two interrelated senses: the ability to obtain personalized care in support of the wellbeing of one's family unit and community (a feminist value) and the opportunity to select privately whatever care the individual desires or none at all (a Texas cultural value). Thus, a long-term policy goal might be to loosen the state's restrictions on registered midwifery care, perhaps by reverting to a voluntary licensing structure, so that women of all income levels may freely hire the local midwife of their choice without regard to credential or recognition by the system. Until all women are free to choose from all existing maternity care options, we cannot say that Texas is truly a safe state for birthing mothers.

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