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The COVID-19 pandemic: A focusing event to promote community midwifery policies in the United States

Adelle Dora Monteblanco [a,b,*]

[a] Department of Sociology and Anthropology, Middle Tennessee State University, Murfreesboro, TN, United States
[b] Department of Sociology and Anthropology, University of Texas at El Paso, El Paso, TX, United States

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ABSTRACT

The COVID-19 pandemic has placed unprecedented stress on health care systems across the globe. This stress has altered prenatal, labor, delivery, and postpartum care in the U.S., motivating many pregnant people to seek maternal health care with community midwives in a home or freestanding birth center setting. Although the dominant maternal health care providers across the globe, community midwives work on the margins of the U.S. health care system, in large part due to policy restrictions. This commentary extends previous research to theorize that the COVID-19-related disrupted health care system and the heightened visibility of community midwives may create a "focusing event," or policy window, which may enable midwives and their advocates to shift policy.

1. Introduction

COVID-19 has placed unprecedented financial and clinical stress on health care systems across the globe (Sohrabi et al., 2020), and this stress is altering and/or disrupting various types of routine care, including prenatal, labor, delivery, and postpartum care (Davis-Floyd et al., 2020). Nearly 4 million babies are born in the U.S. every year (Martin et al., 2018), and labor and delivery needs continue throughout this pandemic. But COVID-19-related real and/or perceived fears—including coronavirus exposure and overcrowding at hospitals, and newly implemented hospital policies intended to reduce transmission, such as universal masking, mother-infant separation, and labor companion restrictions—are creating turbulence for patients, patients' families, and providers. Thus many pregnant people are turning to midwives for their prenatal, delivery, and post-partum care in a home or freestanding birth center setting (Davis-Floyd et al., 2020).

Midwives are skilled and professional birth care providers who promote low-intervention births and focus on low-risk pregnancies. To be recognized as midwives according to the international definition put forward by the International Confederation of Midwives (ICM), they must successfully complete a government-recognized midwifery education program, where they are trained to detect complications and seek appropriate hospital assistance during obstetrical emergencies (International Confederation of Midwives, 2018) (Many U.S. Direct-Entry Midwives, who are also professional midwives, do not meet this definition, as will be discussed below.) The benefits of midwives have long been clear: improved maternal and newborn health outcomes, reduction in unnecessary interventions, and cost savings to families and the health system (Homer et al., 2014; Van Lerberghe et al., 2014). In fact, the midwifery model offers support and care to both the physical and psychosocial needs of their patients (Yoder & Hardy, 2018), especially helpful to Black women who weather historical, structural, and/or personal racialized trauma (Alang et al., 2017).

In particular, out-of-hospital or community midwives (henceforth referred to as community midwives)[1] have always thought of themselves as crisis responders (Monteblanco & Leyser-Whalen, 2019). As a study of community midwives' perception showed, participants believed that their unique flexibility (their constant preparedness to serve large geographic areas) and training in out-of-hospital care (particularly their ability to improvise when supplies are limited) prepared them well for crisis response. These skills, which seem to go unnoticed or undervalued in non-crisis times, become highly valued during a disaster that overtaxes existing medical systems and limits access to medical facilities.

For example, the midwives of Bumi Sehat and of Mercy in Action have

* Department of Sociology and Anthropology, Middle Tennessee State University, Murfreesboro, TN, United States.
E-mail address: adelle.monteblanco@mtsu.edu.

[1] Many maternal and social science scholars have transitioned from the phrase "out-of-hospital birth" to the phrase "community birth"; this term, which refers to both place and space, is "meant to convey that the birth is occurring within a woman's own community" (Cheyney & Davis-Floyd, 2019). This is then applied to practitioners; the language of "community midwives" defines these practitioners for what they are and not for what they are not. Further, this language avoids the possibility of reifying hospital birth as the norm (Cheyney & Davis-Floyd, 2019). In this commentary, the phrase "community midwives" is used.

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long provided highly successful "low-tech/skilled touch" care in disaster zones, including in the aftermath of the 2004 Indian Ocean earthquake and tsunami, the 2013 Super Typhoon Haiyan in the Philippines, and the 2017–2018 volcanic eruptions in Bali (Davis-Floyd, Lim, Penwell, & Ivry, 2021). In the United States, community midwives prepare their clients for extreme heat events (Monteblanco et al., 2020). These authors argue for the *decentralization of maternity care* in preparation for the increasing natural hazards that are bound to accompany the onrushing Climate Crisis, and for the integration and empowerment of local community midwives such as the ones I discuss in this commentary.

Although community midwifery is regarded somewhat tenuously by mainstream U.S. medicine, this pandemic is disrupting the health care system and creating demand for such services (Davis-Floyd et al., 2020; Rogers, 2020; Schmidt, 2020). As hospitals seem to be increasingly a site of real and/or perceived risk during this pandemic, community birth with a midwife is becoming increasingly popular among pregnant people who may not have considered this setting or provider before (Davis-Floyd et al., 2020).

It is necessary to briefly mention that coronavirus transmission risk is not simply eliminated with a move from hospital to home or birth center for prenatal, labor, delivery, or post-partum care; childbirth in particular, "creates multiple sources of exposure (air, fluids, surfaces) and requires frequent and repetitive physical contact with health workers in a concentrated period" (Davis-Floyd et al., 2020). While a pregnant person may feel safer among her and her family's own germs in the household, if community midwives do not have access to personal protective equipment and same-day testing, there is still risk of transmission, with the community midwife carrying the largest burden.

Still, pandemic-era increased use and visibility of community midwifery services may provide an opportunity for midwives and their allies to shift U.S. policy. This commentary extends previous research to theorize that this real and/or perceived disruption in hospital-based maternal health care, along with community midwives' heightened visibility during this pandemic, offers a "focusing event," or window of opportunity, in which to create and modify policies that support community midwives' legal practice and expand their scope of care.

As context for this argument, I begin with a discussion of community midwives' historical and current occupational marginalization and a brief overview of homebirth. The medical, political, and legal opposition to midwifery and the misinformation associated with planned out-of-hospital birth explains why midwives might seek to organize during the COVID-19 pandemic. The literature review concludes with a discussion of focusing events and how COVID-19 fits within the broad definition. I then offer initial evidence of midwives' current policy efforts, considering their wider implications.

2. Midwifery and community birth

Occupational status brings with it decision-making power and prestige (David, 1975; Kalleberg, 2011), and community midwives' lack of prestige compared to other maternal health professionals, such as physicians, has its roots in history. The maternal health field's historical pathologization of pregnancy and birth and subsequent takeover of care by physicians (Ehrenreich et al., 1973; Rothman, 1982; Wertz & Wertz, 1989) has left community midwives near the bottom of the maternal health occupational hierarchy.[2] Community midwives are criticized by not only other maternal health care providers but also the public, the media, and lawmakers (Corcoran, 2002; Monteblanco, 2018; Morris & McInerney, 2010; Tovino, 2004).

Until the late nineteenth century, though, community midwives—referred to previously as a variety of names (e.g., lay midwives, immigrant midwives, and grand midwives)—were the dominant maternal health care providers in the U.S. (Cassidy, 2007), and in many areas of the world, they remain the primary providers of maternity care today (Kozhimannil et al., 2015). It was not until the twentieth century in the U.S., that the pregnancy and birth processes came to be seen as the domain of medical doctors (Rothman, 1982; Oakley, 1984). Prior to that time, birth took place in the private sphere of the home (Hunt & Symonds, 1995), and birth attendants were often laywomen who earned their knowledge and skills through observation and participation at births (Bourgeault & Fynes, 1997). The history of U.S. Black midwifery begins in the 17th century when these well-respected women were enslaved and transported to the Americas where they tended to a variety of health concerns from the plantation mistresses and enslaved women; these grand midwives continued to offer skilled caretaking and nurturing to their community after the Civil War (Goode & Katz Rothman, 2017). Other early community midwives were highly-trained immigrant midwives who were educated in European professional midwifery schools. Yet they were unable to organize, because they spoke different languages and tended to attend solely to their own immigrant communities. These diverse community midwives, along with their acquired practical knowledge (such as the delivery of breech babies without surgery), were nearly eliminated in the U.S. in the twentieth century because of several connected factors. These factors include: cultural changes in the view of childbirth; the rise of biomedicine as the dominant medical discourse; the professionalization of medicine (which brought an increase in the number of health care providers, pressure from medical professional organizations aimed at eliminating competition, and the reconceptualization of birth from something to be managed rather than attended); and increasing state regulation of birth care (Ehrenreich et al., 1973; Wertz & Wertz, 1989; Boyer and Donegan, 1978; Leavitt, 2016; Litoff, 1978; Borst and Apple, 1990).[3] These influences pathologized pregnancy, moving birth out of the private female sphere of the home and into the public, medicalized, male-led sphere of the hospital (Hunt & Symonds, 1995). In the U.S. today, despite a midwifery renaissance, midwives assist with less than 10% of all births (American College of Nurse, 2018) and practice "on the fringes of the mainstream medical system" (Foley, 2005).[4]

In light of these historical changes, birth came to be seen not as an ordinary everyday occurrence but as an extraordinary pathological event. These changes delegitimated lay, grand, and immigrant midwives (Gallo-Cruz & Rutherford, 2011) and initiated new categories of U.S. midwives: Direct-Entry Midwives and Certified Nurse-Midwives. The position of the lay midwife was absorbed into what is now known as the Direct-Entry Midwife (DEM), who enters directly into midwifery practice, usually with some type of academic and clinical training via apprenticeships, formal schooling, and/or self-study. Although DEMs[5] are restricted to working in home and birth center settings (Foley, 2005), there are thousands of DEMs providing maternal and infant care

[2] The medical workforce and health care professions have never remained static; in fact, they are continually contested and evolving because of the changing expectations of illness and medicine, increased access to technology, and consumer demand (Nancarrow & Borthwick, 2005).

[3] The similarities and differences between the midwifery model of care and dominant medicine is often debated in the literature. Some scholars view the obstetrics and midwifery models in opposition (Lowis & McCaffery, 2004), while other scholars see commonalities (Foley & Faircloth, 2003).

[4] In the United States, midwives have *always* held a subordinate status, "because [their care] dealt with women and was conducted by women" (Chamberlain, 2012); for example, their work was and is associated with the taboos of childbirth and abortion.

[5] With the exception of Certified Midwives, DEMs who graduate from university training programs, are trained in the same way as CNMs without having to pass through nursing training first. They are certified by the American Midwifery Certification Board, a daughter organization of the American College of Nurse-Midwives, and are able to practice in hospitals; they are very few in number.

throughout the country—even in states that forbid their practice, where DEMs risk prosecution.[6] Various credentials and licenses are available to DEMs; the most popular credential for DEMs is the nationally accredited title of Certified Professional Midwife (CPM), which is a required credential for state licensure (Midwives Alliance of North America, 2016).

There are around 3000 CPMs, who are legal, licensed, and regulated in only 35 states despite their proven excellent outcomes (Cheyney et al., 2014); they practice solely out-of-hospital, in homes and freestanding birth centers. Around half of these CPMs graduate from government-recognized programs and therefore meet the ICM international definition of the professional midwife. The other half learn via apprenticeships with one or more senior midwives; these CPMs do not meet the international definition, and thus are coded by ICM and the American College of Nurse-Midwives as "traditional birth attendants" (Davis-Floyd et al., 2020). Increasingly, states are requiring that CPMs meet the international definition by graduating from govern ment-recognized schools; therefore, the time-honored apprenticeship route to becoming a CPM may eventually disappear.

The modern Certified Nurse-Midwife (CNM) credential requires formal nursing training: a bachelor's degree in nursing (which certifies them as registered nurses, or RNs) and then a master's degree in midwifery. CNMs have prescription privileges, receive government insurance reimbursement, and are legally permitted to practice in every U.S. state. However, hospital bylaws and state laws strongly limit their scope of practice (for example, some states have laws that prohibit CNMs from using forceps to assist births and/or from performing abortions).[7] There are over 12,000 CNMs in the United States; they practice largely in hospitals, but may also practice as community midwives, serving patients in freestanding birth centers and homes (American College of Nurse, 2018).

While there are real and perceived differences between CPMs and CNMs, midwives of both types who work in home and birth center settings believe that their occupational identities generate prejudice based on false impressions of their skills (Monteblanco, 2018). This stigma shapes their professional interactions and the false impressions mean that midwives must frequently negotiate the stigma attached to their occupational identity.

Much of the negative public and medical perception of community midwifery comes from the idea that planned hospital births are safer than planned home or birth center births. Because of data restrictions and an absence of an integrated health care system that provides effective transfer to hospital should the need arise during a home or birth center birth, we do not definitively know whether this is true or false. However, numerous studies have shown that planned home or birth center births have lower rates of medical intervention (e.g., C-section, Pitocin) than planned hospital births, and that there is no difference in maternal and neonatal outcomes between low-risk hospital births and home births (Cheyney et al., 2014; Stapleton et al., 2013; Johnson & Daviss, 2005).[8] The American Public Health Association (American Public Health As, 2001) and the World Health Organization (Technical Working Group W, 1997) support home and birth center birth if the pregnant person is low risk and under the care of regulated and credentialed midwives.

Home and birth center-related risks are mitigated in well-integrated health systems (Hutton et al., 2019); more specifically, in places where midwifery is well-integrated into the larger health care system and midwives can easily transfer patients to hospitals when necessary (including U.S. states such as Texas and New Mexico), rates of obstetrical interventions and adverse neonatal outcomes are lower (Vedam et al., 2018). However, in locations where midwifery is not well-integrated (such as Oregon), planned community birth carries a slight increased risk of perinatal death over in-hospital birth (Snowden et al., 2015).

Planned birth center and home births in the U.S. declined between 1990-2004, but have experienced a resurgence since 2004 (MacDorman & Declercq, 2019). Prior to the pandemic, women reported that their decision to birth at home was influenced by comfort, avoiding unnecessary medical intervention, and the perception that their home was the safest place to give birth (as determined by a diversity of health outcomes) (Boucher et al., 2009). With the development of the pandemic, news outlets and a rapid response article are reporting that midwives are receiving an increase in inquiries about birthing at home or a birth center (Davis-Floyd et al., 2020; Rogers, 2020; Schmidt, 2020).

Negative public perceptions and misinformation about community midwives and home or birth center birth contribute to policy decisions about licensing, ability to practice, and health care integration. However, midwives have an opportunity to lobby for change during this pandemic, when hospitals are less appealing than ever for births. Community midwives' skills are right for this moment. Under current conditions, midwives and their advocates may successfully lobby for increased access to licensure and increased scope of practice in out-of-hospital settings, as indeed, many are doing when they are not too busy dealing with the increased volume of clients in their practices (Davis-Floyd et al., 2020).

3. Focusing events and an opportunity for community midwives

Social scientists have long noted the effectiveness of sudden events as triggers for policy change (Baumgartner & Jones, 2010). These "focusing events" include disasters such as earthquakes, oil spills (Birkland, 1998), and terrorism (Birkland, 2004a, 2004b). Although policy change is typically (and frustratingly) gradual, focusing events can create faster and larger shifts in policy (Yeo & Knox, 2019) because these events disrupt extant power structures. These disruptions offer windows of opportunity for politically disadvantaged interest groups to draw attention to previously ignored or overlooked problems (Birkland, 1998). While not all disasters are focusing events, extreme disasters are likely "to prompt policy learning and change because focusing events have a way of revealing systematic deficiencies" (Gerber, 2007). Two such focusing events in the U.S. were the September 11, 2001 terrorist attacks and Hurricane Katrina in 2005, both of which drew sustained public attention and provided evidence of past policy failure; the policy windows they created enabled the reshaping of emergency management and hazard mitigation policy in the U.S. (Birkland, 2009; Yeo & Knox, 2019).

The COVID-19 pandemic fits the definition of a focusing event: an unexpected, rare, and harmful event that holds the attention of both policy makers and the public (Agendas, 2013; Birkland, 1997). It therefore offers an excellent opportunity for community midwives and their advocates to lobby for policy changes. Immediate policy changes might allow them to help mitigate the strain placed by the COVID-19 pandemic on hospitals, as many are already doing, while long-term policy changes might allow them to safely and legally practice in states where they have

[6] In some states, homebirth midwifery without medical intervention is legal, but a midwife might be charged with practicing *medicine* without a license if, for example, she injects a client with the pharmacological agent like Pitocin in order to stop postpartum hemorrhage. Other charges that can be brought against a midwife include negligence, contributing to the death of an infant, and/or contributing to the death of a mother. The risk of criminal prosecution to midwives is substantiated in the legal literature (Corcoran, 2002; Tovino, 2004). Charges can be brought by patients, by physicians, or by the state and can take a variety of forms (e.g., sanctions by state medical boards, civil lawsuits, and/or criminal charges).

[7] For a more complete comparison of types of midwives, see the American College of Nurse-Midwives' report which aims to clarify the distinction among U.S. professional midwifery credentials: https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf.

[8] The percentage of pregnant patients deemed "low-risk" and thus eligible for out-of-hospital birth is changing as scholars report an increasing prevalence of chronic conditions among childbearing women in the U.S.; still, chronic conditions that might deem patients "high-risk" occurred in 91.8 per 1000 delivery hospitalizations, far from the majority of childbearing women (Admon et al., 2017).

not yet obtained legalization and licensure. I argue that COVID-19 is a "focusing event" that is disrupting the medical care system while at the same time placing higher demands on it; this offers community midwives and advocates the best chance in decades to lobby for their policy agenda.

4. Current and future assessment

As of April 2020, local and national media are documenting a resurgence in home and birth center birth (McAboy, 2020; Thompson, 2020; Villalon, 2020). Google Trends notes that searches for the phrase "home birth" increased between March 1-28, 2020; in fact, the week of March 22-28 offered the largest spike in searches for the phrase "home birth" since October 9-15, 2016 (Google Trends Internet, 2020). The Big Push for Midwives, an organization that campaigns for more birth options for women in the United States,[9] has long organized and mobilized political support for the legalization of midwifery (in states that had banned it) and the expansion of midwives' scope of practice. The Big Push for Midwives is tracking political organizing at the state level throughout the pandemic; it reports the emergence of lobbying efforts in Georgia, Illinois, North Carolina, Michigan, Maryland, and New York.

In New York, lobbying efforts are paying off. New York's Executive Order No. 202.11 (issued on March 27, 2020) modifies the New York Professional Midwifery Practice Act to "allow midwives licensed and in current good standing in any state in the United States, or in any province of Canada, to practice in New York State without civil or criminal penalty." As interpreted by the Birth Rights Bar Association (Birth Rights Bar Associat, 2020), this definition allows CPMs, who would have previously risked criminal charges related to lack of state-specific licensure, to practice in New York. In response to the focusing event of the pandemic, then, New York state policy was expanded to include CPMs licensed in other states and Canadian Registered Midwives (Birkland, 1998). Although this is a temporary stop-gap measure (Birkland, 1998), it may open the door to long-term changes in policy that advance midwifery as a field of practice.

This pandemic is a crucial moment, and an excellent opportunity, to study the concept of a focusing event in the context of U.S. midwifery—including stakeholders, policies, and health outcomes. The success of focusing events is shaped by a variety of institutions. Because midwifery-friendly policy changes threaten the dominance of large players in the field of maternal and fetal health, such as the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association, these "status-quo oriented groups" (Birkland, 1998) may downplay or even prevent the promotion of community midwifery as a response to the pandemic. For example, these groups might claim that the COVID-19-related dangers to pregnant people giving birth in hospitals are being exaggerated, and for this reason, their participation in this context should be examined. Yet near the beginning of the pandemic, ACOG issued an uncharacteristic policy statement encouraging collaboration with CPMs. Noting the irony, one CPM said: "Now, after persecuting midwives like me, you want me during a pandemic!" (Davis-Floyd et al., 2020).

Importantly, "focusing events do not guarantee an opportunity for policy change" (O'Donovan, 2017); thus future research will have to assess if this pandemic created the "right" conditions for community midwifery policy change. More specifically, how are community midwives and advocates leveraging this crisis and with what tactics, collaborations, imaginaries, and short or long-term success? (Bernstein et al., 2020)? [10] There are numerous policy measures that could be used to assess how well community midwives and advocates succeed in using this policy window and will likely differ across U.S. states.

Future analysis must include attention to a variety of policy changes, including but not limited to, a pathway to licensure in states where CPMs are still not legal, increased scope of care and professional autonomy (e.g., reduced oversight from obstetricians), Medicaid reimbursement (which some CPMs receive but many do not), and improved systems regarding credentialing and home to hospital transfer. Due to the positive health outcomes associated with midwifery integration (Hutton et al., 2019; Vedam et al., 2018), these policy changes should be assessed on the ways they do or do not create conditions for safer home births in the U.S. These policies and outcomes will be of interest to providers or social scientists that promote healthy families.

5. Conclusion

Because of the altered hospital care, the real and/or perceived risks associated with the hospital, and the increased visibility of community midwives, the COVID-19 pandemic offers a window of opportunity for midwives to demonstrate their skills to a wider audience and challenge the perception that hospital-based, physician-managed birth is the only safe type of birth. In fact, this crisis has already revealed that the U.S. needs community midwives' previously undervalued skills. Further, these circumstances may offer midwives the leverage to advocate for policies that support their legal practice and broaden their patient access and scope of care. With successful policy efforts, midwives and their advocates may create a new model of U.S. maternity care with more options for families across the country.

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[9] For more information, see their websites (http://pushformidwives.nationbuilder.com/about; https://www.facebook.com/PushForMidwives/).

[10] There are numerous examples of established and effective collaborations between midwives, obstetricians, and professional organizations that are already driving changes in maternity care in the U.S. For example, the Council on Patient Safety in Women's Health Care includes an alliance of nearly 30 organizations, although none which explicitly represent the interests of community midwives (The Alliance [Internet]., 2020).

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