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## **The Role of Midwives in Reducing Motherhood Mortality: Implications for Illinois and Beyond**

Morgan Christie

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SOUTHERN ILLINOIS UNIVERSITY

**PAUL SIMON  
PUBLIC POLICY INSTITUTE**

## **The Simon Review**

### **THE ROLE OF MIDWIVES IN REDUCING MOTHERHOOD MORTALITY: IMPLICATIONS FOR ILLINOIS AND BEYOND**

By Morgan Christie  
Celia M. Howard Fellow, 2019-2020

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# THE SIMON REVIEW

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## **ABSTRACT**

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Over the past ten years, the United States has experienced an increase in its motherhood mortality rate. Advocates, researchers, and legislators have suggested that expanding the profession of midwifery may be one solution toward decreasing the rising motherhood mortality rates in America. This paper addresses the issue of midwifery, both nationally and within Illinois. Within the paper, a midwifery-led model of care is reviewed, as well as barriers to midwifery and legislation related to maternal healthcare. Public opinion polling was also conducted with Illinois voters to collect information on perceptions of midwifery. The paper further outlines policy recommendations for improving maternal healthcare broadly, as well as how to support the expansion of midwifery. Finally, this paper addresses changes and concerns related to maternal healthcare that have occurred during the COVID-19 pandemic. This project was completed to better understand how midwifery can address motherhood mortality and serve to improve maternal healthcare in the United States.

# **THE ROLE OF MIDWIVES IN REDUCING MOTHERHOOD MORTALITY: IMPLICATIONS FOR ILLINOIS AND BEYOND**

## **INTRODUCTION**

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Over the past decade, the United States has experienced an increase in its maternal mortality rate. In 2007, the Centers for Disease Control and Prevention (CDC) reported a rate of 12.7 maternal deaths per 100,000 live births. The most recent calculation of the maternal mortality rate was reported in January 2020, marking the first time in over ten years the United States released an updated statistic reflecting maternal deaths. This statistic – 17.4 maternal deaths per 100,000 live births – reflected data collected in 2018 and represented a rise from the 2007 rate (Hoyert & Miniño, 2020). The overall maternal mortality rate indicates that in 2018, over 650 women died of maternal causes (Belluz, 2020). The CDC reported that about 700 American women die from pregnancy-related issues every year, and that 3 in 5 of such deaths are preventable (CDC Vital Signs, 2019). In Illinois specifically, maternal mortality rates have shown between 56 and 93 deaths over the past ten years, with the Illinois Department of Public Health (IDPH; 2018) reporting an average of 73 maternal deaths from 2008 to 2016. The IDPH further stated that over 70 percent of these deaths were preventable (Nowicki, 2019).

Moreover, along with the increasing rate of motherhood mortality, the United States has the highest motherhood mortality rate among high-income countries. For example, if ranked among countries with comparable levels of wealth, such as the United Kingdom or Germany, the U.S. would come last (Belluz, 2020). In fact, the United States' maternal mortality rate is likely higher than that found by the CDC in 2020. The updated statistics do not reflect deaths related to pregnancy-related suicide or drug overdose, and underestimates pregnancy-related deaths for

women over 45 (Martin, 2020a). In a statement provided to ProPublica, IDPH’s deputy director of the Office of Women’s Health indicated she believes the current statistic is “not a complete and accurate picture” of maternal mortality (Martin, 2020a).

Given the state of maternal mortality in America, it is clear that interventions aimed at reducing maternal death are much needed. To address the increasing rate of motherhood mortality, researchers and legislators have suggested that the use of midwives may help reduce the United States’ maternal death rates (Nowicki, 2019; Weisband et al., 2017). Midwives are traditional healthcare providers who are trained to provide care for both mothers and infants before, during, and after pregnancy (Midwives Alliance of North America, 2020). Midwifery training focuses on developing professional knowledge and acquiring skills that allow midwives to deliver quality care, including services related to pregnancy health, reproductive education and contraception, and labor-related care (American Pregnancy Association, 2020; Midwives Alliance of North America, 2020). Midwifery care is unique because it is based on individual needs across a variety of domains, including physical and mental health, cultural identification, and spiritual or religious preference (Midwives Alliance of North America, 2020). In other words, midwives provide maternal healthcare on an individualized basis, attending to the needs and identities of those they care for.

Despite the common goal of midwives to provide quality maternal care, one challenge to expanding midwifery in healthcare is that several types of midwives exist. Professional midwives fall into two categories: nurse-midwives and direct-entry midwives. Certified nurse-midwives (CNM) receive their training in hospital settings and are trained as both nurses and midwives (Midwives Alliance of North America, 2020). A CNM earns a nursing degree either prior to or during their midwifery education training (American College of Nurse Midwives,

2017). CNMs are licensed and have prescriptive power (American College of Nurse Midwives, 2016). Direct-entry midwives, on the other hand, are trained in out-of-hospital settings and do not have a nursing degree (Midwives Alliance of North America, 2020). Direct-entry midwives are labeled either certified midwives (CM) or certified professional midwives (CPM). CMs receive graduate-level training in science and health either prior to or during their midwifery education training (American College of Nurse Midwives, 2017; Midwives Alliance of North America, 2020). Despite receiving credentials for their education and training, their training is not recognized in every state (American College of Nurse Midwives, 2016). CPMs, on the other hand, do not receive nursing or graduate education. Instead, they must obtain clinical experiences in out-of-hospital settings, including home births and birthing centers (Midwives Alliance of North America, 2020). CPMs are still required to gain competencies in midwifery care, but do not need a higher level of education degree to do so. For this reason, they are sometimes referred to as “lay midwives” (McGowan, 2016). Filby et al. (2016, p. 4) noted that many midwives feel their profession is “commonly misunderstood” because of the variety in midwifery training and education. Despite the lack of a standard definition for midwifery personnel, midwives have a clear focus in providing maternal care before, during, and after pregnancy.

Regardless of the differences between the types of midwives, the suggestion of some that midwives can help reduce the rate of motherhood mortality in the United States continues to gain momentum. We need a better understanding of midwifery and its outcomes in order to effectively prevent rising rates of motherhood mortality. This paper focuses on a midwifery-led model of care, including birth outcomes, barriers to implementation, and policy implications. The recent data release from the CDC in January 2020 is timely and will allow us to gain better insight into the issue of maternal healthcare.



# **1 REVIEW OF THE LITERATURE**

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## **1.1 WHAT IS A MIDWIFERY-LED MODEL OF CARE?**

During the 1800s, midwifery practice was an everyday part of life and a respected tradition in society (Rothman, 1999). However, as industrialization took place across America, the place of midwives “moved out of the community” (p. 153) and physician-attended births became a normative practice (Rothman, 2012). Sociologist Barbara Katz Rothman was the first person to distinguish a midwifery model of maternal care from a medical model of maternal care (Rothman, 1999). A midwifery-led model of care differs from a physician-led model of care in its approach to patients, such that midwives provide individualized care before, during, and after birth (Midwives Alliance of North America, 2020). Within a midwifery-led model of care, a midwife is able to build a trusting professional relationship with a client in order to provide education and support throughout pregnancy (Midwives Alliance of North America, 2020). This relationship is unique in that mothers and midwives work together consistently throughout the experience of pregnancy, rather than having maternal health check-ups with various nurses and doctors.

In order to fully understand the difference between these two models of care, Rothman (2012) noted it is first necessary to understand the philosophical approaches underlying each model. Unlike obstetrics, midwifery-led models of care “avoid the industrial and seek out the individualized” (Rothman, 2012, p. 153). Obstetricians are part of larger institutions working from a medical model, meaning that doctors are managing women’s care from a standpoint of preventing and treating pregnancy- and birth-related complications (OBOS Pregnancy & Birth Contributors, 2014; Rothman, 2012). On the other hand, midwifery is a woman-centered

profession that contextualizes birth as a natural, personal, and meaningful process (Rothman, 1989, 2012). The International Confederation of Midwives (ICM; 2018) further defined the philosophy of midwifery care as one in which: (a) women’s human and reproductive rights are protected and respected; (b) ethnic and cultural diversity are appropriately attended to; (c) recognizes the importance of “the social, emotional, cultural, spiritual, psychological, and physical experiences of women” (p. 2); and (d) a partnership is developed between midwives and the women they care for. The ICM (2018) definition further describes the underlying ideology of midwifery as “emancipatory” (p. 2) because of the protection of women’s rights and the goal of increasing women’s self-efficacy related to childbirth. Midwives translate this philosophy of care into knowledge and skills for use with women across the pregnancy continuum, working not to just to identify and treat the physical aspects of pregnancy but also other relevant domains of the pregnancy experience (e.g., mental health, cultural; Renfrew et al., 2014).

Midwifery’s woman-centered philosophy of care translates to the use of specific skills in midwifery practice to focus on the needs of the individual patient (Rothman, 2012). In addition to providing women with education, care, and counseling to make choices about their own pregnancies, the midwifery-led model of care also focuses on reducing medical interventions that are deemed unnecessary for normal pregnancies (ICM, 2018; Midwives Alliance of North America, 2020). For example, midwives have a long history of birthing breech babies without technological intervention because they are skilled in the practice of childbirth (Rothman, 2012). It is important to note, however, that midwives do not necessarily act alone outside the current healthcare system. Rothman (2012) recognized that midwives practice “where the women are” (p. 151). In other words, given that the midwifery profession values providing woman-focused maternal care, midwives have found themselves practicing in the settings in which women give

birth, including hospitals (Rothman, 2012). Further, although midwives seek to reduce technological interventions used by physicians, they are trained to recognize when obstetrical referral is needed and collaborate with relevant healthcare professionals (American Pregnancy Association, 2020; ICM, 2018). In fact, as the midwives seek to expand their practice, many midwives are advocating for integration into the medical system (Martin, 2018). Thus, current efforts to increase the use of midwives are not focused on a complete divide between midwives and physicians, but rather increased integration that strengthens midwives' presence in healthcare.

### **Outcomes and Benefits of Midwifery**

Beyond the United States, concerns about maternal mortality have reached the global level. In 2015, the United Nations set goals for improving health services, such as sexual and reproductive health and rights, an area that covers maternal mortality (United Nations, 2016). One of the identified goals is to reduce the global maternal mortality rate to less than 70 deaths per 100,000 live births by the year 2030 (United Nations, 2016). Nove et al. (2018) noted that reaching this goal would require increased access to services for sexual, reproductive, maternal, and newborn health, including healthcare workers. They further recognized midwives as being a crucial part of such a workforce and central to the improvement of maternal healthcare (Nove et al., 2018). Though the United Nations' 2015 goals for sexual and reproductive healthcare were aimed specifically at low- and middle-income countries, the report recognized that globally, only 22 percent of the world's countries have a large enough midwifery workforce to meet maternal healthcare needs (United Nations, 2016). Given the lack of investment in midwifery training and the rising maternal mortality rate in the United States, these recommendations should also be recognized as crucial to the health of America's women and infants.

The emphasis on increasing midwifery care is based on research showing the benefits of midwives on maternal health. For example, Renfrew et al. (2014) conducted a meta-analysis of midwifery outcomes in high-income countries. They identified a number of maternal health outcomes that were improved by midwifery care, including: (a) reduced maternal mortality; (b) fewer preterm and low birth weight babies; (c) less pain both for women who had previously given birth and within the first 24 hours after labor; (d) reduced risk of pregnancy complications and trauma; (e) reduced anxiety and increased autonomy during labor; (f) lower rates of postpartum depression; and (g) shorter hospital stays (Renfrew et al., 2014). A 2016 Cochrane Review comparing midwifery-led models of care to physician-led models of care showed similar outcomes, including fewer losses of pregnancy and fewer technological interventions (Sandall et al., 2016).

In midwifery-led models of care, women were also more likely to have a known midwife supporting them during labor than in other models of care (Sandall et al., 2016). In general, women with access to a midwifery-led model of care also reported increased satisfaction with their experiences, which is an important aspect of continuing to utilize healthcare services (Renfrew et al., 2014; Sandall et al., 2016). Thus, it appears a shift toward a midwifery-led model of care and increased investment in midwives in the United States could significantly improve maternal health outcomes and decrease the nation's motherhood mortality rate.

## **1.2 BARRIERS TO MIDWIFERY**

Despite the documented benefits and positive outcomes of midwifery, there continues to be a hesitancy about expanding midwifery in the United States. Such hesitancy may be tied to myths about midwifery, as well as larger systemic factors. In a systematic review of the literature, Filby et al. (2016) explored the barriers to midwifery care from the perspective of care

providers in low- and middle-income countries. They identified three main categories of barriers that mutually reinforce each other: (a) social barriers; (b) economic barriers; and (c) professional barriers. In many cases, these barriers are reflective of myths or misunderstandings about midwifery, as well as gender-based inequality. Further, as these barriers overlap, they can lead to burnout for care providers and low quality of care for women seeking services (Filby et al., 2016).

### **Social Barriers**

Filby et al. (2016) noted that many of the barriers within the social category were aligned with gender inequality and a socio-cultural understanding of birth. In fact, they noted the largest social barrier for midwifery was the disempowerment experienced by midwives and their position of low social standing, both of which are driven by gender discrimination in healthcare (Filby et al., 2016). McGowan (2016) echoed this idea, noting that the misconception that midwives are unqualified places them in a lower social position compared to other healthcare providers. Further, in some countries, midwifery was culturally constructed as “women’s work” (p. 7) and therefore delegitimized (Filby et al., 2016). Midwives’ perceived lack of legitimacy leaves them in a position in which they must work to justify their profession through explanations of the scientific evidence behind their practice (Vedam, 2012), which adds an additional burden onto midwifery professionals. Thus, it appears that a large social barrier to expanding midwifery practice is embedded gender bias that devalues a system of care led by and for women.

### ***Cultural Competence***

Both midwives and women seeking midwifery care have identified cultural competence as an issue within midwifery practice. Given that nurses and midwives provide maternity care for

diverse populations (Burnard & Naiyapatana, 2004), it is important that their provision of care be culturally appropriate. Williamson and Harrison (2010) recognized the need to avoid engaging in prejudice and stereotypes when working with multicultural identities, emphasizing a perspective of culturally competent care in which culture is integrated into the midwifery framework. In doing so, “health” is not seen as a reflection of individual actions, but rather is placed within a social context (Williamson & Harrison, 2010). The social perspective of cultural competence means that social factors such as education and socioeconomic status are recognized as important health determinants (Williamson & Harrison, 2010). Thus, in order to meet the needs of a diverse population, midwives must ensure culturally competent practice.

### ***Social Determinants of Health***

Cultural competence is especially important when considering inequities in healthcare, especially those based on social determinants of health, including race, gender, and rurality. In terms of race, the CDC’s updated maternal mortality rate indicated that the rate for Black women was 2.5 to 3.1 times greater than the overall mortality rate of 17.4 deaths per 100,000 live births (Hoyert & Miniño, 2020). Between 2008 and 2016, the maternal mortality rate for African American women in Illinois was six times higher than that of non-Hispanic White women (Illinois Department of Health, 2018). The increased rate for Black women compared to other racial groups is reflective of significant healthcare disparities and racial bias in healthcare (Johnson, 2019). Such disparities are unlikely to diminish with the increased use of midwives alone, especially when considering more than ninety percent of midwifery service providers are White (Fullerton et al., 2015; Schuiling et al., 2013). High rates of death among women of color, racial bias in healthcare, and the lack of diversity among midwives mean that cultural

competence is an especially important strategy to implement in order to improve maternal care and reduce maternal deaths for people of color.

Serbin and Donnelly (2016) conducted a systematic review of the literature to examine the impact of individual and institutional racism in midwifery. They found that racism was common within midwifery education and professional organizations, which then influenced racial bias in clinical practice (Serbin & Donnelly, 2016). Further, they found that such racism acted as a barrier to both (a) women of color opting to use midwifery services, and (b) women of color entering the midwifery profession (Serbin & Donnelly, 2016). These findings point to the need for midwives to increase their cultural competence and to create a profession in which women of color feel welcomed as both service providers and receivers. In fact, because midwives of color are “uniquely positioned” to address the maternal care needs of other women of color (Serbin & Donnelly, 2016, p. 703), creating a culturally competent workforce would be beneficial for reducing maternal mortality and increasing midwifery access. In response to the need to better attend to the needs of women of color, the American College of Nurse Midwives issued a statement in which they committed their organization to diversifying the profession, supporting midwives of color, and addressing race and racial bias in training (ACNM, 2018).

Given that the midwifery model of care is aimed at providing individualized maternity care for those seeking services, midwives are also in a position to increase access within healthcare. Another area in which a lack of cultural competence serves as a barrier to care is that of gender inclusivity. Godfrey-Isaacs (2019) noted that an understanding of the differences between gender and sex and using gender-inclusive language are important components to culturally competent midwifery practice. Similar to race-related barriers, gender-diverse populations (i.e., those whose gender identities do not align with cultural gender norms,

including transgender and gender non-binary persons [American Psychological Association, 2015]) are less likely to access midwifery care if their needs are not attended to and their identities are not affirmed. In an attempt to increase its attention to an array of gender identities, the Midwives Alliance of North America changed some of the language for its core competencies to reflect a more gender-inclusive profession, using “pregnant people” and “birthing parent” rather than solely referring to “women” (MacDonald, 2016; Midwives Alliance of North America, 2014). Expanding the language used in midwifery practice is an important component of increasing midwifery access, especially for women who identify as transgender (Godfrey-Isaacs, 2019). The changes made for both race and gender have come with the hope of increased cultural competence within the profession that will help increase access to midwifery care.

For American women living in rural areas, accessing maternal healthcare can be especially difficult. Many rural areas are “maternity care deserts” in which there are few maternity care providers and no hospitals providing obstetric care (Rivett et al., 2019). These maternity deserts exist in half of the United States’ rural counties, affecting more than 5 million women in rural areas (Rivett et al., 2019; Simpson, 2019). Further, for most women who live in a rural area that offers maternity care, the drive to a care provider is often long (about an hour; Simpson, 2019) and requires access to reliable transportation. Thus, the biggest barrier for these women is finding care at all. Rouhana (2006) described a strong history of midwives operating in rural America, where they attend a large number of births. She noted that midwives are able to meet needs other care providers cannot (Rouhana, 2006), which means they are able to provide maternal healthcare in areas without hospitals and birthing centers. This idea was corroborated by a 2016 study of midwifery conducted by researchers at the University of Minnesota. After



surveying rural hospitals in nine states that offered maternity services, they found midwives contributed significantly to the maternity healthcare workforce in rural areas, attending one-third of births in rural hospitals (Plain, 2016). The researchers recognized the important role of midwives in rural areas and identified policy support of midwifery practice as an important step toward improved maternity care in rural areas (Plain, 2016). It should be noted, though, that not all states allow midwives to practice autonomously in rural areas, and that policy support of all midwives can increase access to maternity care for American women. For example, in areas without hospitals or obstetric units, midwives could travel to homes to provide care. Thus, in rural areas often lacking adequate healthcare options, midwives may be the solution to increased access for rural residents and reduced rates of maternal mortality in these areas.

### **Economic Barriers**

One of the economic barriers to midwifery identified by Filby et al. (2016) is the lack of government support for the midwifery profession, a concern echoed in the United States. Although there have been professional bodies and legislators calling for the expansion of midwifery practice, very little movement has been seen in the U.S. For example, in 2000, the American Public Health Association called for increased access to midwives in order for pregnant people to have additional maternity care options. They recommended increased support of midwifery in order to recognize midwives' contributions to healthcare and ensure the public has access to a midwifery model of care (American Public Health Association, 2000). They also noted the future of midwifery relies upon research funding and education (American Public Health Association, 2000). The recommendations from the American Public Health Association are similar to those made by other professional organizations. Despite the call for increased access to midwives, the profession remains underfunded.

The midwifery model of care also holds the potential to reduce healthcare costs in the United States. Some research highlights that lower costs are associated with birthing centers or homebirths compared to physician-led hospital births. For example, in a review examining the economic impact of giving birth in a birthing center or at home, Henderson and Petrou (2008) found that birthing centers and homebirths were associated with lower resource use than hospital births because of fewer interventions and shorter times in birth and recovery (i.e., length of stay). They noted that this meant healthcare costs were generally lower, but not always, such as when more “high grade” midwives were employed at a particular birthing center (Henderson & Petrou, 2008). These findings were supported in a study conducted by Schroeder et al. (2012), who estimated the cost of places of birth using data from a cohort of low-risk pregnant women in England. They found that homebirths and births in a midwifery unit were less costly than those in obstetric units, but that the cost difference was not as great when pregnancy complications were introduced (Schroeder et al., 2012). In general, it appears as if midwifery offers a lower-cost birthing option, though more research is needed, especially for the United States. The lower cost of a midwifery-led model of care compared to a physician-led model of care could reduce the financial barrier for healthcare access.

### **Professional Barriers**

A lack of investment in midwifery training serves not only as an economic barrier, but also a professional one. If midwives are not able to access quality education and training, the profession will not be able to expand (Filby et al., 2016). The lack of research and policy support is also indicative of midwifery’s lower standing within healthcare, a previously identified social barrier. Not investing in midwifery education also translates to fewer midwives in the healthcare profession (Filby et al., 2016), making access to midwives scarcer. Though such concerns are

relevant for other healthcare professionals, Filby et al. (2016) noted the gendered aspects of midwifery often underlie the lack of funding in midwifery. Thus, it is clear that the barriers to expanding and accessing midwifery often intersect and reinforce each other.

### ***Home Birth***

Another professional barrier within midwifery is the spaces in which midwives operate, especially at-home births. As previously noted, many ideas around birth and motherhood are socially constructed, which affects the ways in which midwives practice. In the United States, hospital births are the norm, and home births are often stigmatized. For example, Hafner-Eaton and Pearce (1994) recognized that many Americans view home birth as an “archaic” (p. 813) birthing option. Despite this view, many women seek home birthing options in order to avoid the medicalization of birth that occurs in hospital contexts (Hafner-Eaton & Pearce, 1994; Rothman, 2012). In fact, Vollmer (2019) recognized that in addition to religious and personal reasons, women often seek home births because of a previous history of medical trauma. Thus, though home birth may be viewed as an outdated option, many women may desire a home birth in order to have a more natural and personal pregnancy experience.

Rothman (2014) recognized that much of the conversation around home birth centers on its dangers because “pregnancy and birth are [...] understood as risky”. She further noted that the move to giving birth in a hospital occurred despite evidence suggesting doing so also presents its own dangers (Rothman, 2014). We know that midwives, whether in hospitals or at home births, lead to better maternal healthcare outcomes (Renfrew et al., 2014; Sandall et al., 2016). In fact, midwives are specifically trained to understand the complications that can arise during birth, including how to treat such complications or when to refer to a more intensive level of care (Martin, 2018; Rothman, 2012, 2014). Further, the newborn death rate for home births is similar

to that of hospitals, serving as one demonstration of comparable levels of care (Johnson & Daviss, 2005). Additional research on home births is rare, given legal restrictions on home births in the United States (Berlatsky, 2015).

The focus on danger and safety surrounding childbirth leads to restrictions on midwifery practice. For example, in Illinois, home births are legal, but can only legally be attended by medical doctors and CNMs together (Kranich, 2013). That is, CNMs cannot attend home births on their own unless they have previously obtained a written agreement from a medical doctor (Kranich, 2013). Kranich further noted that because of this, few midwives are legally allowed to attend home births. Yet the desire for home births has not subsided and many women still opt for home delivery. As a result, women seeking home births are likely to deliver their children without a professional or find a midwife who is willing to provide care illegally – options that increase the danger of home birth due to lack of access to necessary equipment, such as oxygen (Berlatsky, 2015; Vollmer, 2019). Ultimately, restrictions on home birth limit women’s autonomy by reducing the number of available delivery options, thereby restricting access to quality maternal healthcare. Given the fact that home births still occur, policies that support the expansion of midwifery practice should therefore recognize home birth as an important and valid delivery option. Further, such policies should include necessary resources for midwives attending home births to decrease illegal or underground midwifery practice and promote safe maternal care.

## **2 CURRENT LEGISLATION**

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### **2.1 MATERNAL DEATH IN ILLINOIS**

In October 2018, after reviewing maternal mortality data from 2008-2016, the Illinois Department of Public Health (IDPH) released a report on maternal morbidity and mortality in the

state. After noting the increase in maternal mortality nationwide and the racial disparities in maternal deaths in Illinois, the IDPH identified factors contributing to maternal death in Illinois, including: (a) lack of communication between care providers; (b) inconsistent policies and procedures for treating pregnant women across hospitals; (c) missed opportunities to attend to physical, mental health, and social determinants of health; (d) quality of care impacted by lack of provider skill and education; (e) difficulty accessing care, especially for women without insurance; and (f) lack of public awareness and education about postpartum health (IDPH, 2018). Prevention strategies related to mental and postpartum health are especially needed, given that postpartum suicide is the one of the leading causes of post-pregnancy maternal mortality (Joy, 2019) and often overlooked in conversations about maternal health.

Beyond outlining contributing factors in maternal mortality in Illinois, the IDPH also identified a number of recommendations for the prevention of maternal death in the state.

Among these recommendations were:

- Extending postpartum care by expanding Medicaid coverage from 60 days to one year following delivery. Included in this recommendation was a specific call for insurance plans to expand case management and outreach coverage for high-risk mothers.
- Creating and expanding programs in which mothers can receive care in their homes, including doula services, during and after pregnancy.
- Improving access to substance use and mental health services for women during and after pregnancy.

Further, in November 2018, Illinois Department of Public Health Director Dr. Nirav Shah announced the IDPH would be conducting a medical study to examine the factors contributing to

maternal morbidity (Shah, 2018). For the study, medical records for women who experienced maternal morbidity must be submitted to the IDPH, with records from 2016 through 2020 included (Shah, 2018). Shah noted in the IDPH memo that the purpose of the study is to gain insight into contributing factors of maternal morbidity for Illinois women, with the goal of developing policies to improve maternal health. If the factors contributing to inadequate maternal care for Illinois patients can be identified, updated policies and procedures may help create a better system of maternal care in Illinois. Some Illinois legislators are working to make midwives part of the improved system of care.

## **2.2 ILLINOIS LEGISLATION**

In response to the rising motherhood mortality rate in the United States and in support of women's healthcare, the past few years have brought legislative changes for maternal care. In Illinois, Representatives Mary Flowers and Robyn Gabel (among others) have been especially vital as they seek to create more options and protections for childbearing women. Rep. Flowers recognized that maternal mortality is an important and overlooked issue in America (CST Editorial Board, 2020). She therefore created legislation in 2019 that required hospitals to collect maternal mortality data that can be used to determine areas of care that require increased attention and resources (CST Editorial Board, 2020). Flowers is particularly concerned about the racial disparities in maternal care. Nowicki (2019) noted that the racial disparity in infant deaths is actually greater today than it was in 1850, before the Civil War. Flowers commented that this fact illustrates there are "real problems here in the United States" (Nowicki, 2019). Rep. Gabel has sponsored a number of bills relating to maternal healthcare, including those directly advocating for midwives and home birth.

Further, in 2019, Governor J. B. Pritzker signed a bill to address maternal mortality in Illinois. The new law requires hospitals to collect data on maternal mortality rates. Governor Pritzker also created a task force to examine the high motherhood mortality rates among African American women. This legislation is timely, given that the Illinois Department of Public Health reported that between 2008 and 2016, the maternal mortality rate for African American women was six times higher than that non-Hispanic White women. The following section outlines select legislation with particular relevance to the current paper. See Appendix A for a list of recent legislation pertaining to women's care.

### **HB0001 – Infant and Maternal Mortality**

Authored by Representative Flowers, the Task Force on Infant and Maternal Mortality Among African Americans Act was created in direct response to the high maternal mortality rate among African Americans. In order to address racial disparities in maternal health, HB0001 established the Task Force on Infant and Maternal Mortality Among African Americans. The task force consists of relevant health professionals, such as the Director of Public Health and medical providers and is working to create guidelines to decrease infant and maternal mortality among African Americans in Illinois (HB0001, 2019). The bill also requires that one task force member be an “African American woman of childbearing age who has experienced a traumatic pregnancy, which may or may not have included the loss of child” (p. 9; HB0001, 2019). The task force will also review national data collected on maternal mortality to identify trends in disparities based on race and identify best practices and interventions for reducing racial disparities in maternal care (HB0001, 2019). In July 2019, the Task Force became a public act (Public Act 101-0038), effective immediately.

## **HB0002 – Pregnancy and Childbirth Rights**

Authored by Representative Flowers and co-sponsored by Representative Gabel, the Pregnancy and Childbirth Rights Act was introduced in the House in November 2018. The legislation includes a list of rights pertaining to pregnancy and childbirth. Included in these rights are:

- The right to receive health care before, during, and after pregnancy and childbirth.
- The right to choose a certified nurse midwife or physician as her maternity care professional.
- The right to choose her birth setting from the full range of birthing options available in her community.
- The right to receive information in a language in which she can communicate in accordance with federal law.
- The right to receive emotional and physical support during labor and birth.

In August 2019, HB0002 became a public act (Public Act 101-0445) and took effect January 1, 2020.

## **HB2449 – Home Birth Safety Act**

Co-authored by Representative Gabel, the Home Birth Safety Act is a recent piece of legislation that explicitly advocates for the expansion of midwifery practice in Illinois. The Home Birth Safety Act supports the licensure of midwives (HB2449, 2019). The Act would specify limitations on licensed midwives' scope of practice, but would ultimately serve to legally regulate the practice, thereby increasing access to midwifery services. Included in the bill are



provisions for midwives' qualifications and administrative procedures (HB2449, 2019). Further, the language included in the bill was developed by the U.S. Midwifery Education, Regulation, and Association (US MERA; Betancourt, 2017). The US MERA is a national midwifery organization that has previously developed standards for the profession (Betancourt, 2017), so their work on the bill will help to maintain a clear vision of midwifery practice and allow for consistency between Illinois law and national standards. Though promising for the midwifery profession, the Home Birth Safety Act has yet to be voted on. The last action on the bill took place in March 2019, when it was re-referred to the Rules Committee. Despite the lack of movement, though, it seems the bill continues to garner support, with Representative Joyce Mason signing on as a co-sponsor in March 2020.

## **2.3 FEDERAL LEGISLATION**

In addition to statewide legislation, the past several years have seen the introduction of a number of federal bills targeting maternal mortality. Of those reviewed in the following section, only one has become law at the time of writing. However, the number of bills addressing maternal healthcare is increasing, indicating legislative interest in reducing maternal mortality.

### **H.R.1318 – Preventing Maternal Deaths Act of 2018**

Introduced in March 2017, the Preventing Maternal Deaths Act of 2018 created resources at the federal level for the collection and analysis of maternal mortality data in all 50 states (H.R.1318, 2018). The bill also supports states with previously established maternal mortality review committees, ultimately providing the nationwide infrastructure necessary to gain a better understanding of maternal death in the United States (Kozhimannil et al., 2019). Though the legislation is important, Kozhimannil and colleagues (2019) noted several important

considerations for the bill's implementation, including: how maternal deaths are defined, the accessibility of such data, how data will be integrated for analysis following collection, and challenges related to collecting adequate sample sizes for at-risk groups (e.g., racial and ethnic groups, sexual minority groups). The legislation became a law (Public Law No: 115-344) in December 2018.

### **H.R.5761 – Ending Maternal Mortality Act of 2018**

In May 2018, Illinois Representative Raja Krishnamoorthi introduced the Ending Maternal Mortality Act of 2018. The bill would require the Department of Health and Human Services to publish a prevention plan to reduce maternal mortality every two years (H.R.5761, 2018). As part of the published document, the plan would identify specific factors contributing to motherhood mortality, including concerns related to public awareness, healthcare disparities, and quality of care (H.R.5761, 2018). The bill has not seen any movement since it received introductory remarks in May 2018.

### **H.R.5977 – Mothers and Offspring Mortality and Morbidity Awareness Act**

The Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act was introduced in May 2018 by Illinois Representative Robin Kelly. If passed into law, the bill would establish programs to address the rising rate of motherhood mortality in the United States and would expand Medicaid covered for pregnant and postpartum women (H.R. 5977, 2018). Senator Richard Durbin also commented that the bill would address racial disparities in maternal healthcare in an effort to improve the cultural competence of pregnancy care (“Durbin, Kelly Announce Legislation”, 2019). Building off recommendations from the IDPH’s (2018) report, the bill would specifically address racial bias training for healthcare providers and improve

communication about collaborative care professionals (“Durbin, Kelly Announce Legislation”, 2019). The bill was referred to the House Committee on Energy and Commerce and has not seen movement since May 2018.

### **H.R.2902 – Maternal CARE Act**

In another effort to decrease racial disparities in maternal care and improve outcomes for women of color, Senator Kamala Harris reintroduced the Maternal Care Access and Reducing Emergencies (CARE) Act in May 2019, which is led in the House by Representative Alma Adams (“Maternal CARE Act”, 2019). Citing racial bias against Black women and inequitable healthcare treatment, the bill will establish a grant program of \$25 million to create implicit bias training for healthcare providers (H.R.2902, 2019; “Maternal CARE Act”, 2019). Further, the bill seeks to have training be a clinical training component for medical schools (“Maternal CARE Act”, 2019). In addition to \$25 million toward implicit bias training, the bill would also allocate \$125 million toward the identification of high-risk pregnancies and provision of culturally competent care (“Maternal CARE Act”, 2019). Importantly, the legislation has been supported by a number of midwifery associations, including the American College of Nurse-Midwives and the National Black Midwives Alliance (“Maternal CARE Act”, 2019). The bill was referred to the Subcommittee on Health in May 2019 and has not seen action since.

## **3 THE FINDINGS IN ILLINOIS**

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### **3.1 PUBLIC OPINION POLLING**

In order to gain insight into Illinois voters’ perspectives of maternal mortality and midwifery, the Paul Simon Public Policy Institute conducted a statewide poll on the issue. Field work for the Simon Poll™ was conducted from Monday, February 10, 2020, to Monday,

February 17, 2020. Live telephone interviews were conducted by Customer Research International of San Marcos, Texas, using the random digit dialing method. No autodial or “robo” polling is included.

The sample included 1,000 voters with a margin of error of plus or minus 3.1 percentage points. The margin of error for the Republican sample (n=232) is 6.4 percentage points and the margin of error for Democrats (n=475) is 4.5 percentage points. The sample obtained 56 percent male and 44 percent female respondents. The entire poll and results can be accessed online through the Paul Simon Public Policy Institute’s website, paulsimoninstitute.siu.edu.

### **3.2 RESOURCES FOR REDUCING MOTHERHOOD MORTALITY**

Respondents were provided with a definition of the midwifery-led model of care and informed that some experts have suggested midwives can help reduce death or injury during child delivery. They were then asked to identify which of three statements they most agreed with. These statements were:

- 1) In order to address the high motherhood mortality rate, the state of Illinois should allocate more resources to maternal care, including the use of midwives.
- 2) In order to address the high motherhood mortality rate, the state of Illinois should allocate more resources to maternal care but should not use midwives.
- 3) I do not believe that any additional provisions should be used to address the motherhood mortality rate, including the use of midwives.

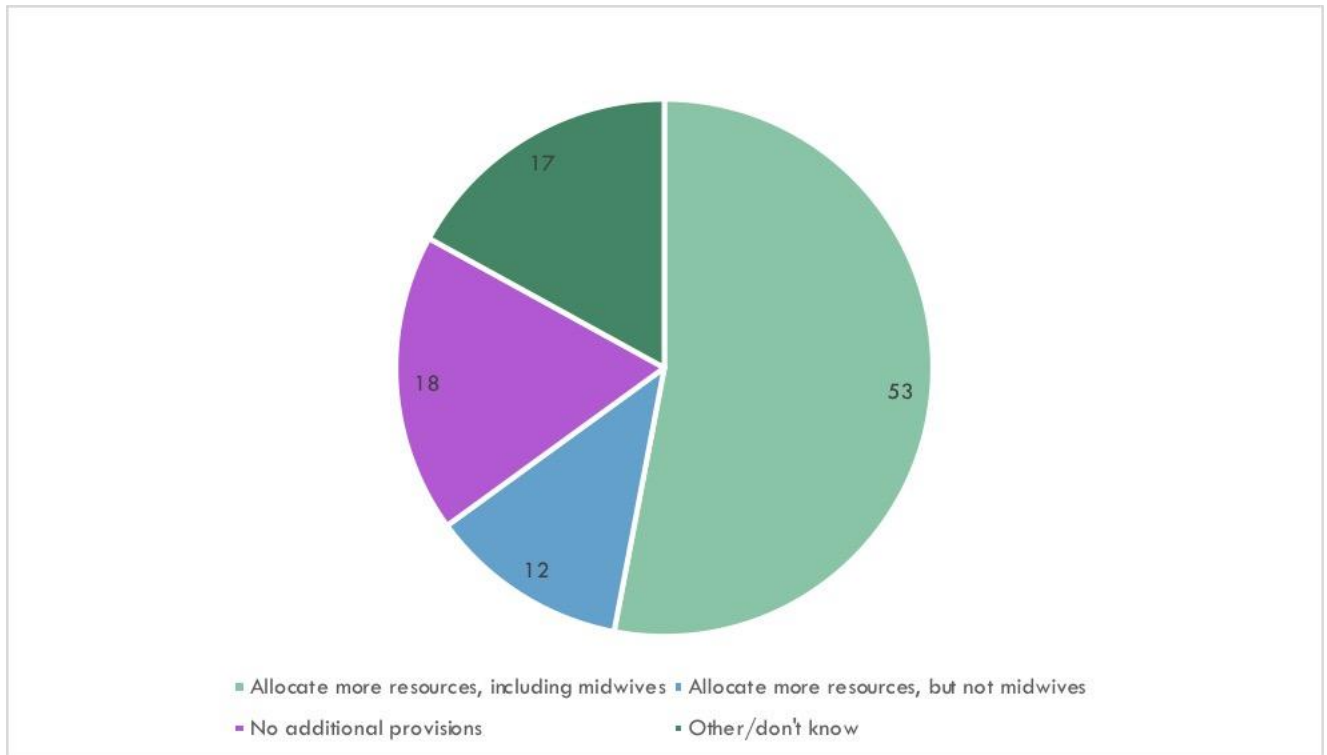
Fifty-three percent of voters indicated they agreed that Illinois should allocate more resources to maternal care, including the use of midwives (see Table 1 and Figure 1). Twelve percent of voters agreed that Illinois should allocate more resources to maternal care but did not endorse the use of midwives. Approximately one in six respondents, or 18 percent, reported they did not

believe Illinois should institute any additional provisions to address motherhood mortality.

Further, seventeen percent of voters indicated they did not know or weren't sure how Illinois should address motherhood mortality.

*Table 1*

<b>Response</b>	<b>Percent (n=1000)</b>
Allocate more resources to maternal care, including the use of midwives	53%
Allocate more resources to maternal care, but should not use midwives	12%
You do not believe that any additional provisions should be used to address the motherhood mortality rate, including the use of midwives	18%
Other/don't know	17%



*Figure 1: Responses to three statements about how Illinois should address the motherhood mortality rate, if at all. Values are rounded and may not sum to 100%.*

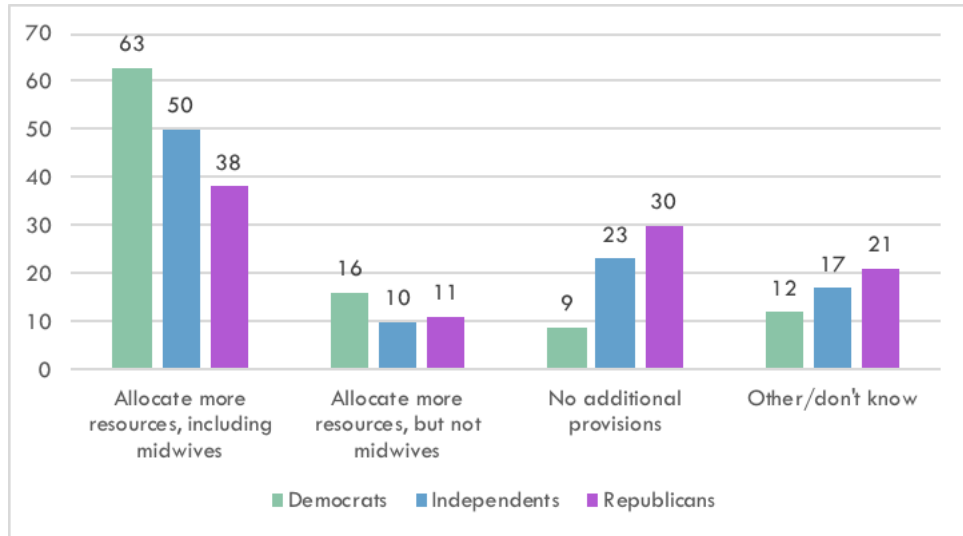
In response to these statements, differences emerged based on political party (see Table 2 and Figure 2). Higher proportions of Democratic (63 percent) and Independent (50 percent) voters said they believe Illinois should allocate more resources to maternal care, including the use of midwives. In contrast, Republican voters were least likely to support the use of midwives at 38 percent.

Democrats were also more likely to support the allocation of resources to maternal care, but not for midwives, at 16 percent. Independents and Republicans had similar proportions of voters supporting Illinois allocating more resources to maternal care but opposing the use of midwives at 10 percent and 11 percent, respectively.

Based on party affiliation, Republicans (30 percent) were most likely to believe Illinois should not enact any additional provisions to address motherhood mortality, including the use of midwives. Twenty-three percent of Independents did not believe any additional provisions should be in place. Democrats followed the Independents with only 9 percent reporting they did not believe any additional provisions should be in place.

*Table 2*

	<b>Democrats</b>	<b>Independents</b>	<b>Republicans</b>
Allocate more resources, including midwives	63%	50%	38%
Allocate more resources, but not midwives	16%	10%	11%
No additional provisions	9%	23%	30%
Other/don't know	12%	17%	21%



*Figure 2: Responses by political party to three statements about how Illinois should address the motherhood mortality rate*

When examined by region (see Table 3), modest differences in opinion emerged. Sixty-one percent of voters in Chicago supported the allocation of more resources to maternal care, including midwives, with 51 percent of suburban voters and 49 percent of downstate voters taking this same view. Similarly, slight differences also emerged when examined by gender (see Table 4). Women (56 percent) were more likely to endorse more maternal care resources, including midwives, when compared to men (50 percent). In contrast, more men (21 percent) indicated they did not think any additional provisions for maternal care should be in place than did women (16 percent).

**Table 3**

	<b>City</b>	<b>Suburbs</b>	<b>Downstate</b>
Allocate more resources, including midwives	61%	51%	49%
Allocate more resources, but not midwives	13%	13%	11%
No additional provisions	12%	20%	21%
Other/don't know	14%	17%	19%

**Table 4**

	<b>Men</b>	<b>Women</b>
Allocate more resources, including midwives	50%	56%
Allocate more resources, but not midwives	11%	14%
No additional provisions	21%	16%
Other/don't know	19%	14%

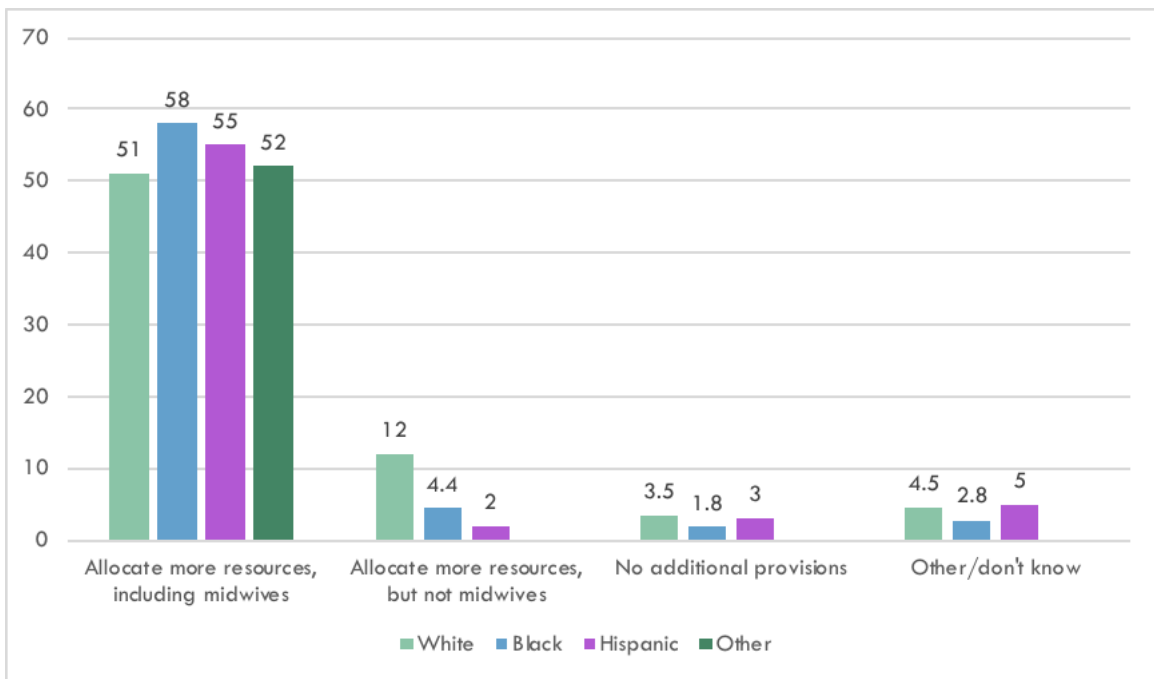
When examined by race, similar response patterns emerged across racial categories, but Black and Hispanic voters indicated a greater endorsement for midwives than did White voters (see Table 5 and Figure 3). Fifty-eight percent of voters who believed Illinois should allocate more resources to maternal care, including the use of midwives, identified as Black. Hispanic voters followed Black voters at 55 percent in supporting the allocation of resources to maternal care and midwifery, and over half of White voters (51 percent) took this same view. In terms of opposing additional provisions for maternal care, White voters had the greatest endorsement of this view (19 percent), followed closely by voters who identified as non-Black and non-Hispanic



(e.g., Other; 17 percent). Black and Hispanic voters had similar rates of opposition to additional provisions, at 16 percent and 15 percent respectively.

**Table 5**

	<b>White</b>	<b>Black</b>	<b>Hispanic</b>	<b>Other</b>
Allocate more resources, including midwives	51%	58%	55%	52%
Allocate more resources, but not midwives	12%	13%	11%	15%
No additional provisions	19%	16%	15%	17%
Other/don't know	18%	13%	19%	15%



**Figure 3:** Responses by race to three statements about how Illinois should address the motherhood mortality rate.

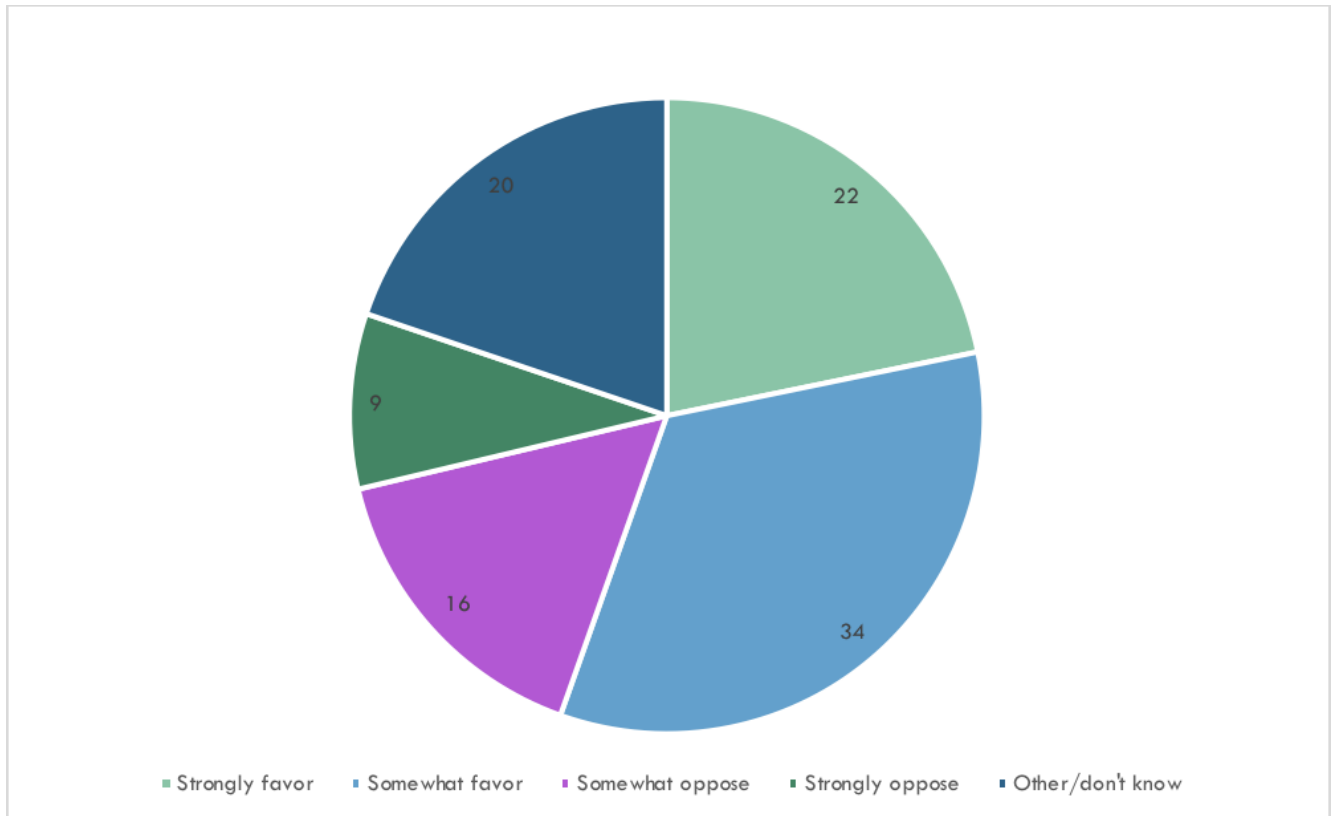
### 3.3 FAVORABILITY TOWARD MIDWIFERY-LED MODEL OF CARE

When asked if they favored or opposed a midwifery-led model of care, most respondents endorsed this model (see Table 6 and Figure 4). Overall, over half the voters polled (55 percent) reported they would favor a midwifery-led model of care. Twenty-five percent of voters

indicated they opposed a midwifery-led model of care, with 20 percent of respondents expressing uncertainty about whether or not they would support such a healthcare model. There were no major differences across region or gender.

**Table 6**

<b>Response</b>	<b>Percent (n=1000)</b>
Favor	55%
<i>Strongly favor</i>	22%
<i>Somewhat Favor</i>	34%
Oppose	25%
<i>Somewhat Oppose</i>	16%
<i>Strongly oppose</i>	9%
Other/don't know	20%

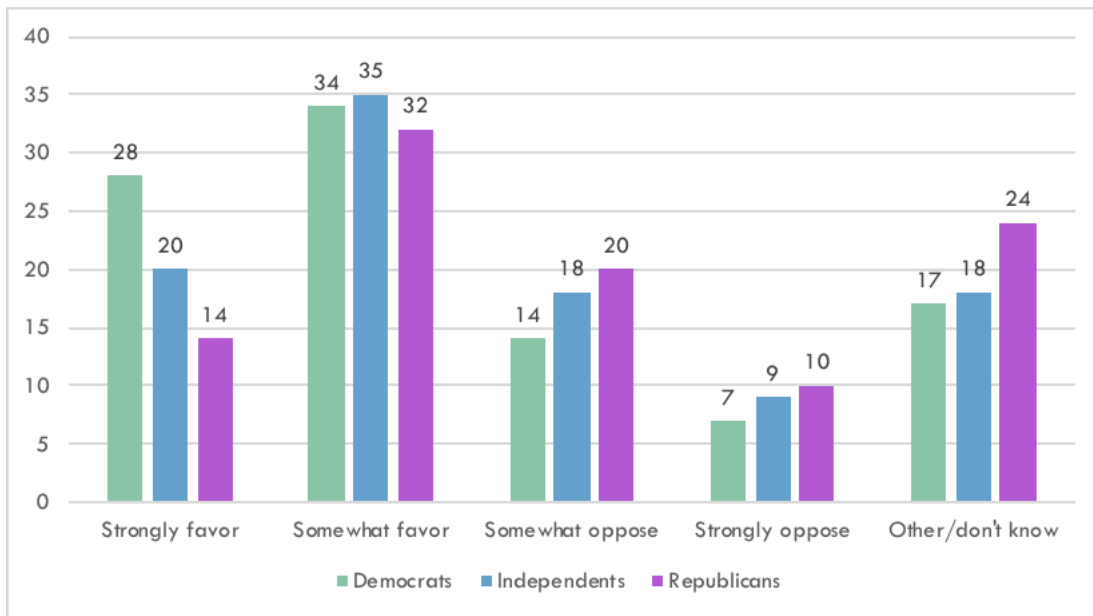


**Figure 4: Favor or Oppose Midwifery**

Voters identifying as Democrats (62 percent) were most inclined to say they would favor a midwifery-led model of care (see Table 7 and Figure 5). Independents followed the Democrats, with 55 percent reporting they would favor a midwifery-led model of care. Republicans represented the smallest proportion of voters with nearly half (46 percent) favoring this healthcare model.

*Table 7*

	<b>Democrats</b>	<b>Independents</b>	<b>Republicans</b>
Strongly favor	28%	20%	14%
Somewhat favor	34%	35%	32%
Somewhat oppose	14%	18%	20%
Strongly oppose	7%	9%	10%
Other/don't know	17%	18%	24%



*Figure 5: Favor or Oppose Midwifery by Political Party*

In general, there were slight differences in favorability based on region (see Table 8) and gender (see Table 9). Sixty-one percent of respondents from Chicago favored a midwifery-led

model of care, compared to 54 percent of suburban voters and 54 percent of downstate voters. Respondents from the suburbs (29 percent) endorsed stronger opposition to a midwifery-led model of care than respondents from the city (19 percent) or downstate voters (23 percent). In terms of gender, over half of both men (52 percent) and women (58 percent) favored a midwifery-led model of care. Men and women equally opposed a midwifery-led model of care at 25 percent each.

*Table 8*

	<b>City</b>	<b>Suburbs</b>	<b>Downstate</b>
Strongly favor	27%	21%	19%
Somewhat favor	34%	33%	35%
Somewhat oppose	13%	18%	15%
Strongly oppose	6%	11%	8%
Other/don't know	21%	18%	23%

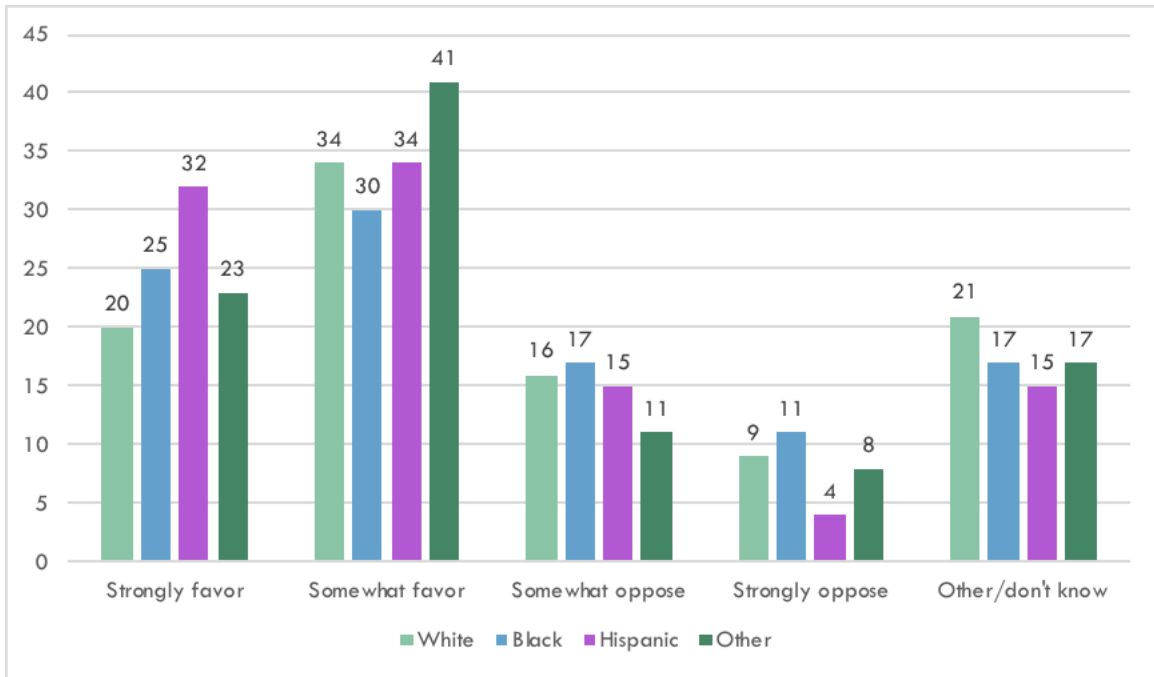
*Table 9*

	<b>Men</b>	<b>Women</b>
Strongly favor	19%	24%
Somewhat favor	33%	34%
Somewhat oppose	16%	16%
Strongly oppose	9%	9%
Other/don't know	23%	16%

When examined by race, Hispanic voters (66 percent) reported the strongest endorsement for a midwifery led model of care (see Table 10 and Figure 6). Black and White voters similarly endorsed this healthcare model, with 55 percent of Black respondents and 54 percent of White respondents favoring a midwifery-led model of care. Hispanic voters also had the lowest rate of opposition for midwifery at 19 percent, followed by 25 percent of White voters and 28 percent of Black voters opposing a midwifery-led model of care.

**Table 10**

	<b>White</b>	<b>Black</b>	<b>Hispanic</b>	<b>Other</b>
Strongly favor	20%	25%	32%	23%
Somewhat favor	34%	30%	34%	41%
Somewhat oppose	16%	17%	15%	11%
Strongly oppose	9%	11%	4%	8%
Other/don't know	21%	17%	15%	17%



**Figure 6: Favor or Oppose Midwifery by Race**

Unfortunately, national polls have not specifically addressed voters' opinions toward midwifery. Given this, it is unclear how Illinois voters' attitudes toward midwifery compare to a national sample. The lack of a national comparison highlights the importance of conducting future research and increasing policy work related to the implementation of a midwifery-led model of care whether for Illinois or for the nation.

## **4 IMPLICATIONS AND RECOMMENDATIONS**

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### **4.1 NATIONAL POLICY RECOMMENDATIONS**

Broader policy recommendations to address America’s maternal mortality crisis have also emerged. For example, the National Conference of State Legislators (NCSL) released state policy recommendations in April 2019. Among their recommendations was the use of evidence-based home visiting programs to support both pregnant and new mothers (NCSL, 2019). They recognized home visiting can reduce infant and maternal mortality (NCSL, 2019), likely by providing a means by which infant and maternal health can be continually monitored and mothers can receive support. NCSL (2019) also recommended expanding the healthcare workforce and addressing maternal mental health. They noted that in states where midwives are covered under Medicaid (e.g., Washington and Oregon), mothers reported increased levels of care and feeling well-supported (NCSL, 2019). Thus, as legislators look for ways to improve maternal health outcomes, considering midwives and home visits within policy remains important. In terms of mental health treatment, midwives are often trained to recognize relevant mental health concerns. Though they are not trained mental health clinicians, they may play an important role in recommending services and providing resources for women in need.

The Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN; 2009) has also provided recommendations for midwifery expansion. They provided three main policy recommendations: (1) recognize midwives as health care providers for insurance coverage and expand the use of midwives; (2) increase the presence of midwives in hospital settings; and, (3) allow third party reimbursement for midwives’ services. These recommendations would allow for increased access to midwifery, both because midwives would be a covered healthcare option and their services would be increasingly more available. AWHONN’s recommendation for

Medicaid expansion aligns with the American College of Nurse-Midwives' (ACNM) policy position of improving the licensure process for midwives (ACNM, 2020). ACNM specified that legislation related to midwifery licensure is important because it would allow midwives to be included in the Medicaid definition of "medical staff" and thereby reduce barriers to expanding midwifery (ACNM, 2020) in order to have midwives be included in the definition. Further, increasing midwives in hospital settings aligns with many midwives' goal of being integrated into our existing healthcare system (Martin, 2018). In general, incorporating midwifery services into legislation and policy aimed at reducing motherhood mortality would provide women with more options for maternal care and could serve as a support for improving maternal health in the United States. Support policies that recognize midwifery as an important healthcare profession and supports midwifery education, training, and practice are essential to expanding the profession and increasing access to maternal healthcare.

## **4.2 RECOMMENDATIONS FOR FUTURE DIRECTIONS FOR ILLINOIS**

As Illinois seeks to reduce its maternal mortality rate, special attention should be paid to groups with especially high rates of maternal mortality and decreased access to resources, including women of color, low-income women, and women in rural areas. Koblinsky and colleagues (2016) recommended that in order to prioritize maternal health, collaborative care across healthcare services is necessary. They also suggested that quality maternal health services are those that attend to the needs of the specific population (Koblinsky et al, 2016). Given the both diverse population and rural landscape of Illinois, it may be especially crucial for Illinois to support midwifery expansion in order to meet the needs of its citizens. As previously noted,

midwifery has the potential to be a culturally competent form of maternal care that provides increased support and accessibility for many women. Thus, in order to best serve the women in the state, policies improving and expanding midwifery education, training, and practice should be supported. Verani and colleagues (2011) also recognized the need for policymakers to collaborate with healthcare professionals in order to create policies that maximize their public health impact. It is therefore recommended that Illinois policymakers seek out expert advice and attend to the most recent scientific data as they battle rising maternal mortality rates.

Finally, it is important to recognize that maternal healthcare is ultimately a gendered issue that overwhelmingly impacts women. As previously noted in this paper, the intersectionality (i.e., a consideration for how interconnected systems of power create social disadvantage across cultural, group, and individual levels, especially for those belonging to multiple social categories [Cole, 2009; Moradi & Grzanka, 2017]) of race, gender, income, and geographic location, further creates a healthcare system in which women seeking maternal care are neither treated equally nor provided with equal access to services. As maternal healthcare policies are created, they have the potential to combat inequities in healthcare and fill gaps in policy that do not adequately address women's needs (Lombardo et al., 2017). In order for such policies to work best and promote gender equality, though, they not only require input from healthcare experts, but also from women themselves (Lombardo et al., 2017). Therefore, Illinois should conduct more research about the impact of midwifery on maternal health and identify the needs and desires of women in the state.

### **4.3 MATERNAL HEALTHCARE DURING THE GLOBAL PANDEMIC**



In March 2020, the United States began experiencing the impact of the global coronavirus pandemic. Coronavirus disease 2019 (COVID-19) is a contagious respiratory infection that has affected millions of people around the world (Chen et al., 2020). The disease was first reported in China in December 2019, and by the end of January 2020 it had been declared an international Public Health Emergency by the World Health Organization (WHO, 2020). Among the concerns stemming from COVID-19 are those relating to maternal and infant welfare during the pandemic. As the United States responds to the coronavirus crisis, almost one million women will give birth from March to May (Martin, 2020b). These births will not only create an overall strain on the current healthcare system, but also pose their own challenges surrounding maternal health, including keeping infants and mothers safe throughout the pandemic.

In terms of the effect of COVID-19 on pregnant women, little is known given the virus's novelty. Based on current available research, pregnant people do not seem to be at greater risk of contracting COVID-19 than those who are not pregnant (CDC, 2020). However, the CDC (2020) recognized that pregnant people may be at increased risk for certain infections and may experience more severe illness to certain viruses (e.g., influenza) than those who are not pregnant. That is, when pregnant, individuals may be more likely to contract certain viruses, including respiratory viruses similar to COVID-19 (Martin, 2020b). Given this, the CDC has identified pregnant people as an at-risk population, along with those who are disabled and racial and ethnic minorities (CDC, 2020).

The current recommendations for protecting pregnant people from COVID-19 are similar to those of the general public, including hand washing, social distancing, and frequently disinfecting surfaces (CDC, 2020). Though useful, these recommendations are proving to be

particularly challenging for certain groups of pregnant people, including pregnant healthcare workers. Martin and Yeung (2020) noted that America's healthcare workforce is about 90 percent female, and the CDC has offered little guidance for protecting this particular group. Further, given that the majority of healthcare workers are female, women are at an increased risk of contracting COVID-19 in healthcare settings (Waldstein, 2020). Pregnant healthcare workers have cited concerns about staying at home, such as being fired and being needed in the fight against the pandemic (Martin & Yeung, 2020). In general, there exists a lack of data to inform recommendations for protecting pregnant people against COVID-19, especially those working on the frontlines of the pandemic.

### ***The Intersection of COVID-19 and Gender***

Despite the lack of evidence-informed recommendations, the United Nations Population Fund (2020) stated the pandemic is influencing the provision of sexual and reproductive services, and that these services are essential and must be maintained. It appears that the pandemic is also uniquely impacting people along the lines of gender. In terms of maternal healthcare, it is clear COVID-19 will largely impact women. In fact, Allsbrook (2020) recognized that current data has already indicated the pandemic is heightening barriers to healthcare experienced by women. These barriers have been made even worse for women of color, women living in low socioeconomic conditions, and women in rural areas (Allsbrook, 2020). Given the United States is already struggling to provide adequate healthcare to pregnant women (as evidenced by the high maternal mortality rate, especially for Black women), COVID-19 will likely exacerbate maternal healthcare disparities (Allsbrook, 2020; Guo, 2020). As recommendations and data related to COVID-19 change daily, many have speculated the negative impact on maternal healthcare may not emerge until the pandemic subsides (Guo, 2020).

The current pandemic has not only highlighted the ways in which disparities exist for women's health, but also the specific ways in which the healthcare system needs to be improved. Simpson (2020) noted COVID-19 has displayed how the healthcare system is "fragile", while Allsbrook (2020) wrote that the current crisis has constrained the healthcare system in a way that exposes its inability to meet women's needs. Specifically, the pandemic has brought attention to four key barriers to accessing women's healthcare: (1) health insurance limits the number of healthcare options available to women, especially for those unable to afford comprehensive coverage; (2) racial bias has created healthcare disparities and a lack of healthcare equity for women of color; (3) stigmatization of reproductive healthcare results in limited services and restrict women's healthcare options; and (4) many healthcare providers are inaccessible, especially for low-income and rural populations (Allsbrook, 2020). These concerns have become more prominent throughout the pandemic as services close and access to healthcare is further restricted for many women. Though a complete review of the impact of COVID-19 on maternal healthcare is beyond the scope of this paper, the following section outlines key concerns that have emerged throughout the pandemic.

### **Practical Concerns**

As healthcare practices have changed in response to COVID-19, childbearing experiences have drastically changed. Many pregnant people have found themselves unable to access care the ways they typically would, such as attending regular in-person visits. Providers have been forced to find the best ways to attend to maternal healthcare during this time, and pregnant people are experiencing increased stress as a result (Martin, 2020b). Two primary concerns that have emerged include how labor and delivery experiences might be different, and how women can navigate the birthing process during a pandemic.

### *Labor and Delivery Experiences*

As hospitals around the country are inundated with COVID-19 cases, many providers and pregnant people are searching for out-of-hospital solutions to pregnancy care. As hospitals limit the number of visitors allowed inside, some hospitals have elected to deliver pre- and postpartum care via telehealth (Guo, 2020). In many cases, birthing classes have been conducted online using YouTube or Skype (Martin, 2020b; Slaton, 2020). Weigel (2020) recognized that although this option reduces coronavirus exposure, some women may not have telehealth coverage through their insurance, especially for mental health care. Further, not everyone has equal access to the technology to engage in telehealth services, and telehealth may only be a viable option for women with low-risk pregnancies (Martin, 2020b). Another concern is the rising domestic violence rates that come with remaining at home (Lewis, 2020), which may pose yet another challenge for pregnant people trying to maintain their health and reduce stress during this time.

Delivery experiences have also changed during the pandemic. Many hospitals are requiring women to reduce the number of visitors in the delivery room. In some cities, such as San Francisco, no visitors were allowed in the delivery room during the start of the pandemic (Slaton, 2020). This policy has since changed, and now one visitor is allowed, meaning women must decide who they want present during delivery (e.g., spouse, doula, midwife); (Slaton, 2020). Women who have had to make this decision have reported anxiety, anger, and fear (Martin, 2020b). Early in the pandemic, it was also suggested women may be separated from their infants for the first two weeks in order to follow quarantine guidelines (Guo, 2020), although it is unclear if this has happened. Finally, some physicians have also proposed that in order to control who is in the hospital, women in their 39<sup>th</sup> week of pregnancy should have an induced labor (Martin, 2020b). This option has been debated, with advocates worrying women

will feel pressured to have induced labors or that their options are limited and may receive poor communication about the process from providers during this time (Simpson, 2020). The variability of delivery options is quickly changing, with the bottom-line being that women are experiencing increased stress surrounding pregnancy and delivery at this time.

### ***Home Birth and Midwifery***

As people seek to avoid hospitals during the pandemic, many women have considered the option of home birth. Though experts have indicated people do not need to create home birthing plans instead of giving birth in hospitals (North, 2020), increasing fears about maternal and infant health in the face of coronavirus are driving many women to consider the option. Considering home births mean many women are seeking support from midwives and doulas, who have also stated they would feel more comfortable supporting clients in a home birth setting than a hospital setting during the pandemic (North, 2020).

But seeking a midwife also has its own challenges. Home birth midwives are typically not covered by insurance, which would leave pregnant people paying for services out-of-pocket (North, 2020). This option further limits access for low-income women. The increasing demand for midwives has also put a strain on those providing midwifery services at this time, given the high demand and increased attention toward protecting maternal and infant health (Simpson, 2020). Further, as healthcare providers limit their services in response to the pandemic, many women of color and rural women are experiencing increased difficulty accessing services because of racial bias and travel distances (Simpson, 2020). That is, accessing providers to provide quality care has become even more of a challenge while navigating the impact of COVID-19.

Ultimately, as Allsbrook (2020) pointed out, the pandemic is revealing the ways in which accessing maternal healthcare in the United States is challenging for many women. Perhaps the concerns we are experiencing related to labor and delivery represent a failing of the current healthcare system to provide affordable and accessible care for American women. Further, as people seek options for pregnancy care, the pandemic is also showing us that hospital births are not the only viable option for pre- and postpartum care. If policies aimed at the education and training of midwives are supported, the midwifery profession would be able to expand, thereby increasing the number of birthing options available to women. As the pandemic progresses and eventually ends, it is possible we will see reform related to maternal healthcare.

## **5 CONCLUSIONS**

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Despite the evidence promoting the benefits of midwifery, the profession remains constrained by a lack of regulation and support from public policy. At the same time, motherhood mortality continues to be a prominent issue in the United States. Increasing women's access to maternal healthcare options is necessary to reduce national motherhood mortality rates. Midwifery could serve as one solution toward lower motherhood mortality and improved maternal healthcare. Further, midwifery is an individualized approach to healthcare that is more accessible, more affordable, and, in some cases, more culturally appropriate. Given the increased attention to reducing racial bias in midwifery, expanding the profession may also be one step toward decreasing inequities in healthcare.

Lawmakers in Illinois have proposed a number of bills to address maternal healthcare and motherhood mortality, with many of these bills still working their way through the House. The number of bills proposed in the past few years addressing this issue represents care and concern

for women's health and even includes considerations of midwifery expansion. As Illinois strives toward lower maternal mortality, lawmakers should pay special attention to the social, economic, and professional barriers to maternal healthcare, especially those related to midwifery. Given that Illinois is a bellwether state (Everson, 1990), it has the potential to lead the trend toward improved maternal care across the country. Illinois women will benefit from continued efforts to increase maternal healthcare access and options.

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**APPENDIX A – MATERNAL HEALTH LEGISLATION IN ILLINOIS**

<b>Bill</b>	<b>Title (Status)</b>	<b>Brief Description</b>
HB0001	<b>INFANT &amp; MATERNAL MORTALITY</b>  <i>(Public Act effective July 12, 2019)</i>	Creates the Task Force on Infant and Maternal Mortality Among African Americans Act. Creates the Task Force on Infant and Maternal Mortality Among African Americans.
HB0002	<b>PREGNANCY &amp; CHILDBIRTH RIGHTS</b>  <i>(Public Act effective January 1, 2020)</i>	Amends the Medical Patient Rights Act. Provides that every woman has certain rights with regard to pregnancy and childbirth, including the right to receive care that is consistent with current scientific evidence about benefits and risks, the right to choose her birth setting, the right to be provided with certain information, and the right to be treated with respect at all times before, during, and after pregnancy by her health care professionals and to have a health care professional that is culturally competent and treats her appropriately regardless of her ethnicity, sexual orientation, or religious background. Provides that a woman has the right to a certified nurse midwife as her maternity care professional and to examine and receive an explanation of her total bill for services rendered.
HB0003	<b>HOSPITAL REPORT CARD ACT</b>  <i>(Public Act effective August 23, 2019)</i>	Amends the Hospital Report Card Act to require that each hospital include in its quarterly report instances of preterm infants, infant mortality, and maternal mortality. Requires the reporting of racial and ethnic information of the infants' mothers, along with the disparity of occurrences across different racial and ethnic groups.
HB0004	<b>MEDICAID-DOULA SERVICES</b>  <i>(Assigned to Appropriations – Human Services Committee January 28, 2020)</i>	Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that doula services shall be covered under the medical assistance program. Sets forth certain certification and training requirements a doula must satisfy to qualify for reimbursement under the medical assistance program.



HB0005	<b>MATERNAL CARE</b>  <i>(Public Act effective August 23, 2019)</i>	Amends the Department of Human Services Act. Requires the Department of Human Services to ensure access to substance use services statewide for pregnant and postpartum women, and to ensure that programs are gender-responsive, are trauma-informed, serve women and young children, and prioritize justice-involved pregnant and postpartum women. Amends the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. Requires the Department of Public Health to establish a classification system for specified levels of maternal care. Requires the Department to implement substantive measures that benefit maternal care and provide a greater amount of available information in order to further medical research.
HB0006	<b>IDPH-WOMEN'S HEALTH CLINICS</b>  <i>(Placed on Calendar – Consideration Postponed February 18, 2020)</i>	Amends the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. Requires the Department of Public Health to establish women's health clinics throughout the State to provide affordable health care for women. Requires the services provided at the women's health clinic to be offered at an affordable price and to include specified services, including women's health examinations, pregnancy confirmation, prenatal care, labor and delivery services, postpartum care, family planning examinations and birth control services, and care for sexually transmitted diseases and infections.
HB0007	<b>MEDICAID-DOULA-MIDWIFE SERVICE</b>  <i>(Assigned to Appropriations – Human Services Committee February 18, 2020)</i>	Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires services provided by community midwives, doulas, and breastfeeding peer counselors to be covered and reimbursed under the medical assistance program for persons who are otherwise eligible for medical assistance. Effective immediately.
HB2433	<b>HOSPITAL-BLOOD PRESSURE</b>  <i>(Public Act effective July 19, 2019)</i>	Amends the Hospital Licensing Act and the University of Illinois Hospital Act. Requires every hospital to ensure that it has the proper instruments available for taking a pregnant woman's blood pressure. Provides that the Department of Public Health shall adopt rules for the implementation of the requirement.

HB2438	<b>MATERNAL MENTAL HEALTH</b>  <i>(Public Act effective August 16, 2019)</i>	Amends the Illinois Insurance Code. Requires an accident and health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Amends the Medical Practice Act of 1987, the Nurse Practice Act, and the Physician Assistant Practice Act of 1987. Provides that licensed physicians, advanced practice registered nurses, and physician's assistants who provide prenatal and postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for mental health conditions.
HB2449	<b>HOME BIRTH SAFETY ACT</b>  <i>(Re-referred to Rules Committee March 29, 2019)</i>	Creates the Home Birth Safety Act. Provides for the licensure of midwives by the Department of Financial and Professional Regulation and for certain limitations on the activities of licensed midwives. Creates the Illinois Midwifery Board. Sets forth provisions concerning application, qualifications, grounds for disciplinary action, and administrative procedures. Amends the Regulatory Sunset Act to set a repeal date for the new Act of January 1, 2030. Amends the Medical Practice Act of 1987, the Nurse Practice Act, and the Illinois Public Aid Code to make related changes.
HB2895	<b>IDPH-HEMORRHAGE TRAINING</b>  <i>(Public Act effective August 16, 2019)</i>	Amends the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. Provides that the Department of Public Health shall ensure that all hospitals require specified employees to complete educational training on the management of severe maternal hypertension and postpartum hemorrhage. Provides that hospitals must demonstrate completion of the training of new hires with a course certificate from the Department. Provides that the Department shall ensure that all hospitals conduct continuing education yearly for specified employees. Provides that the continuing education shall include yearly simulations or drills regarding management of severe maternal hypertension and obstetric hemorrhage for all employees that care for pregnant or postpartum women. Provides that hospitals must demonstrate compliance with the education and training requirements.
HB5226	<b>MEDICAID-MATERNAL MENTAL HEALTH</b>  <i>(Referred to Rules Committee February 18, 2020)</i>	Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that, to address maternal mental health conditions and reduce the incidence of maternal mortality and morbidity and postpartum depression, pregnant women eligible to receive medical assistance shall receive coverage for prenatal and postnatal support services during pregnancy and during the 24-month period beginning on the last day of the pregnancy. Provides that prenatal and postnatal support services covered under the medical assistance program include, but are not limited to, services provided by doulas, lactation counselors, labor assistants, childbirth educators, community mental health centers or behavioral clinics, social workers, and (cont.)

		public health nurses as well as any other evidence-based mental health and social care services that are designed to screen, identify, and manage maternal mental disorders.
HB5629 SB3851	<b>MIDWIVES PRACTICE ACT</b>  <i>(Assigned to Appropriations – Human Services Committee March 3, 2020)</i>	Creates the Certified Professional Midwives Practice Act. Provides for the licensure of midwives by the Department of Financial and Professional Regulation and for certain limitations on the activities of licensed midwives. Creates the Illinois Midwifery Board. Sets forth provisions concerning application, qualifications, grounds for disciplinary action, and administrative procedures.
SB0025	<b>REPRODUCTIVE HEALTH ACT</b>  <i>(Public Act effective June 12, 2019)</i>	Amends the Mental Health and Developmental Disabilities Code. Provides that as soon as possible but not later than 24 hours, excluding Saturdays, Sundays and holidays, after emergency admission of a respondent to a mental health facility on an inpatient basis, the respondent shall be personally examined (rather than examined) by a psychiatrist. Provides that for the purpose of this provision, a personal examination includes an examination performed in real time (synchronous examination) via an Interactive Telecommunication System as defined in the Illinois Administrative Code.
SR0063	<b>INVESTIGATE MATERNAL MORTALITY</b>  <i>(Resolution adopted April 30, 2019)</i>	Urges the General Assembly to continue to investigate and identify areas in which the State can improve with respect to the prevention of maternal mortality, especially among vulnerable populations.

SRJ0012 SRJ0014	<b>HOME BIRTH CRISIS COMMITTEE</b>  <i>(Referred to Assignments January 31, 2019)</i>	Creates the Home Birth Maternity Care Crisis Study Committee to provide the General Assembly a consumer-focused, evidence-based solution to the Illinois Home Birth Maternity Care Crisis.
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