HOUSTON MIDWIVES AND PUBLIC HEALTH POLICIES: HOW THEIR FIGHT CAN HELP US ALL

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DEDICATION

To all midwives, especially those who made this study possible. May they find unending energy to fight for all women and provide a sense of community that knows no bounds.

To Jesse, for your love, support, and sacrifices during the most difficult times. I could have never finished this without you.

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ABSTRACT

This study examines the themes of policy experiences and priorities from 14 midwives in the Houston metro area. As midwives increasingly take responsibility for improving reproductive health, they struggle to achieve their goals when met with policymakers that don't share their vision. Using critical medical anthropology, I focus on how this discord affects women's health and is damaging to society when representatives pass over bills that would grant midwives authority as primary birth care providers. The experiences shared with me through interviews are compared to the literature of midwifery associations, collaborative organizations active in maternal and child health, and Texas midwifery's biggest competitor, the Texas Medical Association, to contextualize the struggle of midwifery advocacy within a holistic narrative. This study finds that Houston area midwives are well-versed in the policy objectives in Texas legislature, but are less active in the strategic planning of political objectives, especially as they expand into the arena of public and global health.

Key Terms: **midwife, birth, public health, public policy, birth center, gender, equity, reform, human rights**

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CHAPTER ONE:
Introduction

Statement of topic

This case study seeks to understand how local Houston midwives participate in advocacy to enact change within maternal health legislation. I explore how midwives identify problems with the current system and why they may or may not be involved in advocacy. Existing literature, including *Birth in Four Cultures* (1993) by Brigitte Jordan and *Birth as an American Rite of Passage* (1992) by Robbie Davis-Floyd, have a longitudinal and cross-cultural focus over an expansive population of midwives to complete a larger narrative. This study differs by creating a present-day snapshot of local midwives and their attitudes around policy reform. Historically, midwives in the US have taken part in long political battles for freedoms in their scope of practice, but even those who choose not to be directly involved have insight on what still needs to be done. This study is a response to that data. Interdisciplinary studies on midwifery and public health (Farmer 2005; Singer and Erickson 2013; Kotch 2005; Davis-Floyd and Johnson 2006; Davis-Floyd and Sargent 1997; Davis-Floyd and Cheyney 2019; Ginsburg and Rapp 1995) are very successful at contextualizing how the body is situated within politics. We know that the body is a source of commodification (Csordas 1990) but case studies exploring what it would take to systemically decommodify the maternal body in a technocratic society (Cogburn et al. 2019; Georges and Daellenbach 2019) are limited. By examining the biases that midwives believe lead to stalls in policy reform and how they adapt through survival or deviant strategies, I argue that the restrictions on midwives are unjust, unscientific, and create an epidemic of capitalism-driven structural violence in maternity care.

There are several case studies on the progressive agendas of midwives in other states during the 1990s and 2000s (see Davis-Floyd and Johnson 2006 for several), but new studies combining midwifery with human rights during the present political climate have yet to be created. I argue that issues leading to midwifery exclusion from mainstream culture and healthcare are only a symptom of a larger structural problem, yet public health experts believe they can be the tool to improving maternal and infant health locally, nationally, and around the world. It is my belief that the disciplines of medical and applied anthropology offer an opportunity to submit solutions to the public as an acknowledgment of personal duty to engage in social problems—not just to describe them.

Background

Women's Health Movement

The advancement of midwifery in contemporary America follows a complex series of phenomena triggered by second-wave feminism and the Women's Health Movement that began in the 1970s. Notions of the "natural" female role in society were being questioned as part of a larger look at gender bias in medicine. Policies in public health surrounding women beginning in the 1930s "reinforced the perception that women's healthcare is essentially reproductive healthcare" (Mottl-Santiago 2002:228). The presence of gender bias in policy was indicative of the sexist logic and flawed methodology that propelled women of the "1960s, 1970s, and early 1980s [to focus] on issues of equal rights, equal pay, reproductive freedom, and the election of women to public office" (Munch 2006:21). A natural consequence in an attempt to shake off patriarchal control over women's health was a demand for a *holistic model* of birth based on "midwifery, home birth, unmedicated hospital-based

birthing options, and woman-friendly hospital childbirth policies" (Mottl-Santiago 2002:229). The revival of the holistic model rejected the *mechanical model* of birth that increasingly relied on technology. The mechanistic world view that emerged out of an increasingly secularized Western society continued to transform into a *technocratic model*—a term coined by Davis-Floyd—which added emphasis on hierarchy, institutions, and patriarchy (1992). The rise of the mechanized model was also offset by the reduction of meaningfulness in the social and religious experience (Turner 2008:59). The changing hegemony of birth models will be discussed in detail throughout the theoretical framework explication.

The most iconic social actor for traditional midwifery during this time was Ina May Gaskin. The setting for this natural birth revolution was The Farm, which was started by herself, her husband Stephen, and their many followers in 1971. Ina May used her work as a midwife to encourage empowerment for women, to renounce fear during labor and delivery, and to teach each woman to find her own unique way of giving birth (Gaskin 2002). She remains active in the birthing community, giving talks, leading workshops, and providing continuous updates for her five books, which continue to be heavily referenced in midwifery education courses.

Concerns shifted in the 1980s and 1990s towards equal representation of women in clinical trials after finding that women only received a portion of the extensive funding and aggressive disease treatment that men did, even when they were proportionally affected by the same diseases (Mottle-Santiago 2002; Munch 2006; Wiley and Allen 2017). Additionally, advocacy groups were established to represent the diversity of women whose health needs did not align with the predominant culture on account of ethnicity, age, disability, sexual and gender identity, or socio-economic status (Mottle-Santiago 2002:229).

The 1990s were led by the development of women's health programs within federal agencies, such as the Centers for Disease Control and Prevention (CDC) Office of Women's Health. Welfare programs like Temporary Assistance for Needy Families (TANF) also went through reformation because of new block grants to states, leading to decreased enrollment for the most vulnerable families, as well as lower enrollment rates in Medicaid. Suggestions have followed that programs dedicated to reproductive health, such as the Association of Maternal and Child Health Program, should become comprehensive lifespan systems (Mottle-Santiago 2002:230-231). The idea was, and remains, that women's health should be approached holistically, not just reproductively, and that this approach can be optimized by use of collaboration between traditional and non-traditional healthcare settings (2002:230), also referred to as *medical pluralism* (Leslie 1980; Baer et al. 2003). This recommendation is echoed today by many nurse-midwives who want to expand their authority and utilize their full scope of practice.

A Brief History of Midwifery Licensing and Differences in Philosophy

Certification, licensure, accreditation, regulation, legalization—each one plays a part in the semantics and practice of midwifery. Each one labels and disjoints a model of care that has the potential for unification. They're also necessary in ensuring that all healthcare providers meet standards of care even in emergencies. One of the biggest disagreements between care providers is how and to what degree midwives should be educated and regulated.

Before the 20th century, US midwives were community based. Midwifery was often passed down within the family through apprenticeship. Midwives were recognized as

authorities on local belief systems in pregnancy and birth, and by extension puberty, sex, and menopause. Their contribution to maintaining tradition provided women with a community of support extending into post-partum and early child years and fostered trust and reciprocity of care among local women. But as the authority of biomedical doctors grew in the early 20th century, the authority of traditional midwives declined until it was almost extinguished through fear-based campaigns. Physicians and hospitals claimed midwives were "dirty, illiterate, ignorant, and irresponsible, in contrast to hospitals and physicians, which were portrayed as clean, educated, and the epitome of responsibility in healthcare" (Davis-Floyd 2006:32-33). New technologies promising to eliminate discomfort during birth refocused consumer demand towards medicalized birth as physicians' reputation as the facilitators for modern health grew. Use of new biomedical technologies was restricted to physicians and obstetricians who were beginning to establish a hierarchical knowledge of modern birth by "super-skilling" themselves and developing a professionalized, regulated brand of medicine (Davis-Floyd 1997, 2006). Midwives, having never regulated their profession before, could not compete with the new medical institution that was now so rooted in patriarchal authority through exclusive male colleges and government regulations. Their presence all but disappeared in America until the second-wave feminist movement encouraged a resurgence of consumer interest in natural labor and delivery techniques. Modernization had resulted in a focus on technology, prosperity, and convenience.

Now that medicalized birth also reflected those values, many women wanted to reassert intuitive knowledge as authoritative in their birth experience (meaning the mother's psychological and physiological experiences during birth would be trusted rather than being replaced with technology) by hiring midwives. The counter-culture birth movement was

pivotal to the establishment of midwifery education programs. In 1965 the American College of Nurse-Midwives (ACNM), founded in 1955, began an accreditation process. In 1970 the ACNM began administering national certification and accreditation for their programs (Davis-Floyd 2006:66; NACPM 2014b). And after fifty years of "building a legal and regulated profession with a solid organizational base and long-established standards of education and practice" (Davis-Floyd 2006:41), Sister Angela Murdaugh, president of ACNM in 1981, took a risk by pursuing dialogue with lay midwives. She invited their presence and participation at the ACNM headquarters in Washington D.C. and asked that they create their own organization and standards so that they might someday lawfully serve women (Davis-Floyd 2006:42). The suggestion wasn't immediately successful and was argued about by lay and professional midwives, but the appeal of a like-minded community that retained value in traditional practices led to the development of the Midwives Alliance of North America (MANA) in 1982 and unlike ACNM, included midwives in Mexico and Canada (Davis-Floyd 2006:43). From 1983 to 1998, MANA and its daughter organizations the North American Registry of Midwives (NARM) and the Midwifery Education Accreditation Council (MEAC) established a credential—the Certified Professional Midwife (CPM), educational standards, and exam standards that embodied their philosophy (Davis-Floyd and Davis, 1997; Davis-Floyd 2006; MANA 2019).

Currently there are three types of midwifery licensure paths available in the US, which I have summarized from an online graphic produced by ACNM (2017):

1. Certified Nurse-Midwives (CNMs), who are advanced practice nurses with a graduate degree in Nurse-Midwifery, are able to attend births in hospital, birth center, or home

settings, though most are employed by hospitals. They are legally authorized to practice in all 50 states.

2. Certified Midwives (CMs) go through the same midwifery training as CNMs but are not trained nor certified as nurses. CMs have no legal status in Texas. Both CNM and CM programs are overseen by the Accreditation Commission for Midwifery Education (ACME) and the American Midwifery Certification Board (AMCB).
3. Certified Professional Midwives (CPMs) have multiple paths towards education, but increasingly the most common and recommended path is through a MEAC-accredited program, although still almost half of CPMs are educated via apprenticeship. CPMs are legal, licensed, and regulated in Texas and 34 other states (2019). They are trained specifically for low-risk births in birth center and home settings and may not practice in hospitals in any state (Ross et al. 2018). Regardless of their initial path towards certification, all CPM students must sit the North American Registry of Midwives (NARM) exam. CPMs and CMs are both direct-entry midwives, meaning that they enter midwifery education directly without passing through nursing training.

MANA and ACNM continue to have contrasting philosophies over appropriate educational routes and midwifery scope of practice. Each organization approaches a cost/benefit analysis of becoming more medicalized in order to reach a larger audience and the conclusions lead to pretty heated language. Their lack of commitment to work together can be self-defeating; they compete with each other "in state legislatures over whose direct-entry certification should prevail" (Davis-Floyd 2006:64). Some CPMs feel that CNMs are too willing to abandon the facilitation of normal birth physiology in favor of the self-preservation that comes with increased medicalization. If they start down this path, how do

they protect the midwifery model of care from becoming indistinguishable from the risk-averse practice of physicians? Some CNMs feel that CPMs are too willing to ignore risk in favor of expanding their parameters for what constitutes normal birth in a process that Davis-Floyd and Davis (2018) call "normalizing uniqueness" and contrast with the obstetric "standardization of pathology." It is possible that their alternative birth movement (ABM) may not have a future in a technology-obsessed society. Even women with low-risk pregnancies have come to expect and desire interventions and additional monitoring as the new normal way to give birth. After all, caring for women is about more than protecting tradition—it's also about providing resources that are culturally relevant to modern day women, and part of providing women-centered care is meeting modern requests (Davis-Floyd 2006:62). However, it is possible for the midwifery model of care to generate a knowledge system that judiciously combines evidence-based traditional practices with contemporary evidence-based biomedical practices.

"Plain" or "renegade" midwives (Davis-Floyd 2006:185; Davis-Floyd and Johnson 2006:447) practice outside of all regulation and certification. Researchers, legal midwives, and unregulated midwives all use these terms to maintain a distinction between legal status and philosophy of care (see Davis-Floyd and Johnson 2006 for more depth). They remain steadfast about following the parents' wishes, even when it puts them at increased legal risk for attending births that would be categorized as high risk in a hospital and threatens the reputation of the direct-entry midwifery profession. Renegade (uncertified, unregulated) midwives are few in number and are more likely to be associated with a particular religious or cultural group. They are adept at practicing under the radar. Ironically, their direct-entry colleagues express some of the same concerns that had been directed to them by CNMs. This

perspective illuminates the spectrum of compromises, risks, and priorities where all midwives and clients must evaluate and decide which "risks and benefits are most acceptable to her and most in keeping with her belief system and her family's best interests" (MANA 2016a). The difference was that MANA long kept its voting membership open to all midwives, even those who could not legally practice, in appreciation of the value that lay midwives offer to various communities (2006:185-187). For some years now, MANA has limited voting members to credentialed midwives only, yet still accepts all other types of midwives as non-voting members. MANA continues to distinguish itself from ACNM by pursuing a more varied policy agenda regarding education paths and licensure freedoms, and is passionate about bringing issues of health equity, social justice, and racial justice to the legislative table. They depict these issues and more as inextricably linked to the status of maternal and neonatal health. ACNM members, even though they created their own brand of direct-entry midwives—the CM, or certified midwife—continue to act in policy reform by and for themselves; much of their literature is focused on midwifery regulation, insurance coverage and reimbursement, prescriptive authority, and liability.

Midwives agree that moving away from medical intervention with the average birth will improve reproductive health and approach the issue with a sense of urgency that is often not shared by policymakers. Because CNMs constitute the vast majority of midwives, with 12,218 active in 2019 (ACNM 2019b) (as opposed to around 3,000 practicing CPMs and around 150 practicing CMs), they have the most presence and participation in publishing peer reviewed research and working with public policy. Literature suggests that the list of changes desired by midwives can be assembled into two fundamental principles: 1. that non-hospital births attended by a certified midwife are just as safe as hospital births for low-risk women

(Cheyney et al. 2014; Stapleton 2013), 2. therefore midwives should be granted the same cultural status as obstetricians. Issues that make it to the legislative floor may not reflect these principles because their success would require an overhaul of much of the medical system, and the change in direction from negative societal perceptions of midwifery to using midwives as the first response for seeking maternal care would flip the hierarchy of resorts (Romanucci-Ross 1977; Baer et al. 2003) in maternal healthcare upside down. It's much easier to ask for comparatively minor policy changes, hoping they will add up over time.

The ACNM has a current policy agenda with the goal of "advocating for policies that reflect and promote ACNM's standards, expand the midwifery workforce, and increase the visibility and recognition of the value of midwifery care" (ACNM 2019a). They fight for the right to practice without physician oversight in all states, as well as for the credentials of CMs to be recognized fully, and for CPMs' licensure bills to reflect the US MERA (Midwifery Education, Regulation, and Association) coalition agreements and the positions of the ACNM (2019a). The ACNM anticipates that the passing of regulatory certification laws across all states will enable women of all socio-economic statuses to have access to midwifery in all settings and throughout their lifespan. Because the cost of using a midwife is a third lower than hospital costs, which average $86 billion a year (NACPM 2016), women with higher incomes are more financially prepared to pay a midwife out-of-pocket. Low-income women who want to deliver outside of a hospital must be prepared to pay in cash or are limited by state Medicaid amendments. While the reform agenda brought to legislators aims to help all women, it can benefit ethnic minorities and those with low-incomes the most.

As recognition of CMs and CPMs in public policy remains low, it is no surprise that "CPM services are not currently recognized under Medicaid at the federal level."; however,

thirteen states have made amendments to cover CPMs based on the evidence that their care offers benefits to women (NACPM 2016). To address this division, the National Association of Certified Professional Midwives (NACPM) began development of the MAMA Campaign in 2009 with the primary goal of "securing recognition of CPMs in federal legislation that would mandate reimbursement for CPM services by Medicaid" (MAMA 2009). Currently in Texas direct-entry midwives are only recognized by Medicaid if they work in licensed birth centers, and CNMs are reimbursed at 85% of the rate of pay as physicians for the same service (ATM 2020).

Theoretical Framework

Critical Medical Anthropology

In their celebrated book, *Critical Medical Anthropology* (CMA), Merrill Singer and Hans Baer stated that the first phase "of critical medical anthropology had largely been devoted to establishing the legitimacy and vital importance of medical anthropologists addressing issues of macro-micro relationship, political economic aspects of healthcare and disease, and the nature of class, gender and race relations as they impact the health arena" (1995:44).

I am using the following diagram from *Medical Anthropology and the World System* to describe how the macro and intermediate social levels of Baer et al.'s healthcare analysis can be used to apply CMA to my topic. In this diagram, the capitalist system, corporate and state sectors, and plural medical systems occupy the macro social level, and policy making occupies both the macro and intermediate social levels. Parallel to the upper levels of mainstream medical care lie alternative medical systems (Baer et al. 2003:39). Here is where

the midwifery model of care would be placed within America's medical systems as an example of “medical pluralism,” a term coined by Charles Leslie (1977). At the macro-social level, a large amount of the decisions made by insurance providers are focused on increasing profits and on having control over certain types of medical treatment. Overall, the CMA gaze is fixed upon the control that the ruling elites have on our legislature, which is “...legitimized by laws that give biomedicine a monopoly over certain medical practices and limit or prohibit the practice of other types of healing" (Baer et al. 2003:41). It is my objective to incorporate this analysis into a detailed study to understand why and how midwifery struggles to convert our healthcare system into a cooperative one, as opposed to a competitive and profit-driven form of medical pluralism (2003:9).

Using critical medical anthropology, I focus on how this discord affects women’s health and is damaging to society when representatives pass over bills that would grant midwives authority as primary birth care providers. My research is an attempt to unmask the depths of inequalities stemming from a broken healthcare system (Singer 1995:80) by building on the work that medical anthropologists and midwives before me have sought to bring into public view.

Structural Violence

A closely related subject to CMA is Johan Galtung's concept of structural violence, which he introduced in 1969. He later defined structural violence as "any aspect of a culture that can be used to legitimize violence in its direct or structural form. Symbolic violence built into a culture does not kill or maim like direct violence or the violence built into the structure" (Galtung 1990:291). Examples of this can be seen in healthcare structures, where Paul Farmer

refined the physiological aspect of this term further by addressing how social structures can determine the health of individuals and who has access to care (Farmer et al. 2006:1686). Though Farmer's work is primarily in infectious disease, the same analysis can be used for conflict within public policy because the resulting social arrangements in healthcare are "embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people" (2006:1686). The most vulnerable of us are simply struggling to survive. All basic human rights serve to perpetuate survival and equality, but this concept "is trampled in an age of great affluence, and…should be considered the most pressing of our times" (Farmer 2005:6). If we reflect on the structure of healthcare, and on the structures that allow our leaders to ignore the needs of women during and after pregnancy by willfully blocking them from the most beneficial of maternity care providers, I believe we have no choice but to acknowledge the violence of that structure and how it contributes to the preventable maternity-related deaths of more than 700 women every year (MMRC 2018:6). This problem is compounded by the reality that those with lower socio-economic status are disproportionately affected and more likely to be non-white; we cannot discuss class-related violence unless we simultaneously fixate on systemic racism. When we look at these statistics, the proof of deep-seated racism throughout the healthcare structure is apparent: black women are three to four times more likely to die from childbirth complications than white women (2018:6; CDC 2016).

While the foremost discussion of structural violence covers physical harm, "a violent structure leaves marks not only on the human body but also on the mind and the spirit" (Galtung 1990:294). Public health initiatives addressing health equity also impact how authority is shared between mothers and their care providers. Under current initiatives, not

only are women's bodies subject to interventions that may not be medically necessary, but they are also left with feelings of trauma as they mourn the loss of their agency, taken without consent by their providers. Structural violence legitimizes authority that isolates the patient and "'gives the victims a chance', usually to submit, meaning loss of freedom and identity instead of loss of life and limbs..." (1990:293). Davis-Floyd provides examples of this by naming and defining the *technocratic model* of medicine. In this model, a woman's body is treated as a defective machine with little regard for her psychological well-being, contrasting with deeply humanistic or holistic models of care (Davis-Floyd 2018; 1992). The assembly-line style interventions which represent the technocratic model are aimed at preventing a malfunction or breakdown (Davis-Floyd 1992) in a way that can be applied to women universally. Because these methods have become accepted as routine, women are less able to articulate a birth plan to their provider and are routinely bullied into believing they are gambling on their baby's life by questioning the physician's authority. Once the baby is born, the mother's psychological well-being may again be routinely damaged through delaying or preventing un-interrupted bonding time with her newborn, resulting in further trauma such as increased chance of postpartum depression (PPD) and reduced rates of success with breastfeeding (Cheyney 2008; Davis-Floyd 1992; Hunter 2006). The connection of c-sections with PPD as a product of structural violence will be used throughout to describe how midwives and physicians approach statewide medical policy and the larger structural issue of MCH.

At times, violence is linked to ritual behavior and rites of passage. Galtung's statement on submission and loss of freedom and identity can be contextualized within ritual aspects of birth as well, regardless of the level of willingness a woman displays. In *Sufferings,*

Theodicies, Disciplinary Practices, Appropriations, Veena Das discusses how ritual practices can be used to emphasize the societal control over an individual. For example, using Max Weber's account (1963), a caesarean scar constitutes the inscription of a woman's role in her initiation ritual. The mark serves as an obstacle to forgetting her experience. It is an affirmation that the law of society, medical instrumentation, and the authority of the medical practitioner wielding the instrument has been irretrievably inscribed on her. According to Emile Durkheim (1976), these violent medical procedures become a necessary part of creating a common narrative and legitimizing society (Das 2010:564-565).

Authoritative Knowledge

In summation of authoritative knowledge as a theoretical framework, which Brigitte Jordan (1993, 1997) pioneered, she stated "the best way to avoid change or revolution is to make change or revolution unthinkable….it does this in such a way that all participants come to see the current social order as a natural order, that is, the way things (obviously) are" and in this way, a body of knowledge can become legitimized regardless of if the knowledge is correct (1997:56-58; 1993:152-154).

In the same way that CMA and structural violence can be observed at the macro and micro levels, medical authoritative knowledge can be used on multiple levels to encourage a desired set of behaviors among women. What is special about this theoretical concept is that it was developed specifically for use in a new subset of anthropology in the 1980's: the anthropology of birth. Jordan's statement in her 1993 preface to *Birth In Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States* is something that I have understood in my soul for a few years now, but only recently have I

been able to articulate the bigger picture and connect it with the urgent recommendations made by other academics referenced in this thesis. She wrote that the "anthropology of birth must focus on the study of birthing *systems* and not the comparison of individual and isolated practices" (1993:xi). And it is this particular framework that I've worked so hard to understand when analyzing policy in its formation, integration, and use as a gatekeeping tactic across the United States and the world. Medical authoritative knowledge, in connection to policy, can continue to be built upon in future literature. Yet for all of the detailed descriptions of how policy has been used to suppress a woman's right to informed choice, more can be said about how high midwives believe their ceiling of influence in policy formation is, how they can break through it, and what changes would need to occur to offer the most comprehensive, revolutionary change that has been fought for over the last century. I will be answering these questions throughout my analysis to illustrate the range of motivations and beliefs shared by Houston midwives.

Medical authoritative knowledge is tightly interwoven with the technocratic model of birth. Evolution of the technocratic model has been successful in the US, as well as other countries, because of shifting cultural expectations. According to Davis-Floyd, understanding and confronting "dilemmas" created by this shift will help us create viable, long-lasting solutions in healthcare. I summarize these eight dilemmas from *Birth as an American Rite of Passage* as:

1. Desire to make the natural birth process appear to confirm, rather than refute the technocratic model, is caused by a desire to protect the technocratic model in which the medical system is deeply invested.

2. What can be done to control the natural process of birth when it is inherently resistant to control?
3. As a method of establishing control over a natural process, how can the dissemination of new cultural beliefs and expectations about birth be used to reshape the phenomena from an individually transformative experience to one that is culturally dependent on the medical institution?
4. Liminality during birth exposes disruptive potential physically and intellectually to a cultural system. How might these risks be "fenced in" while also allowing controlled access to the revitalizing powers available to the woman and the medical system?
5. How can we use the medical system to enculturate a noncultural baby? That is, what kind of medically themed "rituals" can be responsible for and depended upon in the same way that spiritual rituals of the past may have been?
6. If birth, a naturally female phenomenon, creates so much power for a sex that has poses a major conceptual threat to male dominance, how can men assert their power in birth in a way that sanctions the patriarchal authority that is observed in the rest of society?
7. How can technology be used to create disassociations from the sexual nature of birth?
8. How can women be encouraged to accept a patriarchal belief system that denigrates them, when the ideal of gender equality is increasingly popular (1992:60-72)?

If we continue to view the technocratic model of birth as an outlet for ritual behavior, we can more easily understand the transition of power from a religious authority figure (who, for example, is uniquely ordained to baptize a child) to a doctor. Each one employs the authoritative knowledge useful in designing and enacting a core value system; this power is

available to the leading figure alone—not to the general public (Davis-Floyd 1992:46). Sharing this power with the public could lead to power struggles, transformation of core values, and professional competition in a way that is no longer manageable by a single source of authority.

CHAPTER 2:
Literature Review

Historically, American women have been underrepresented in legislatures and policy agendas that don't directly positively affect the ruling majority. Even when backed by research, proposals about women's health have a lower chance of being passed. Lynette Ament wrote a dedicated plan on approaching policy by presenting it in a way that policymakers find "easy to understand and connect it to things policymakers worry about....perhaps if the respondents feel strongly that policy changes based on the research data will positively affect them, they will join forces with the researcher to promote policy change" (1994:329-30). She also noted that "research does not determine policy outcomes, political forces and the values of policymakers do" (1994:329).

Patriarchal biases on what women should be allowed to do with their bodies are far from absent in public policy. Regrettably, policy makers are allowed to make decisions over a body of knowledge that they themselves are rarely educated on. Values referenced above are deeply embedded in how women's health is addressed and reemphasize the power that authoritative figures have to affect social order and values even when their information is not correct. Instead, the focus should be on finding practical, evidence-based solutions that

facilitate optimal health for mothers and babies and create financially sustainable programs (Cheyney et al. 2019:174). But moving away from the existing practices within women's health and towards midwives as primary birth care providers suggests a likely overhaul of much of the healthcare sector. Smaller, individual changes can be achievable with more immediate results, but are a stopgap measure to addressing the deeper structural issues.

High-profile medical organizations present a large hurdle and sometimes publicly attack the midwifery agenda. The Texas Medical Association (TMA) provides many examples of this as an organization that has high stakes in policy outcomes and aggressively works to limit the scope of practice of other providers. The American College of Obstetrics and Gynecology (ACOG) has maintained a distance from fully embracing the benefits of midwifery for several decades, but on occasion acknowledged them in press releases and the ACNM in studies. In their 2018 policy statement, they indirectly opposed home birth, but acknowledged the woman's right to choose and the importance of collaboration (ACOG 2018). The length of their latest list of legislative priorities makes it clear that change continues to come slowly, even for individual items. Some items on the list, like protection from cuts in WIC and providing a safe workplace environment for mothers to express breastmilk, shows how volatile progressive policy decisions can be (ACOG 2019). Their list is dominated by making small changes to Medicaid, private insurance policies, and other items that have been heavily debated since the Women's Health Movement. Amidst it all is a small section regarding their stance on midwifery: to support the full scope of practice for nurse-midwives (which includes lifetime well-woman care), to "oppose recognition of and reimbursement to midwives who do not meet the International Confederation of Midwives (ICM) educational standards" (meaning CPMs who do not go through MEAC-accredited

programs) and to “ensure that the educational and professional standards of the American Midwifery Certification Board (AMCB) and the ICM are used to evaluate, certify and license all midwives” (ACOG 2019).

Some independent physicians find it difficult to facilitate collaboration because they believe CPMs lack “formal academic education or medical training, and their requirements fall short of internationally established standards for midwives and traditional birth attendants” (Cheyney et al. 2014:447). The tendency of some doctors to feel distant from midwives because of these reservations only compounds the problem of establishing change in public policy. As protected elites, they have established far greater influence over policy than midwives. Additionally, institutions like ACOG are sheltered by corporate political action committees (PACs), insurance companies, foundations, and other for-profit organizations (Hoffman 1994) whose "actions favor curative rather than preventive approaches to healthcare...[and] ally themselves with [First and] Third World elites and, through jobs, favors, and outright bribery, influence health policies" (Baer et al. 2003:41; Jordan 1993:214). Conversely, it is reasonable to deduce that physicians who have more positive experiences with midwives are more likely to collaborate with them in research and in developing public policy reforms.

The Centers for Disease Control (CDC) is a federal health agency that provides basic health and disease information to the general public. The limitations of such an agency can be seen when comparing their self-reported goals to build “on [their] significant contribution to have strong, well-resourced public health leaders and capabilities at national, state and local levels to protect Americans from health threats” (CDC 2019a) and to “base all public health

decisions on the highest quality scientific data that is derived openly and objectively" (CDC 2019a) with their limited publications on the actual birth process.

One such publication from their Pregnancy Mortality Surveillance System (CDC 2016) addresses trends in pregnancy-related deaths between 1987 and 2016. In a graph showing pregnancy-related mortality ratios, where the ratios steadily increase from 7.2 percent in 1987 to 16.9 percent in 2016, they fail to investigate further, claiming that "the reasons for the overall increase in pregnancy-related mortality are unclear," while hinting in their reproductive health section that prevention of these deaths ultimately falls solely on women maintaining a healthy lifestyle. However, this statement is oversimplified and fails to address the systemic problems that contribute to these deaths. More importantly, inconclusive or evasive answers from a governmental authority may also be responsible for minimizing the urgency that policymakers may feel. This is further evidenced by the CDC's yearly vital statistics on birth and ACOG's evidence of contributing to the obstetric paradox, where high rates of elective and medically unnecessary caesareans have become expected and encouraged.

The "medical gaze," discussed by Michel Foucault (1963/1973), "constructs the maternal body and childbirth itself in particular ways—as risky and therefore in need of intensive medical management—whereas the midwifery "gaze" (which is equally socially constructed) is premised on a challenge to, and a contestation of, the power and authority of obstetric norms" (Cheyney 2008; Davis and Walker 2010, cited in Cheyney, Everson, and Burcher 2014:451). This fear-based pathology approach to pregnancy and birth culminates in the suppression of intuitive knowledge amongst women and is led by groups who want to maintain their authority.

Medical anthropology has become more involved in studying the causal relationship between global health and insurance. Essays like *Toward an Anthropology of Insurance and Health Reform: An Introduction to the Special Issue* by Dao and Mulligan (2016) have provided us with an analysis that can applied to all medical subfields. As I touched on in the introduction, midwives who have resisted professionalization in exchange for legal status argue that midwives who are willing to make the exchange will eventually be indistinguishable from the medical model of care and place too much focus on avoiding risk at all costs. This phenomenon of medicalized care results in a growing trend of medical staff who pursue the profession on the basis of pay rather than a deeper "soul calling" that exemplifies feelings of sisterhood by midwives. The ensuing focus on routinization in hospitals also meant that "the processes and consequences of changing financial models for healthcare, with a particular focus on provider/patient relationships" led to "quantifiable outcomes [that] replaced long-term personal relationships with patients" (2016:7).

Traditionally, motherhood is depicted as transformative, empowering, even holy. How women experience this process is influenced in part by their belief system(s), access to physical and educational resources, and relationships with their providers. Ina May Gaskin recalled in her first book, *Spiritual Midwifery*, the powerful role that a calming, loving atmosphere could provide in the progression of labor. She encouraged experimentation with romantic touch during labor to assist in the production of endorphins and oxytocin that would help relax and open the body (2002:47). The role of positive touch cross-culturally takes different forms (Rasmussen 2006). Emotional and physical support from midwives and "god-sibs" (groups of women who gathered together to attend births in their communities. The term is the origin of the word "gossip") in medieval times extended into the post-partum period as

well. This support was based on the belief that the new mother's vulnerability could endanger men, but also provided a culturally respected post-partum recovery period for them to focus on healing and establishing a bond with their baby (Kitzinger 1997:211). Until the 1970s in Jamaica, the "nana," or lay midwife, stayed with the new mother for nine days before ritually re-introducing her to everyday life. Her authority was trusted to remind mothers of appropriate social behavior—something that could not be found in area hospitals (Sargent and Bascope 1996).

The post-partum period can be a dangerous time for women as well. In Hungary, no visitors are allowed during the post-partum hospital stay, mothers are encouraged to supplement breast milk with formula immediately, to feed their baby on a schedule, and to wear protective gear while caring for baby. Practices like these inhibit the ability of the new mother to bond with her baby or to trust her instinct and the baby's cues, all of which an contribute to PPD. After discharge, mothers are offered little to no community support, and receive little to no attention during post-partum checkups (Chalmers 2006).

Being open to critiquing our own conceptualization of medical authoritative knowledge helps us understand where we place ourselves alongside other medical systems around the world. *Birth in Four Cultures* describes themes of superiority among varying birth cultures, describing how each side believes they have higher ethical and moral standards in treatment of women, use more superior techniques, and are more grounded in science (Jordan 1993:122-23). And while claims for technological superiority have been made by obstetricians for decades as justification for excluding midwives from legal practice, midwifery advocates conclude that "technocratic approaches have not...significantly improved maternal or infant health outcomes globally, nor have they proven to be economically

sustainable" (Davis-Floyd and Cheyney 2019:4). Theresa Morris, a sociologist, takes these examples and more to suggest that moving "toward a system that promotes midwifery care and out-of-hospital birth" (2013:170) would help curb the enthusiasm for c-sections in the US, but established legislation in favor of obstetricians remains a major hurdle. She argues that the US' focus on protecting mothers and babies is contradicted by their high use of drugs and interventions that often cause harm—in what is called the "obstetric paradox" (Cheyney and Davis-Floyd 2019) —and midwives should take advantage of this contradiction by launching a policy conversation (2013:171-2). Suellen Miller and her colleagues (2016) have globally labeled overly interventionist care as TMTS ("too much too soon") and insufficient care as TLTL ("too little too late"). Cheyney and Davis-Floyd (2019) suggest replacing both TMTS and TLTL with RART—"the right amount at the right time".

In 1948 the United Nations determined that access to healthcare and social services, with a special focus on providing them to mothers and babies, was a human right. Healthcare as a human right has expanded in discussion among researchers and activists, but 71 years later, America seems just as far away from that ideal. Implementation of a healthcare system that provides this would require massive structural change and a change in how Americans relate to the status quo. The consumerism that shapes the American way of life is at odds with this tenet, where 27.5 million Americans (8.5%) (Berchick et al. 2018) make too much money to qualify for Medicaid, but don't make enough to afford basic health insurance coverage. Even those who are insured face ever rising copays, premiums, and out-of-pocket expenses that produce billions in profit to insurance companies each year while medical bankruptcy becomes increasingly common.

Proponents of healthcare as a human right agree that prerequisites for equity in health must be based around accountability framework and addressing social determinants of health (SDH). Part of accountability acknowledges we must question using "…the free market model of healthcare as a commodity rather than a social necessity" (Singer and Erickson 2013:10) and that "healthcare can be considered a commodity to be sold, or it can be considered a basic social right. It cannot comfortably be both at the same time" (Farmer 2005:175). Though many Americans defend our privatized insurance system, "the United States is widely considered to have the most inefficient and inequitable healthcare system in the developed world". Despite us spending "17% of the US Gross Domestic Product (GDP)—nearly twice the amount of any other developed country" (Horton et al. 2014:2) we still have the same high-tech level of care as other developed countries but 27.5 million people without insurance—leaving us with an inequitable, discriminatory, and inefficient healthcare system (Horton et al. 2014; Anderson, Daviss, and Johnson, in press).

Most social health systems in America, including but not limited to those focused on the health of mothers and babies, remain stigmatized because of their focus on assisting the poor. Instead, the World Health Organization (WHO) recommends taking a universal approach towards all social protection systems so that recipients are not singled out and stigmatized. Rather, a universal approach, such as in healthcare, can encourage social cohesion, social inclusion, and the preservation of "dignity and self-respect of those who need social protection the most" (2008:87).

The WHO is highly collaborative in its effort to provide equitable solutions for preventable illness and health stemming from structural violence, and in the 72nd World Health Assembly of 2019, global leaders in health and human rights met to discuss that year's

theme: how to achieve universal health coverage. The WHO also believes that the universal approach to healthcare relies heavily on the full integration of midwives into a universal healthcare system. Its goals for maximizing the benefits of midwifery are not dissimilar from those of US midwives.

According to the WHO's reports (2008, 2013, 2019) on improving health equity, when midwives are fully integrated in the healthcare system and educated to international standards, they are equipped to provide aid in "sexual and reproductive health, immunization, breastfeeding, tobacco cessation in pregnancy, malaria, TB, HIV and obesity in pregnancy, early childhood development and postpartum depression" (WHO 2019:iv), among others. These advantages are especially valuable in rural areas and communities that are far from traditional health centers, and a consistent presence of trained professionals will enable continuity of care throughout the life course. Their care in areas suffering from natural disasters, epidemics, and military conflict are particularly essential. Projections show that preventable maternal deaths, neonatal deaths, and stillbirths would be decreased by over 80% (2019).

CHAPTER 3:
Research Design

Setting

The Houston metropolitan area is a convenient hub to observe the complicated symbiosis of midwives and physicians. The Houston area has 85 hospitals with more than 19,300 beds (City of Houston Texas 2019). There are also 13 birth centers in the larger Houston metro area, with 65 CNMs in Harris county which equates to one midwife per

71,284.8 residents (Texas Health and Human Services 2017). CPM statistics are unknown, but I estimate 27 CPMs within the Greater Houston Midwives Alliance who appear to be actively practicing in the Houston area (2019).

Birth statistics are collected annually by Texas Health and Human Services but are not released in their associated year. The most current update shows that out of 403,439 births in 2015, 4.9% were attended by midwives and 1.6% were out of hospital (OOH) births. The first year on record, 1970, comparatively shows 230,624 births with 2.3% of births attended by midwives and 2.6% OOH births (2015). The decrease in OOH births since 1970 is likely because more hospitals are opening on-site birth centers or birth suites that employ their own nurse-midwives in response to increased consumer demand.

The Houston metropolitan area population of 6,997,384 has a median age of 34.6 and a median income of $65,394. 14.3% of the population live below the poverty line. About 65% of the population is non-white (Census Reporter 2018).

Sampling

While recruiting participants, my search criteria included all registered midwives living and working within the Houston metropolitan area who were over 18 years of age. I included midwives who attended births in all settings. I had a preference for speaking with midwives who were active participants in birth policy reform at the local, state, and/or national level, but expanded on this to include some midwives who were not involved but either wanted to be involved or wanted to express their views on the state of the midwifery legislative process. While I focused on recruiting midwives, I was open to suggestions from

midwives of mothers, non-professional advocates, or legal representatives whom they believed could offer an additional perspective. As I could not offer translation services, my study excluded all non-English speakers. However, this exclusion did not have any effect on the result of my participant demographic.

During February 2020, I conducted interviews with 14 midwives out of the 18 midwives and one obstetrician I attempted to contact. Out of the five that I did not meet, one midwife did not have time in her schedule, and three midwives and one obstetrician either gave no initial response to my request or did not remain in contact long enough to set up an interview. The views and experiences shared with me represent a mix of 10 hospitals, birth centers, and private practices within the Houston metro area. All midwives in this study are Caucasian. 65% of participants are CNMs and 35% are DEMs. Of these, one midwife is retired, one midwife is currently only working as an advanced practice registered nurse (APRN) and plans on opening her own midwifery practice, and one holds the Licensed Midwife (LM) required to practice legally in Texas but is not a CPM. Each midwife was assigned a pseudonym.

Challenges

The fact that most of us were meeting for the first time affected the comfort level of both myself and the participant, but in most cases the atmosphere relaxed over time. Regardless of this small improvement, participants would show a hesitancy in answering some questions in depth; some in particular were concerned that their responses would negatively reflect on their professional associations or would not be consistent with the official viewpoints of their organization.

Snowball sampling had some limitations as well. I began recruiting through a nurse-midwife whom I had previously interviewed a few years ago. She does participate in activism and collaboration with both CNMs and CPMs but has more contacts within nurse-midwifery. Responses to my recruitment letter with her assistance led to an overwhelming majority of responses from nurse-midwives. This unequal proportion of nurse-midwives to direct-entry midwives later impacted whom they suggested I connect with for further interviews. Attempts to meet with more CPMs were less fruitful and first-time responses from CPMs took longer. The number of actively practicing CPMs are fewer in general, and I was less successful with maintaining enough contact with them to arrange interviews. Because I got a strongly positive response from midwives wanting to participate, my focus quickly favored collecting diverse data instead of focusing on depth of data based on the first few midwives who contacted me. Challenges over time constraints—my own for data collection and the busy schedules of the midwives—meant I was able to meet each person only once and would not easily be able to synthesize what we discussed to come back with follow-up questions that would add more depth.

Assumptions

I based my approach and formulation of interview questions on a few assumptions. I expected midwives to be eager to share their views and experiences because they have a history of struggle through policy and cultural acceptance. However, I believed it was likely that *all* midwives would be more involved at the local, state, and national levels of policy reform and advocacy because of how directly reform affects their ability to serve women. When formulating my interview questions, I put more emphasis on asking midwives to

identify the social actors and advocacy methods of their community. I expected to receive a higher percentage of detailed accounts on why my participants believed certain advocates were the most effective, what changes had been made recently, and what strategies would deliver the best results. I also assumed that collaboration among midwives with different credentials would be higher because the literature shows that they have many common goals and struggles. I assumed that because my first participant, Lori (whom I had interviewed and knew a little better at the start of data collection), places a lot of emphasis on advocacy, that her participation would be representative of other midwives in Houston. However, I have learned that midwives do not necessarily prioritize their time in a consistent way, and that the credentials of each midwife appear to play a larger role in the available time each midwife has and how they approach problem-solving stylistically and logistically.

Objectives

My data from interviews represents the spectrum of advocacy participation by midwives at the individual level. This data was collected through note-taking, audio recordings from semi-structured interviews, and follow-up email correspondence. I explore and analyze midwives' responses on why bills in favor of expanded midwifery practice are passed over and what methods midwives use and recommend to increase their success in professionalizing midwifery and providing the midwifery model of care to all women. I rely on a holistic approach in my data analysis to understand how the processes to challenge patriarchal authority unfold, as the beliefs and practices in American healthcare are grounded in a long history of gender studies, medicine, politics, religion, and consumerism. Anne Suryani's article on qualitative research notes that in order for a case study to be well

constructed, it must be holistic, context sensitive, comprehensive, systematic, and layered. This often takes shape by collecting data at the individual level and analyzing it within a variety of social complexities (2013:119).

Textual analysis will be used to dissect common themes and language of websites that represent organizations which educate others on various movements or ideologies. Organizations form a collective political agenda, pool resources, and gain higher cultural and political statuses through increased visibility. The examples presented in this section are *not* intended to represent the full spectrum of contributions to the complex narrative of midwifery.

Advocacy in maternal and child health (MCH) policy will be qualitatively analyzed at individual (interviews) and organizational (textual analysis) levels using the following standards for success set by *Maternal and Child Health: Programs, Problems, and Policy in Public Health*:

1. Sound assessment of the problem and possible solutions, sufficient to identify and justify the best clear alternative program or policy options that have strong odds of success in addressing the problem and improving outcomes.
2. The clear articulation of both the problem *and* the suggested program and policy strategies for resolving or addressing the problem.
3. The identification of key decision makers, those who can influence decision makers, other stakeholders and constituents who have or should have interest in the problem, including both those who may agree and may disagree with the advocacy position.
4. The development of a strategy for achieving the goals of the advocacy efforts that may include the following:
    a. Identifying an existing coalition or forming a new coalition to support the effort

b. Developing and executing a communication strategy to reach and educate key players in the desired action and to anticipate and address issues that may be raised in opposition; communication targets potentially include the decision makers, those who can influence them, other stake holders, the media and the general public

c. Follow-up, follow-up, and more follow-up including reminders, thank you notes, and communication about the results/successes of the advocacy effort (Kotch 2005:662).

To determine if the advocacy agenda and strategies of midwives are successful, I will analyze whether or not the ABM is effective as a social movement (Daviss 2006), if they are productively active in matters of human rights violations (Farmer 2005; Galtung 1969, 1990; Singer and Erikson 2013), and if the goals of their policy reforms follow the pattern of system-challenging praxis rather than system-correcting praxis (Baer et al. 2003).

CHAPTER 4:
Results and Discussion

Interviews

Motivations for Midwifery as a Career

Defining moments, such as the transformative experience of pregnancy and birth, change our identity and life direction forever. Davis-Floyd describes intuitive knowledge as a tool that encourages normal physiologic birth behavior. It facilitates connectedness between the woman, her body, her baby, and her midwife (1997:324). Throughout my interviews, I found that intuitive knowledge, which is often suppressed rather than heeded due to our

cultural value on objective knowledge, can be made known in various stages of life. Some defining moments pass without being self-realized for many years. These moments were often recalled as experiences of the soul or being present in DNA.

Sandra's conceptualization of birth, much like my own, began at a young age. Her experience watching animals give birth possibly unknowingly began the process of internalizing beliefs about her body and the birth process. She was also fortunate to be a descendant of midwives and nurses: "When I did come into nursing—kind of following my grandmother's footsteps—I always knew I had no interest in [it] being medical surgical nursing…all the nursing schools recommend, 'oh, we'll do at least a year.' I was like, nope. I went directly to labor and delivery. I knew that's what I was supposed to be. Yeah, I know that's *where* I was supposed to be." Her experience as a nurse at Jefferson Davis in Downtown Houston was unusual and gave her experience working among midwives; after a while, she saw midwifery as her calling and an extension of her nursing training. For Sandra, her path to midwifery was continuously shaped over time.

Amy's passion began early as well. She recalled her experience watching dogs give birth as a child. Growing up, her ambition was to become an obstetrician. During her hospital birth, she experienced obstetric violence and described being hit by her provider as part of her traumatic experience. She had a positive experience with nurses during her birth, however, and decided to pursue nursing instead, but the hospital setting didn't mesh with her own birth and women's health philosophy. Amy was unaware that birth options existed out of the hospital. She worked as a nurse to provide love and support to birthing women in a way that was intuitive to her. She learned of midwifery for the first time while on the job when a midwife brought in a patient transfer: "I happened to be pregnant with my third child at the

time so I hired her on the spot and I had my next three children with her at home in the water. She became my hero and mentor and she is one of the Legacy midwives of the Houston Community. I also quit my job at the hospital and followed her into home births for 10 years as her birth assistant. She's the one that told me to go back to school to become a certified nurse-midwife and be the new generation of home birth midwives and that's what I did." Amy's experience leading to midwifery, which showed the resilience of self-appointed intuitive knowledge, culminated in a spontaneous moment of transformation. Her understanding that birth went beyond the woman's body was similar to that of indigenous healers in South Africa, where health is believed to be affected by life, family, religion, and emotions (Mlisa 2013).

As I discuss later, support systems for new moms are a major determining factor of life choices. Women often complain about having no knowledge of the birth process or the physiological changes they would experience until they were pregnant themselves. The technocratic birth model and the normalization of patriarchal control over women's choices are powerful enculturation processes that become hard to fight when there has been no exposure to alternative ideologies. It was Jessica's loss of familial support that led her to obtain doula certification (a birth companion who provides guidance and physical and emotional support during labor but does not have medical training) and enter the alternative birth community. While her pregnancy led her there, it left a lasting impression on her beyond the impact it would have on her personally. She used birth education resources to learn how to apply her interests and talents in a way that could address the gaps in healthcare and quality of care for the most women possible. She chose to be a CNM so that she could also provide reproductive and primary care and is in now the process of establishing a birth center.

Several of these themes illustrate part of the shared narrative of midwives whose passion grew out of their own birth experiences and blossomed into advocacy for other women. The midwifery career, like the transition into motherhood, is often grounded in intuition—a bodily knowing or sense of spiritual calling that one is meant to become a midwife. The fundamental beliefs that women should have the right to choose their provider and birth setting, that increased midwifery autonomy and authority can improve many aspects of MCH, and that the healthcare and political systems they live and work within suppress choice and increase profit despite their multiple costs, led these midwives to advocate for women on an individual level.

All styles of advocacy, however personal, beckon the deviant behavior necessary for individual and cultural progress. Midwives work to demystify authoritative knowledge and reestablish birth as a powerfully female phenomenon. Success is made possible because the holistic birth model provides evidence-based care, supports women in acquisition of birth knowledge, and provides physical and emotional guidance through all stages of pregnancy and postpartum (Davis-Floyd 1992). For some, advocating for individuals naturally entailed advocating at the state level within the bounds of midwifery practice. For some, there was an understanding that personal freedoms over birth are intricately bound with systemic classism, racism, and power, and their understanding was expressed in diverse ways. Even fewer midwives connected their personal beliefs on birth, human rights, and healthcare to the current events of policymaking, elections, and global health concerns. However, I argue that the same intuition that led each woman into midwifery and advocating for women's rights and improving health outcomes, however dormant, can also be used to transform MCH by advocating for health equity at national and global levels. According to Daviss, "becoming a

midwife is nothing short of a lifelong engagement in social activism" because professionalization means that "establishing a midwifery monopoly on birth would require an overhaul of the American value system" (2006:414, 417). Daviss discussed midwifery professionalization within a political vacuum, but I believe it extends deep into the capitalist system that Americans defend. The success that Daviss hopes for depends on a holistic perspective in the same way birth does. It requires the detachment of physicians from corporate personhood, restructuring of the healthcare system, and re-conceptualizing health insurance, human rights, and the nature of choice. The success of midwifery entering into the mainstream without restructuring the entire system will have far less impact on MCH and reducing mortality if hundreds of millions of Americans are restricted by their insurance and other economic inequalities. And while I believe midwives are key to restructuring healthcare, understanding the depths of perspectives and actions of the midwives who have shared their experiences with me goes beyond this short study. The challenges I described in chapter three mean that I've received only a portion of what can be explored through multiple, longitudinal studies on midwifery activity in public policy and health equity in the US.

Policy Concerns and Strategies

When I asked midwives to tell me about the changes that they needed to see most, prescriptive authority was an easy and prevalent answer. Legally, prescriptive authority is a product of the expanded scope of practice bills that are advocated and lobbied for at the state level. In Texas, the 86th legislative session of 2019-2020 proposed bills H.B. 1792 and H.B. 927. They were created to increase the authority of all APRNs, of which CNMs are one of four advanced roles, and H.B. 927 offered the expanded scope of practice specifically to

underserved rural communities. Both bills died in committee while waiting for a vote and will have to be re-submitted in the next session. TMA claims responsibility for their defeat, but they did not explicitly state how their influence was responsible for this result. Their activity around these two bills and other policy concerns will be further discussed in my textual analysis. A similar Texas bill, S.B. 2438, proposed to add APRNs as in-network providers for insurance purposes in Medicaid, met the same fate.

In 2019 Wendy, a CNM and prominent state advocate, presented a written testimony for S.B. 2438 to argue that the bill was "a critical step towards reducing maternal mortality in Texas, and improving care for women and newborns, including those in rural and underserved areas." She also testified for H.B. 1792 before the subcommittee on Health Professions of the House Public Health Committee. She explained that the implications of the procedures during the hearing signaled to her what the results would be even before the hearing was over: "In forming a subcommittee to hear this bill and others, Rep. Thompson essentially signaled that these bills would not be voted on in the larger committee. It was another hurdle to jump over, because it had to be voted out of a subcommittee before it could be voted on in the committee. In the Senate, it was scheduled for a hearing too late to actually go anywhere. But the TMA did not want it to even get a hearing in the Senate, and it was heard, so that is a small win. The year before, our bill only had a hearing in the House. The TMA is correct that both these bills 'died' in committee. They were not voted on, so we don't even know for absolute sure how some of the members would have voted." Still, TMA could use their deep pockets to their benefit. Though illegal to admit exchanging donations for a legislator's vote, Wendy attested that "it is something everyone is aware of." Their regular presence in the capitol has also been a hurdle for midwives. They come "in large numbers in their white coats and stethoscope (so

gimmicky!!!) every 2nd Tuesday of the month. We just don't have the ability to do that. I can get maybe 30 midwives there once a session!"

Outside of medical organizations, some physicians are very supportive of midwives. Physicians may choose to collaborate by giving standing orders for prescriptions or set up patient transfer agreements. Linda, a CPM, described her relationship with her backup physician very positively, while Lori, a CNM, said that she was at the mercy of her physician to renew their agreement for next year and was unsure if it would happen. Many physicians hesitate to collaborate with midwives because they worry about increased legal liability (Linda correspondence; Morris 2013; Cheyney et al. 2014). Wendy explained that hospitals are also free to interpret certain laws in ways that fit them, meaning if an individual hospital is midwife-friendly they could interpret midwives as belonging under the umbrella of physician responsibility. This would provide at least some relief for midwives during patient transfers from home or freestanding birth centers to hospitals. Hospitals and physicians with blanket statements could lessen the paperwork load, decrease hostility among care providers during transfers, and create a more peaceful transfer and labor experience for women. It's a small step to be sure, but a welcome one. Wendy went on to explain that open interpretation of local mandates carried risks as well, meaning hospitals could just as easily interpret credentialing so that specific individuals are excluded from working with hospitals. Exclusivity can be devastating for midwives who work in smaller communities because lack of ability to transfer care when needed can force them to close their businesses.

Margaret, who works in an off-site, hospital-affiliated office as a CNM, had concerns that were relevant to policy, but several of them were framed around changing local philosophies of care. Nevertheless, it was clear that she felt lasting change would require

changes at the institutional level or higher. Margaret's journey into midwifery began after seven years as a L&D nurse when she was solicited to apply to a new midwifery graduate program rather than continuing into the Women's Health Nurse Practitioner (WHNP-another advanced specialty of NP) program: "I was resistant at first. I did not think of myself as a midwife, because I'm not a granola person. I'm kind of more medically minded. And, you know, the faculty talked to me about…different kinds of midwives and so I did apply and got into the program. And as a nurse, I just wanted to be I guess more involved in making clinical decisions and that kind of thing." Margaret's biggest concerns included educating the public on care options and making the cost of care less complicated. She described flaws in hospital care; physicians didn't spend enough time with their client during appointments, were generally less personable with their clients, and were more likely to prescribe unnecessary medications and procedures. She was eager to see hospitals legally required to provide midwifery care as an option but said Texas, as the "good ol' boy," "conservative," "white man state" would never allow it. Her view of Texas as a strongly conservative state may have been why Margaret prioritizes collaborating with her backup physician to provide new medical students with experiences in observing normal physiological birth and healthy collaborative relationships between midwives and physicians. Unfortunately, Margaret and other midwives' commitment to enriching the education of medical students and other hospital staff is limited by staff turnover. Progress made with one generation of staff does almost nothing for the next generation and would only be longitudinally successful if medical schools covered topics on collaboration, normal physiological birth, and midwives as competent, valuable care providers.

Liability and risks associated with CPMs were also on Margaret's mind. There are 27 direct-entry midwives practicing in the Houston area, yet Margaret was unaware that they were legal in Texas. She expressed doubts that CPMs were providing evidence-based care: "is there evidence to say breech delivery at home is safe? I haven't seen it. Is there evidence to say VBAC (vaginal birth after cesarean) at home is safe? There's evidence to say it's not safe because it's not it's not even safe in the hospital a lot of times. I'm not saying [that] women don't have a right to choose that." Even if CPMs had liability insurance, the risks were too high. Lori, a nurse-midwife who owns two birth centers and is active in the Consortium of Texas Certified Nurse-Midwives (CTCNM) and the American Association of Birth Centers (AABC), does not agree with CPMs taking on breech births either. Any negative birth outcomes under the care of CPMs damages the reputation of all midwives, and Lori is trying to find balance in her practice. Risk-aversion for midwives takes its own form of self-preserving behaviors when focusing on professionalization. While physicians have become highly risk-averse to prevent malpractice suits, midwives worry about losing their license because of a single bad outcome. Traditional methods for managing high-risk birth scenarios may diminish, but Lori is more concerned about keeping her license so that she can continue to serve 200 more women rather than giving up her right to practice because of one bad outcome. A single misstep can negatively affect her ability to continue serving women and endangers the professionalization of all midwives.

Midwives agreed that if physicians and midwives were to have the same bad outcome, physicians would be much better protected than midwives. We expect loss to happen in a hospital from time to time, as loss is inevitable, but the cultural authority of physicians includes the assumption that physicians "did everything they could" (resulting in high c-

section rates) to avoid it. The accusation of selfish recklessness against mothers who choose midwives in the US is tied to the midwives' decisions too. If midwives, especially CPMs, try to take on births that have higher risks without also having an infrastructure of protection and collaboration should things go wrong, they may not be able to survive or thrive in American healthcare. Some midwives feel like the sacrifice isn't worth it. Increased legitimacy brings increased regulation and restriction.

Erikson and Colo described the politics of home-birth (and I believe their description extends to the way all midwifery reform is approached in politics), as changing from an "emphasis on full-bodied, full-scale midwifery knowledge to a more restrictive and falsely narrow representation of midwives' ways of knowing. Homebirth midwifery is forced to appear to be something much less than it is in order to be palatable to the legislators….to shape its public face, and also to alter the art of midwifery itself" (2006:298). Angela described the concept of intuitive knowledge in her own terms, saying "I just wanted to help women and make better choices for themselves and really encourage women that they have choices no matter what environment they're in. So even though I have this practice of homebirth, [Amy] and I felt it was really important to educate in general about their rights as women in every setting—not just in the workplace or in their marriage…they have autonomy in their bodies in every setting that they're in." Laboring on all fours, pushing intuitively rather than under the command of a physician, and bonding behaviors like skin-to-skin and immediate breastfeeding (Davis-Floyd and Davis 1997:341; Wagner 1997:374) are natural products of the intuition that has been stifled to various degrees by the medical model of care in the past century. But the midwifery model of care, including its trust in intuition as authoritative knowledge, held no direct connection to policy in my interviews.

American midwives have been advocating for bills that expand, decriminalize, and bring visibility to midwives as a vector for improved maternal health and satisfaction of care. However, midwives in this study agreed that the most effective argument for midwifery was money. Money, not intuition, speaks—not only in gaining political influence, but in suggesting reforms as well. Julie described her experience with legislators and the importance of discussing policy in a way that they can connect to, recalling that "they do listen to research and numbers, but they don't want to read it themselves. They want you to highlight it for them. They listen with their eyes but not their hearts." Sometimes, in order to relate to them, she found herself fighting for aspects that weren't important to her at the time. Sometimes she didn't know what she was fighting for, but it was always important to her to stick to evidence-based policies. To be effective in policy, as Ament (1994) described, midwives had to adjust their arguments to something the (mostly male) legislators would relate to. For this reason, midwives described their strategies to be focused on showing midwifery's economic benefit to Texas and how they could reduce maternal and infant mortality and morbidity. While midwives *use* the midwifery model of care to achieve these results and more, it is reserved for discussion amongst peers, advocates, and clients as an educational tool.

Unnecessary interventions from in-hospital births disconnect women from their bodies, the support of the female community, and their babies. These disconnects are widely documented by mothers, midwives, and researchers through blogs, professional organizations and agencies, books, and academic and medical journals. High rates of caesarean sections in the US have become the expectation of consumers and physicians. Rates of PPD are also on the rise (TMA 2020a; MMRC 2018), especially among low-income and non-white women.

Not only do midwives claim to reduce c-section rates and the higher rates of PPD associated with them, they are better equipped to combat PPD of all causes than physicians because they tend to spend much more time with their clients. The expansion of midwifery practice in this example alone would reduce c-section rates and their higher related expenses, infant admissions into NICU, deaths caused by c-section complications, c-section associated PPD, and morbidities and deaths associated with all causes of PPD (Cheyney 2008; Dixon et al. 2019; Morris 2013; MMRC 2018; Miller et al. 2016; Kotch 2005; Sandra, Rachel, Margaret interviews). PPD and death caused by technocratic birth practices show just how important it is for midwives to expand their advocacy efforts into matters of equitable healthcare coverage nationally and around the world. Still, midwifery visibility is comparatively low in the maternal health sector in the US and midwives working at the national level rely on high visibility groups like the World Health Organization (WHO), American College of Obstetricians and Gynecologists (ACOG), and American Public Health Association (APHA) to work with them on structural issues.

Angela understood the evolving relationship between women's intuition and patriarchal authority, and said "I hate to make this a sex issue, but really as soon as men entered the birth world they really took away women. They took—and women gave away—their autonomy and birth...which is fascinating to me. Why did that change happen? Why did we give up our autonomy in our body when men entered the field?" Patriarchal authority is central in establishing the relevance of theory and cultural background, but the majority of midwives didn't focus their conversation on men or any aspect of medical authority. As we were all women, I found there to be a certain amount of unspoken agreement about the fundamental struggle of women to exercise authority over their bodies. Midwives were aware

of this struggle because it is ingrained in American culture, but that didn't mean they were prepared to analyze it in the way I was. Men as figures of power were not dwelled on in our conversations. In our discussion on interacting with policymakers as part of the general public, Diane noted "I don't think women are heard in establishments that are mainly men," and quickly moved on.

The fear of having a stressful patient transfer experience and of losing one's license makes some direct-entry midwives more likely to engage in risky behaviors like delaying a transfer initiation. Barbara's experience as a Licensed Midwife (LM) (after earning their initial CPM certification, she and other LMs sometimes choose to drop their certification over time, because the cost of re-certification every three years is expensive and has no effect on maintaining their legal status. Barbara did mention concerns about making the costs and logistics of re-certification more manageable) revealed that hostile interactions are a more common occurrence: "We really need better ability to transport patients that need to go to the hospital and not have our patients be treated in a prejudiced way once they arrive at a hospital. There are some hospitals that have made great strides for this, and I have literally watched that unfold. But there are still way too many hospitals that ostracize those women and make them feel like they did not make…well thought out, educated choices for themselves and their families when they do enter a hospital. I really think that the…majority of the numbers of bad outcomes are from midwives and their families deciding to transport to a hospital too late because of that fear of how they're going to be treated. I think if that was not a fear, adequate and quick responses to transport would be so much easier. So, they would be…implemented so much sooner before there is a disaster." She and other direct-entry midwives feel stuck in a reactive, rather than proactive, state of practice and policy work. Nevertheless, national

statistics have shown that the outcomes of CPMs' transfers to hospitals are generally positive (Cheyney et al. 2014). Out of every 100 women who plan a CPM-attended homebirth, around 10 are transferred to hospital during labor. Out of these 10, only 3 transfers take place under emergency circumstances, showing that CPMs usually do practice preventatively and do not avoid transferring in time. Even with transfers, the caesarean section rate was 3.7%, compared to 32.2% as the national average in 2014 (Johnson and Daviss 2005; Cheyney et al. 2014; CDC 2019b).

Many aspects of poor birth outcomes in hospitals, midwives argue, can be prevented by reforming laws that restrict midwifery education and independence. Several midwives confirmed how powerful organizations (but mostly TMA) have been blocking them at every step for many years, leaving Diane, a CPM, to focus on remaining on defense so that progress cannot be undone in the meantime. Other political paths to ensure better birth outcomes might be worth investigating as well. The United States and Brazil share a technocratic approach to birth. However, advocate groups in Brazil are modeling how collaboration among a diverse group of social actors can offer alternative methods that may influence policy change in less time. For example, instead of focusing on whom is granted authority to practice, they work to guarantee humanized care that prioritizes the reestablishment of women's autonomy and eradication of both physical and psychological aspects of obstetric violence—regardless of where a woman decides to give birth (Williamson and Matsuoka 2019:104-5). Although this is not midwifery focused, it is human rights centered. Similarly, midwives in Mexico are pushing for legislation to reduce maternal mortality. The "cascade of interventions" (Davis-Floyd 1992) leading to c-sections and preventable c-section related deaths can be fought not

only by midwifery professionalization and equitable healthcare access but by creating laws that define and decrease obstetric violence on a national scale (Dixon et al. 2019).

House Representative Alma S. Adams of North Carolina submitted bill H.R. 6698, or the Maternal CARE Act, in 2018 to the US congress, which shows similarities to work done in Brazil. H.R. 6698 would provide $30 million annually to ten states until 2023 to fund state pregnancy medical home programs. These programs would be focused on reducing maternal mortality and morbidity and racial health disparities by providing implicit bias training to health professionals (prioritizing obstetrics and gynecology), and aid in establishing assessments of each patient during their first prenatal appointment to include mental wellbeing. The terms of the bill, which don't offer equal status to all birth care providers, still ensure that states only receive money if they include doulas and midwives as stakeholders in the program.

Impact that Capitalist Healthcare Monopolies have on Midwifery

Works by Hans Baer and Merrill Singer have influenced how medical anthropology criticized healthcare practitioners concerning the authority projected onto patients and how expressions of systemic authority can vary depending on the patient's socioeconomic and educational background. In general, they believe that CMA addresses "the nature of the structurally constituted relationships between physicians and patients as reflective of the relationship between biomedicine and the encompassing political economy" (Baer, Singer 1995:36). Baer et al.'s concept of CMA focuses on how corporations and governments can withhold certain basic health materials and resources that control quality of life (Baer et al. 2003:42). We've explored the devastating infrastructural effects that our healthcare system

has left on women by giving cultural, political, and medical authority to physicians, but this section will focus on its impact on the individual level.

The basic human right to survive is not motivation enough for elites to make sacrifices. The myth of scarcity of knowledge and resources is a mechanism for the acquisition of profit (Farmer 2005). 80% of preventable maternal and neonatal deaths worldwide (WHO 2019) and 63% of preventable deaths in the US (MMRC 2018) are not evenly distributed among class divides. Diane, Jaime, and Linda said they wanted to see an increased focus on improving birth outcomes particularly for women of color as well as making the path to midwifery licensure more accessible to women of color. In Linda's experience, MANA has only recently begun addressing the disadvantages that black midwifery students have in accessing paying for midwifery school by offering specific scholarships to them. Though Linda has great relationships with her black clients, she knows that it's important to them to be able to have a midwife of color.

Amy, Angela, and Sandra were among those who talked about the freedom and danger of offering their care to those who could not afford it. When I asked how insurance restrictions affect their ability to take clients and receive appropriate reimbursement, Sandra discussed how difficult it is to navigate payments and keep a business afloat while also trying to provide care those who are most in need: "When…a client comes in…we figure out what their benefits are. Sometimes they're out of network benefits. It's not even worth it for them to use their insurance. They can fight for the gap exception or in network benefits by saying, 'Listen, I want to water birth with a midwife and there's not someone close to me that will take your insurance in network.' And sometimes they'll pay. The insurance company will pay the gap exception for in network benefits. But then, with insurance and…pregnancy, they

don't pay for any of this until everything's said and done. So you don't know what's going to happen, right?....It is very scary. And I think the hard part for me too is as I have taken care of people and just accepted that maybe…I'm not going to be paid very well for my time, because my heart is there, you know...you have to do the balance." Her circumstances allowed her to offer choices like extended payment plans, sliding scale payments, or offering services for free. Amy and Angela try to limit free births to one or two per year. They are very flexible with payment plans, but are careful not to make too many concessions for their clients: "we're a bit tenacious about [payments] because we both do have a midwifery heart but we also have a business mind…we can't always just 100% be compassionate because if we don't get paid our doors shut and then we can't serve anybody. Some of us really struggle with the…business part where at the end of the appointment you have to ask for the payment because you grow so close to our clients and trusting relationship. It becomes uncomfortable, but for us it's a respected thing and none of our clients feel strange about it at all. It's like any other interaction…We just got comfortable asking because we don't want our doors to shut."

The longevity of midwifery practice is determined by many factors, including being seen as an appealing choice to women. Cultural expectations and political influences can control how services are perceived. Cultural expectations of the birth experience make it hard to choose an alternative provider. Those who rely on community support may feel ostracized if their community disapproves of midwifery; women who don't rely on a support system are still vulnerable to a barrage of attacks, like being accused of selfish irresponsibility if she chooses to birth outside of the established system. The appeal of midwifery may lose out to the appeal of acceptance and absence of confrontation—a remnant of the American "social body" which persists long after the element of mental and emotional support has disappeared

from practice. As a result, culture reflects and reinforces the power dynamics that direct birth into a public, sterile and impersonal arena (Dixon et al. 2019).

Even when women who want to use midwives are not derailed by cultural consequences, the authority of the medical community is not gone. Healthcare policy continues to function in the background while women choose whether to deviate from hospital birth or accept interventions. For the average woman, if society offers a choice between physician birth attendants and midwives, but the insurance companies don't pay for midwives, there was never really a choice. The effect of forced choice by hospitals and governments is not linear. In Tanzania, the push for increased births at medical facilities is encouraged to meet international developmental standards as a measure of success. Government regulations that restrict home births by imposing fines end up punishing women in poverty the most. Even those who would like to choose facility birth are less likely to because of the economic barriers that leave them unable to procure the birth supplies required by facility workers (the punishment of the poor sounds more familiar when supplies are replaced with outrageous costs of care and insurance coverage for Americans) (Cogburn et al. 2019:58). The illusion of choice, which is dangled in front of women, especially the most vulnerable, disproportionately controls their life course instead. Because of this, I emphasize that which contributes to the process of the monopolization of healthcare services.

In the US, healthcare systems obtain influence through a symbiotic relationship of extensive funding and the cultural validation of their authority via the 2010 supreme court ruling *Citizens United v. FEC,* which states that corporations are people and money is a form of speech. Money offered to political candidates and office holders is used to continue the commodification of the body within politics, reduce the visibility of midwifery, direct cultural

expectations and present midwifery as a fringe profession. The value of word-of-mouth recommendations of midwives and increasing acceptance of their use does not hold the same value to policy makers as financial contributions do.

For those who can afford to pay out of pocket, the choice is real. Systems of oppression that are most effective against the poor can be bypassed with relative ease. The obstacle of out-of-network providers is surmountable. Similarly to the gender pay gap and the known glass ceiling for professional advancement, grassroot and individual advocates must work much harder to achieve the same success. However, when personal rebellion snowballs into a coalition and noticeably disrupts the system, the institution reprises its role "of pacifying social dissent and resolving the contradictions of a capitalist society, including those in the health sector, it periodically must make concessions to alternative health practitioners and their clients, who often belong to lower-middle, working and even lower social classes. Corporate and government elites involved in health policy decision-making may partially or completely legitimate a particular alternative medical system by licensing its practitioners, certifying its educational institutions, and providing subsidies for patient care and medical research" (Baer 1989: 1103).

Determining Structural Problems and Effective Resolutions

Merrill Singer's work (1995) in critical medical anthropology covers systemic dysfunction, or how the "brokenness" of healthcare and disease is revealed through gender, race, and economic discrimination. His awareness of the limits of academic theory was made evident by questioning how CMA might stay alive through application. It was natural, he said, for researchers to begin seeking policymakers' attention when their anthropological evidence clashes with conventional medical belief and policy (1995:82). Midwives have long been

against the medical model of care, and in more recent decades have collaborated with anthropologists to deconstruct physician-patient relationships and the distribution of power in maternal care (Kitzinger et al. 2006; Davis-Floyd 1992, 1997; Hunter 2006). The anthropology of midwifery and birth must apply the same critical praxis attitude to creating privileged knowledge that Singer used and must stay focused on presenting solutions that can be disseminated easily. Not all midwives desire involvement in grandiose social movements and political debates, but their reliance on advocacy in all political settings is an inescapable reality: midwifery, health equity activism, and social theory are inextricably linked.

Betty-Anne Daviss presents social movement theories that describe the spectrum of public response to monopolized power distribution in healthcare: *strain theory*, which states that social movements arise out of a breakdown in society; *resource mobilization theory* (RMT), which claims that breakdowns are a pretty regular occurrence in modern society but are not necessarily accompanied by social movements; and *political process theory*, which "suggests that social movements develop in response to an increase in political opportunities in a changing political system" (Daviss 2006:420-36). These three classic social movement theories coexist, as Daviss showed by discussing midwifery's participation in each, but I do not believe they intermix in a sustainable way (or, each one cannot be deemed successful by Kotch's standards on their own). Individual transformation and motivation of midwives is the determinant of which social movement theory will prove to most accurately represent the movement's current form. After showing how each social movement applies to the midwives in my study, I will turn to the fourth theory Daviss describes and how it can be used by midwives to help us all.

Just like the civil rights and women's liberation movements, *strain theory* relies on participants collectively establishing a unified set of goals and ideologies to gain traction and visibility. It also requires a great deal of sacrifice. As Daviss puts it, "mothers and fathers busy with newborns create space for hours of volunteer work, and natural birth practitioners spend passionate and inordinate hours at meetings, all 'for the cause.' Job satisfaction among midwives becomes a moot point when the stakes and rewards are far beyond any 'job'" (2006:421).

Lauren, a CPM for four years, runs an independent practice out of her home while she homeschools her children. I admitted I'd seen much more advocacy discussed online and in literature where CNMs were on the front lines. Lauren pointed to the logistics of running a business as creating barriers even for simple trips: "We do everything. We answer the phone, we take the bills. You know, we do all of our own invoicing we [take] any question, concern, complaint that comes through our phone…it's not as easy even to drive to Austin…but a lot of the nurse midwives are working together and have a backup situation." Participation by direct-entry midwives, who can add their own expertise to the social movement, may be more isolated from it instead. Most midwives, regardless of their credential, put all of their energy into caring for their clients and keeping their businesses afloat.

Lori's participation in advocacy is well known. Her ability to run birth centers and contribute to advocacy through coalition work and making personal visits to the state capitol seems like a superpower. For thirty years she has worked hard to bridge the gap between CPMs, CNMs, and ACOG to combat the power of TMA. This work has earned her a great amount of respect among local midwives regardless of their differences. Several other local midwives were identified as valuable social actors during my interviews as well. Wendy,

Julie, and Diane have also held positions in CTCNM and AABC and other public service positions, but unfortunately a lot of midwifery progress sits on their shoulders. For most midwives, collaboration and unity were brought up as ideals, not realities. Advocacy within my participants' views was described as if it were a dissected formula—someone can be the spokesperson, someone can work locally, someone else can attend conferences and board meetings.

According to the *resource mobilization theory*, societal breakdowns are so common that the dysfunction becomes normalized. Daviss summarized pitfalls from *The Concept of Social Movement* (Diani 1992) that result in a reduction of the collaboration that makes the strain theory so effective. Most importantly, strain theory requires belief to be transformed into concrete action (2006:421). The expression of outrage in modern society has evolved; most commonly it is associated with online and media outlets. Instead of gathering in homes, voting, and organizing protests, marches, and occupations, citizens sign online petitions, share articles and stories for media attention, and send financial contributions to individuals and organizations that represent topics they care about. Rallying behind a singular person works to deify the leader and leaves others feeling like they can't measure up to an ideal image. As a result, concrete action becomes the expertise of a few high-profile individuals and organizations while the majority stay home and feel like they've done all that they're capable of.

Diane's expectation of consumer mobilization for policy change remained focused on preventative and defensive action. She expressed confidence in the ability to elect officials who support midwives, and said that policy against midwives hasn't been as successful because "The TMA sometimes is petrified of us because when something comes up…if they

try to pass something that would damage midwives, we can have 2000 women at the courthouse in two hours, and they don't have that kind of support from their consumers." It seems that the actions of policymakers in Texas have become so normalized that midwifery advocates are more prepared to preserve existing legislation than to support improvements. Diane also sounded frustrated when I brought up expressing outrage through online advocacy, asking "and has that ever translated to actually a policy change?"

Low participation among Texas midwives make progress slow and inconsistent. According to some interlocutors, they would have to make too many sacrifices to devote enough time to advocacy work. Others like Angela are repulsed by politics, and yet more midwives don't feel equipped with the right tools (Erikson and Colo 2006) or that they can't present the preferred type of public image. Jaime described herself as being "not poised enough" to participate in advocacy at higher levels. She prefers to address the needs of vulnerable communities at the local level and is especially passionate about providing care to black and indigenous women. Since she hasn't seen policies improve outcomes personally, she said she chooses to focus on grassroots advocacy and gather as many women of color into the streets with her as possible. The effects of the RMT, which lead social movement representatives to worry increasingly about appearing sufficiently professional and not losing their new seat at the legislative table, can leave members feeling unrepresented and unworthy or representing their own demographic: "We have been told all our lives that we can't change anything, that you can't fight city hall. At every meeting there is someone who always makes a case why we should not be radical—it will alienate someone, we are not ready, we need to educate a little more, read a little more, get more numbers. Well, you can always make the

case not to be radical. But don't. It's a lie. The doubt is false" (Fresia 1988:198, cited in Singer 1995:80).

The establishment of stratified advocacy systems like ACNM, MANA, and NACPM, which offer a great amount of benefits to their members, also works within the *political process theory*, where an increase in financial resources means easier access to establishing legislative influence. But because each organization still represents separate values and agendas, they become more focused on maintaining and increasing the legitimacy of their profession. This also reinforces the hierarchy of organizational membership where only the most successful and experienced members can attain a leadership position and set the tone for policy objectives. Fortunately, midwifery organizations present their objectives, ideologies, and resources to a wide audience so that all people can become equipped to advocate for themselves during their pregnancy and birth experiences, rather than mystifying birth as medical organizations do.

Because midwives are a powerhouse in community health and mortality prevention nationally and globally, they provide the most streamlined, effective approach to improving MCH through political and social reform advocacy. Change in healthcare systems tends to develop into two parties of behavior, most recently labeled as "system-correcting praxis" and "system-challenging praxis" by Merrill Singer (Baer et al. 2003). System-correcting praxis, which aptly describes the existing American political process, emphasizes "minor material improvements that avoid any alteration of the basic structure in the existing social system…and tends to obscure the causes of suffering and exploitation" while dampening social protest (2003:361). Expanded scope of practice and expanded health insurance coverage, though they are undeniably valuable and beneficial to women, are examples of a

system-correcting praxis. The underlying issues of a capitalist, profit-driven healthcare structure will continue to commodify the body, trample on human rights, and allow policy and elections to be decided through the legalized bribery of corporations. System-challenging praxis, however, aims to unmask the structures of inequity by heightening social action and transforming a society (2003:361), and comes to bear under Daviss' fourth theory, the *new social movement* (NSM) (2006:434). The goal of the NSM is to see midwives combine the ABM with larger ethical issues like providing healthcare as a human right around the world (2006:435).

These distinctions were vital to the construction of my interview questions because they would help me understand where midwives fell along the spectrum of advocacy. I was surprised to find that despite the familiarity that many midwives had with anthropological studies on midwifery and birth, discussions of systemic change did not come easily. Generic questions about policy solutions, foreign healthcare systems, and alternative strategies for advocacy largely remained unanswered without further prompting. Maybe the questions needed to be reformulated, but I also believe that the lack of answers told me that midwives were concerned about only specific policy changes that protected their professional interests; for the majority, structural change was not on their radar. Others brought up better midwifery education systems, paid maternity and family leave, and the use of midwives as primary providers, but had very little knowledge about what made those programs so effective at reducing negative health outcomes.

It was important for me to ask each midwife what she thought about federal proposals for healthcare reform. I knew that they were all well acquainted with the problems associated with Affordable Care Act and Medicaid, but I was not prepared to receive so few answers on

how these programs could be improved upon or compared to the current healthcare reform proposals. The mentality consensus was to step away from insurance as much as possible. Positive experiences with healthcare sharing programs (an alternative to traditional health insurance, where members share their healthcare expenses to reduce monthly premiums and out-of-pocket costs) were also found across the board. Based on their experience, the plans were reasonably priced, had a great reputation for paying midwives fully and quickly, and seemed to have fewer restrictions on birth care providers than traditional insurance plans. However, these healthcare co-ops have many restrictions of their own and are Christian based; they require proof of congregational membership to acquire, meaning they exclude millions of Americans. The responses I collected also showed a trend in distrust and disillusionment toward insurance companies, the medical system, and the political system, resulting in midwives appearing less comfortable interacting with the system any more than was required of them as professionals.

Single-payer healthcare was part of a few conversations, but the kneejerk reactions I received were that they wouldn't be effective because of long wait times, they were too socialist, they wouldn't be appreciated because they would be free, or they were the ideal system but were unattainable. Some midwives didn't offer details on which aspects of foreign healthcare systems were attainable or not but said that these other systems offered a window into the ideal maternity world. When I asked Lauren which maternity care practices from other countries she would like to see implemented in the US, she told me "I've never been asked that before." She spoke highly of countries like Canada and Netherlands, where midwifery care is the standard, reimbursement is a non-issue, and society sees midwives as educated, licensed, trained professionals rather than spreading propaganda about witchcraft.

She did not offer details about how far her knowledge extended on their differing healthcare systems. Her lack of detail was consistent across most interviews and shed light on how little each midwife either understood or prioritized the links between successful midwifery practice, overall improvements in MCH, and healthcare coverage and equitable access. Another midwife who spoke positively about the Netherlands was Julie. She recalled an encounter with Dutch midwives visiting in the early 2000s, who were so fascinated by the American birth system that they were eager to hang out in hospitals to watch "how weird they do birth." She recalled being told that in the Netherlands "if you are not low-risk, and you want to have a hospital birth, you have to pay for it. Otherwise your insurance company pays for it because you have a home birth. And I thought, 'oh my goodness that's just the opposite of here' because the...physicians think everybody is a nail to be hammered. They want to fix it."

The social aspect of equitable healthcare coverage and access was agreeable to midwives when described in general terms, but the economic implications felt taboo. As much as midwives have struggled to reestablish their legitimacy within cultural beliefs against propaganda, the single-payer healthcare coverage has struggled to enter the political and cultural mainstream because of propaganda labeling it "socialist" and "too costly". To counter this misinformation, the Physicians for a National Health Program (PNHP) works not only to educate physicians and the general public about how single-payer, healthcare coverage would work, but also includes posts about the value of midwifery as a profession and as part of the solution in improving access to quality maternity care, despite PNHP being built by physician membership. PNHP advocates for healthcare as a right to be equitably provided as a public service, not sold as a commodity, to remove barriers to quality care faced by the uninsured,

the poor, minorities, and immigrants, and to oppose for-profit, privately controlled health systems (PNHP 2020). Their mission statement is consistent with the findings of CMA, human rights advocates, and global health experts, and has much in common with healthcare systems like the Netherlands.

In the Netherlands, infant mortality is half that of the US. 80% of Dutch women begin prenatal care with a midwife, and 30% give birth at home. Pregnant women are defined "as having either a physiological (low-risk) pregnancy, in which case midwives or general practitioners oversee her care, or a pathological (high-risk) pregnancy, in which case gynecologists oversee her care" (Morris 2013:170). Additionally, maternity care providers collaborate, and healthcare coverage is almost entirely regulated and subsidized by the government and financed through taxes and low-cost insurance premiums with fixed care prices (Wammes et al. 2020). Their "socialist" modes of financing and regulating healthcare are responsible for structuring the successful healthcare and maternity care system that midwives want to emulate in theory but simultaneously think is impossible to replicate.

One of the kneejerk reactions mentioned above—the concept of only appreciating a service if it is paid—implies that the single-payer healthcare system would be free. Similar public services, such as roads, infrastructure, public schools, and libraries are also "free", and in some ways one could argue that they are underappreciated. However, like the public services that already serve us, the single-payer system would be paid for through income-based taxation, which is stable regardless of social appreciation. The luxury of under-appreciation replaces hopelessness and desperation. Healthcare, as a life-saving resource, means no longer having to debate whether you can afford to call an ambulance, or worry about going bankrupt for paying for your infant's open heart surgery, or realize that your

traditional insurance doesn't cover treatment for PPD despite receiving the mental health resource packet from your physician. It means that the value of your life isn't tied to your job's insurance or your SES, also known as "insurance indenture" or "job lock" (Livingston 2009:208. See her work also for thorough criticism of the American for-profit insurance system.) and that you can choose where you go for quality care during pregnancy even if you lose your job, and that you can change providers when your current one coerces you into an unnecessary c-section or is discriminating against you. It means that midwives can begin to offer their services to all, throughout their life course, not just those who can afford to pay out of pocket. According to Rachel, while there are benefits to overhauling the healthcare system, it "isn't set up, in any way, to make this happen. Many people are afraid of "socialized" medicine because of misinformation and so forth. People want the freedom to choose their provider. But really, do we have this already? No, unless you are paying cash for everything. We get a list of providers that our insurance will cover and choose them. Or some plans choose for you. In Houston that list is pretty big, but in other areas there might be very few—or none…because we have a shortage of providers in rural areas. A large part of this is that the reimbursements are so low they can't afford to open a practice there. Our current system is set up to serve no one but the big insurance companies and large hospital corporations. It doesn't serve the consumer or the providers. We have a sort of Stockholm syndrome when it comes to our healthcare system." Some of her concerns are not addressed in conversations about universal healthcare and deserve to have more visibility in the healthcare debate. Similarly, Lori was concerned about how universal healthcare in its current stage of development would impact midwives: "I think it will exclude CPMs, and I don't like that because they're my friends. But I think it will. And I think the only chance for women to use

them will be to pay out of their own pocket and I think a lot still will. And I think that will make the medical establishment take a second look to say 'why are women doing this? What is so great that they want this care, no matter even if they still have to pay cash for it?'" Federal bills H.B. 1384 and S.B. 1129 don't include midwives in the discussion, and barely include nurses. While the bills would address much of the systemic healthcare issues that have been discussed here, the coverage of midwifery care within this system is unknown. Should it be passed without the advocacy of all midwives, the bills in their current form would not be capable of improving MCH as successfully alone.

Textual Analysis

What does TMA Represent

I did not learn about TMA until near the end of my research process, but it has become an important source of physician-focused perspective for me to compare to interviews. The midwives in this study are aware of TMA and its political influence against the expanded scope of practice of APRNs, but our discussions did not include the TMA websites. In Wendy's experience, the APRN alliance reviews and responds to some TMA literature, but many midwives in general rely upon their leadership to keep up with their activity. My analysis of TMA's website is purely my own. My arguments based on a sample of reports by the TMA will be strictly within the contexts of midwifery, insurance, and how they contribute to the global health crisis. The TMA's vision for 2025 states that they aim "to improve the health of all Texans" (2020a). However, their vision across webpages is all but consistent. One older version, still viewable online, stresses the importance of "furthering dialogue and understanding within the membership of the Texas Medical Association"

(2018a). This version dangerously emphasizes TMA's unwillingness to collaborate even with other physician organizations, which ultimately handicaps TMA's ability to practice objectively and promotes the presence of conflicts of interest. Moving back to their vision for 2025, their only patient centered objective is to "promote access to healthcare for all Texans" (2020a). All other objectives listed in pursuance of this vision result in super-skilling physicians and making their work more convenient, such as: 1. Strengthening physicians' leadership role 2. Enhancing the image of physicians, and 3. Reinforcing power structures in medical and political settings.

The self-promotion of their monopolized medical authority shows the violent ways in which TMA is prepared to exercise its authority to eliminate threats. This behavior is a confirmation of the negative effects that structural violence can have in all levels of a pluralistic medical system, and shows that legitimized systems of oppression continue to be used to form a narrative which both isolates consumers from legitimate treatment alternatives and unifies them through social suffering (Galtung 1969; Durkheim 1976; Baer et al. 2003; Das 2010). Addressing the needs of physicians is necessary in improving overall health, but doing so cannot replace the implementation of quantifiable, evidence-based practices that keep the spotlight on the patient. In fact, any claims made to suggest a direct connection between an objective and desired or expected result should be clearly presented alongside sources that verify their claims. But these resources are provided in neither their agenda summary nor their 32-page advocacy agenda (TMA 2019a; 2020a). The inability to balance both pieces shows that they "put all of their eggs in one basket" and is another example of how institutions oversimplify matters of managing public health. Their frequent use of the term "medicine" is also an indicator of the cognitive dissonance that physicians have toward

pregnancy and birth as a normal physiological processes—not an illness. So how can pregnancy and birth automatically be treated under the same umbrella as medicine if there is no pathogen to eradicate? This page is representative of the trends throughout TMA resources and approaches in dialogue.

Comparing Approaches to Problem Solving

Anecdotes within *Healthy Vision 2025* are used as the baseline for contextualizing the policy changes that TMA recommends. I'm not arguing that they aren't necessary or important; on the contrary, the experiences described by physicians in their document (2020a) are often echoed outside of their physician group. Midwives and advocates for improving maternal care also fight for changes within hospital procedures that are believed to contribute to preventable deaths. One anecdote on preventable maternal mortality from obstetrician Eugene Hunt recalls his failure to notice symptoms of PPD in a patient six to eight weeks after a birth and how it changed the way he approaches mental health after birth. Throughout his story, I see a few alarming details:

1. *His patient had a checkup six to eight weeks after delivering, at her request*. There is no indication of the postpartum care schedule that was followed, and this appointment appears to be the first and only postpartum visit that occurred.
2. *Her suicide occurred the morning after their visit.* This was the detail that Dr. Hunt states as the factor that forever changed his approach to postpartum mental care. However, it still shows the consequences of having no postpartum check-up routine for new moms, the lack of training in evaluating and treating signs of PPD, and the lack of attention that hospitals give to the holistic health of the mother.

3. *Dr. Hunt's only suggestion for the future to combat postpartum illness was to talk about PPD as they're discharging the new mother from the hospital.* Neither Dr. Hunt nor the following discussion on PPD offer further details on how care for it can be effectively implemented, what the discussion would consist of, or if there are any additional methods that can be used to reduce preventable deaths longitudinally.
4. *He asks,"what would have kept this tragedy from happening?"* His question shows that not only he is unaware of preventative measures (to what degree I am not sure), but the TMA is also. Statements after his story on his experiences with maternal death were brief. The report makes generalized attempts to acknowledge that changes must happen, such as "Thankfully, most maternal deaths—80 percent in one state study—are preventable"; "Texas physicians propose a clinically proven list of interventions to counter this troubling trend. Physicians, hospitals, nurses, and other members of the healthcare team have rightly assumed responsibility to implement some of these recommendations", and "to ensure that at-risk mothers have the services and resources they need". Each of these claims includes absolutely no details on which study was cited, what the interventions are, how they would be implemented, or what services would be offered to mothers.
5. *As the topic moves on to Medicaid issues such as abrupt ends in coverage only two months postpartum and trouble navigating healthcare coverage, attention to causes in maternal mortality is shifted to drug overdose, cardiac events, homicide, and suicide.* This section linking preventable deaths to a lack of long-term coverage for chronic conditions such as diabetes, substance abuse, and PPD is much more effective at showing cause and effect. The theme of this section, even though it does touch on

> important aspects of maternal mortality, is that contributing factors are presented as largely out of the direct control of obstetric practice (TMA 2020a). Compared to themes of obstetric violence among outside peer-reviewed research, this document represents a detachment from the possibility that obstetricians can also be the perpetrators of root causes of increased mortality and morbidity through interventions and prejudiced conduct.

In 2018, a report from nine maternal mortality review committees (MMRCs) determined that preventable deaths (their study found that 63% of US maternity-related deaths were preventable) could be distributed among contributing factors. The top factor responsible for *all* causes of death was patient/family at 38%, however, "they were often dependent on providers and systems of care, which becomes evident when combined with contributing factor classes and descriptions" (MMRC 2018:24). The second and third factors responsible were providers at 34% and systems of care at 22%. Again, when detailing factors of preventable death *due to mental health*, the MMRCs determined that despite 41% of deaths being due to patient factors, many were also dependent on their provider and system for support and education. 27% of deaths were comprised of failures in provider communication and assessment, and another 22% fell under failures of the system of care (MMRC 2018:27). Given that more than 80% of worldwide maternal and neonatal deaths are preventable (WHO 2019; TMA 2019a) and that collaborative meta-analyses of contributing death factors are plentiful (see the Obstetric Care Consensus of 2019), the topic of maternal mortality deserves more than a four page, low-detail discussion which shows how out of touch physicians are about the system and model of care that they defend. (TMA 2020a:15-18).

In contrast, MANA's online advocacy literature is dedicated to framing how policy change impacts moms and babies rather than the care provider. MANA, like TMA, mentions indirect topics like care payment but frames them within the context of how payment changes affect the type of care received by women (2016b). Here are examples of how MANA presents its arguments to policymakers:

1. *The literature begins with an abstract which links caesarean rates to higher hospital expenditures but not to improved maternal-newborn health outcomes.* This is a great summary of the top concern that midwives have about the United States' maternity care system. Though it does not provide a link to any empirical evidence that supports this claim directly, the sentiment is often repeated and discussed among researchers and consumers. Initially there don't seem to be enough resources in their two-page report to back their claims, but the link later provided is a gateway to further studies organized by topic and is accessible to the general public. Directly after the link, the literature summarizes the report findings.
2. *Emphasis is placed not on how the recommendations would create a better work environment for midwives, but on how the measurable benefits would be felt by their clients.* The ten items listed follow a consistent formula: 1. naming the request to policymakers, 2. describing what each supportive measure would provide for women and newborns, 3. listing any corresponding bills that a policymaker can support to achieve the desired result, and 4. reinforcing that the benefits of physiologic birth and bonding processes should be trusted and are the first line of defense against excessive or unnecessary interventions and spending that can lead to preventable rates of mortality and morbidity (2015).

MANA's website also provides the general audience with citations linked to their claims (albeit not present on every page) in contrast to TMA, which appears to provide studies to members only. Even when not directly cited, their claims and recommendations list the causes and percentages linked to various approaches to birth attendant, setting, and level of intervention. MANA's method of approaching policy change highly differs from that of TMA's; MANA's discussions seek to address *why* certain factors affect maternal and infant health and *how* systemic factors are used to perpetuate the decline in maternal and infant health. The TMA approaches policy by bringing physician authoritative knowledge into focus and describing all outside policy agendas and their pundits as threats that need to be neutralized.

TMA Material as Propaganda

There are seven standard propaganda techniques outlined in a series of books published by the Institute for Propaganda Analysis (IPA) in 1937. The list of techniques has since expanded but the lists and definitions vary (Delwiche 2018). I chose to continue to focus on TMA because they are the largest medical organization in Texas and are believed to be the most powerful influencers of state policy development in healthcare (2020c). This section will focus on the use of transfer, fear, cherry picking, and ad hominem attacks as propaganda within TMA publications based on the following descriptions:

1. Transfer: An attempt to use a symbol of respect or authority to aid in validating an argument (Delwiche 2018; Leonard 2017).
2. Fear: Warns the "audience that disaster will result if they do not follow a particular course of action…by playing on the audience's deep-seated fears, practitioners of this

technique hope to redirect attention away from the merits of a particular proposal and toward steps that can be taken to reduce the fear" (Delwiche 2018).

3. Cherry Picking: Aims to "convince the audience by using selected information and not presenting the complete story" (Leonard 2017).
4. Ad Hominem Attacks: Attacks "the messenger, instead of the argument or evidence that is presented" (Leonard 2017).

In keeping with the contextual relevance of midwifery that can be applied to these posts, I must base my analysis on my own insertion of midwifery as TMA's website makes any mention of midwifery hard to find (though CNMs are one of four advanced roles of Nurse Practitioner). Even their discussions of improving birth outcomes through the introduction of medically appropriate levels of care (2015; 2019c) ignores the presence and relevance of midwifery care.

War symbolism as fear-based propaganda is prevalent throughout TMA literature. The frequency of hostile phrasing confirms one of the obstacles that midwives, especially CPMs, face in policy advocacy—midwives are too busy working in defense mode to spend time building an offense agenda. Two posts focusing on the scope of practice use captions like "When it comes to shooting down dangerous attempts to expand non-medical practitioners' scope of practice, TMA's advocacy army once again proved to be expert marksmen in 2019" (2019b) and "The American Association of Nurse Practitioners (AANP) is obviously intent on picking a fight with physicians. No thanks. We'll take the high road, fully aware of the dangers of their plans, and stick with what we know is best for our patients: the physician-led healthcare team" (2020b). Each post by TMA tends to begin with an attention-grabbing headline. In these cases, the headlines utilize vocabulary that encourages

fear of NPs and their agenda—a sign of ad hominem attacks on their profession rather than fairly discussing the pros and cons of their argument for increasing their scope of practice. The language chosen in this article shows that physicians are fearful of an invasion that would reduce their incomes and mitigate their power and will behave as if they are at war to protect it—lest they allow outsiders like midwives to advance their own "flawed" ambition to the detriment of society. The projection of fear can be transferred to audiences as well, making physician audiences more likely to coalesce around anti-midwifery legislation and consumers more likely to submit to the physicians' cultural authority. TMA employs the same kind of fear mongering propaganda that the American Medical Association did at the beginning of the 20th century. This time their voices are amplified by corporate PACs (political action committees). The benefit to midwives, however, is that because TMA has habitually left midwives out of their arguments against expanded scope of practice, the average reader may see no immediate connection to midwives.

While midwives are not explicitly mentioned here, they face many of the same problems as nurses and chiropractors. In contrast to TMA's Vision for 2025 agenda, posts on increasing non-physician scope of practice directly name the relevant bills that TMA has "brought down", such as Texas bill HB 1792 which would have granted prescriptive authority to APRNs (who include CNMs), and HB 927, which would have granted full independent practice and prescriptive authority to APRNs in health professional shortage areas (meaning rural residents would have further restricted access to healthcare providers) (2019b). The sense of power over political decisions is boasted here, giving the sense that they are capable of "bringing down" any bill without the need for collaboration. It has the potential to cause physicians to transfer the idea of collective power from TMA to the individual power that

radiates from the physician-patient relationship. While TMA doesn't agree with expanded scope of practice bills, they do support bills that promote team-based care. Unfortunately for midwives, this post suggests that so far team-based care only applies to collaborative work between pharmacists and physicians. Power is again monopolized as TMA offers to share it only under the terms they offer. Negotiation to distribute power amongst different specialists is made to seem impossible; continuing a legislative battle for fair distribution is futile. If changes in collaborative work under TMA's brief description were standardized, they would likely provide the same type of modules in medical education that would grant legitimacy to generations of medical students, meaning higher rates of successful, long-term collaboration. This is similar to one of the battles that Houston midwives have fought for. A few midwives from my interviews believe that long lasting, positive relationships between physicians and midwives can be more effective if the benefits to team-based care are a standard part of medical education.

In the post devoted to arguing against the independent practice of Nurse Practitioners (NPs), language moves between speaking positively about how NPs are an integral part of medical communities and arguing that their expanded scope of practice would have no benefits to the community. But TMA President David Fleeger's post also displayed an attempt to incite the audience with fear by cherry picking sources as examples of how unwelcome changes would negatively impact patient health. He claimed that the AANP's arguments for an expanded scope of practice were "twisted and misinterpreted" when citing research, but that he wouldn't "rebut, point by point, the authors' argument" (2020b). The overall theme for arguing against a change in scope of practice was that NPs would use more resources than physicians, leading to higher costs. He referenced only four sources from 1999

to 2009, indicating purposeful omission of any studies for or against his argument that were up to date. His post did not include any quotes from his references to legitimize his argument, which indicates a higher chance that he is presenting these sources out of context. His decision to exclude clear arguments are ad hominem attacks. The negative focus is on NPs, not their arguments, making them appear dangerous and insufficiently uneducated. His omission of details tells the audience "just take my word for it"—words that echo those spoken to laboring women to get them to accept technological interventions.

Dr. Fleeger's concluding remarks imply that physicians are the only care providers capable of being professionals and provide us with a very explicit example of how medical authoritative knowledge is used to make change seem unthinkable because it could undo the established social order (Jordan 1997). He claimed that physicians, as medical professionals, must "lead, supervise, educate, and monitor the other members of our healthcare team. They do not know what we know. They cannot do what we do" (2020b). "Medicine" in these posts has been used to encourage universal trust in the actions and motivations of physicians as a propaganda technique. "Doctors" and "physicians" are words that are often used synonymously with "safety", especially when speaking about birth. Projecting masculine power over the feminine has long been present in research. TMA's use of "medicine" and "physician" as metaphors for "safety" reference how interconnected "male" and "female" are within biology and politics. Emily Martin's (2007) essay, *The Egg and the Sperm*, illustrates how the female reproduction process is described in medical texts as a "failure" to conceive when the menstrual cycle undergoes a passive list of actions like "shedding," "is swept," and "losing." In contrast, the medical texts illustrate the male reproductive process as a victorious one where the sperm is depicted as "strong", "whiplashlike", and "fuel" which rescues an egg

from being wasted. Like Martin's essay, TMA's semantics over politics resemble the mastery they claim to have over the "faulty" birth process. The natural environment—birth and women—must be controlled and protected by the masculine environment—medicine, knowledge, and politics (Lakoff and Johnson 1980; Kitzinger et al. 2006), thereby discouraging questioning what their roles as care providers should be and how titles of medical authority should be distributed.

What Fleeger ignored while admitting the limitations on a doctor's scope of practice was the irony of also demanding that physicians be seen as the authorities on all health matters. He acknowledged the specialty training, skills, and talents that all members of the medical community have and how they're necessary for successful collaboration but stated that only doctors could be trusted with oversight. If a "nurse is not a doctor. And a doctor is not a nurse" (2020b), they should be viewed as equally representing knowledge systems and going through training to address specific roles as care providers. And especially when nurses receive advanced training in midwifery—training that focuses on the normal physiology of birth—why should doctors be presumed the most suitable leaders over a process that is not their specialty? (Obstetricians are trained mostly in birth pathologies, whereas midwives are the experts in facilitating normal birth). Evidently the glass ceiling that disproportionally affects female dominated roles does not apply to this patriarchal position of influence, and it appears that physicians think they have nothing to lose by creating propaganda against healthcare professions that threaten their authority. Ultimately the arguments presented on TMA's website are the preamble to moves taken by TEXPAC, TMA's self-described political arm and source of financial contributions to lobbyist efforts and political campaigns.

TMA's Involvement in the Political Process and its Impact on Midwifery

According to opensecrets.org, which fosters transparency by publishing data on the role of money in politics and policy, TMA's funds raised and spent per election cycle from 2002-2014 averaged between $2 and $1.2 million, but funds raised and spent in 2016 plummeted to around $500,000 and further in 2018 to $250,000. TMA's campaign spending in their best year, 2012, allowed for $1.1 million in contributions to state and local candidates and $89,500 to federal candidates. But 2018 only allowed for $54,000 toward state and local candidates and $19,000 toward federal candidates (CRP 2019). Such a significant change may just represent a temporary setback, but currently it seems to indicate a shift in influence over policy and perhaps also in their previously favorable status among members. Comparatively, the ACNM PAC contributed $48,500 in 2016 and $42,500 in 2018 to federal congressional candidates (CRP 2019, 2020).

My experience navigating TMA's website over the last several months has been confusing, frustrating, and enlightening. I choose to describe this experience because it provided insight into the strategies, however unintentional, that redirected the conversation away from improving the quality of care and back to preservation of authority. As I mentioned when introducing some of TMA's arguments in the previous two sections, references to midwifery have been very hard to locate. The difference, I believe, is that TMA is a large organization which represents an expansive range of topics. To be fair to TMA, I have attempted to search for positions and statements in a way that I have not done for other websites discussed here, and my navigational experience may differ from someone else's.

When I began, I relied on their menu to find statements on politics, insurance, scope of practice, general maternal health, and midwifery. I noticed that throughout all of these links

there was no mention of midwifery. Though TMA's materials are created by and for physicians, absolute avoidance of midwifery seemed unlikely. If there were truly no links between TMA and midwives, omission of information signaled willful ignorance of the discussion of expanding midwifery access to combat the high maternal mortality that so clearly puzzled TMA. In the end I found two posts and one official policy position on midwifery, reminding me that TMA's collective identity as a dominant system came with the power to either ignore or give fleeting attention to "insignificant" practitioners to fit their whim (Baer 1989).

I moved on to the post on healthcare in the 2020 election. The post provided a link to a list of "all policy positions" (2019d) It presented an extremely well organized, comprehensive index of position statements and several statements on the topics I'd been searching for all along. Only one directly mentioned midwives, but around thirty more were directly related to my discussion on midwifery and the more visible posts I had been analyzing.

I continued to wonder why TMA chose to publish reports and posts with no access to their own official positions. For example, in my discussion on their 2025 Healthy Vision document, I said there was no mention of the methods or resources that would be provided to decrease maternal mortality and PPD. The statement was located in the index and recommended a continuing medical education programs that covers diagnosing and treating anxiety and depression (TMA 2018b).

If the TMA's policies promote using scientific, evidence-based studies to improve maternal health (2016a), that iatrogenic premature birth should be reduced (2016b), and that physicians should be able to "seek the best health and medical care for their patients, based

solely on the needs of each individual" to prevent the erosion of high standards in medical care (2016c), reaching out to collaborate with nurse and direct-entry midwives should be a no-brainer and reducing unnecessary interventions should be a priority. Despite frequent statements on the value of evidence-based care and research, very few posts include references to them at all. To acknowledge the legitimacy of nurse and direct-entry midwives to any extent (2016b, 2016d, 2010) and then purposefully exclude all relevant research on the benefits of midwifery reflects the power of elites to shape social reality to their benefit (Baer 1989). If preventing 80% of maternal and neonatal deaths is truly important to physicians, why refuse to listen to the March of Dimes (with whom they are a proud partner), medical journals, and public health groups that show midwives as a valuable resource in reducing mortality and morbidity globally?

Posts covering 2020 presidential election topics like Medicare For All, lower prescription costs, and candidate platforms reinforce a singular political ideology and agenda. TMA claims to want to do what's best for their patients but their actions are inconsistent with their stated beliefs. When discussing their stance against a single-payer system, they argued plainly that it's "not in the best interest of the public, physicians, or the healthcare of the nation" (2019d). Further down "medicine's best interests" became the focus of the post as they announced that 92% of candidates funded by their PAC were successfully elected. The interests of the public and those of medicine are not always the same; in fact, I argue that they are quite different. TMA is willing to pay lip service and make small changes toward reducing maternal mortality and morbidity as discussed in previous sections (Kitzinger et al. 2006), but not if that requires a loss of political power, loss of authority over other healthcare workers and consumers, and accepting the increased legitimacy of midwives and other complementary

providers whose “competitive” presence would also lead to reduced reimbursement from expensive interventions.

How the Issues Come Together with Political Advocacy Groups

Global and public health groups for maternal and child health work to bridge the gaps of separate bodies of knowledge through collaborative advocacy. They are created to work on a national and global scale, unlike national midwifery and medical groups which often divide into state or local chapters. Health Policy Plus (HP+), a five-year project funded by the United States Agency for International Development (USAID), originated from the Health Policy Project (HPP). HP+ works to advance eight health issues, including maternal health, from a foundation of health equity. In an effort to improve health outcomes worldwide, they contribute to and support the efforts of WHO to create universal health coverage (HP+ 2017). At the heart of all debates over universal healthcare is “how are we going to pay for it?” Elise Lang tackled the concept of financing in a blog post for HP+ where she focused on free family planning and HIV prevention and treatment in low and middle-income countries. In Ethiopia, about half of the cost for these services is covered by donors. The perception of consumers, “that essential health services and commodities are ‘free’, is only partially true. Separate stakeholders like the World Bank and the International Monetary Fund work to privatize services through resource mobilization (World Bank 2020; IMF 2020; HP+ 2020). While services and commodities may be cost-free to the clients in public health facilities in many developing countries, someone is always paying for those services” (HP+ 2019). Unfortunately, this incorrect assumption resulted in a staggering decline in donations to keep the program running. Hurried efforts by the Ethiopian government to develop insurance plans

which cover the gap of funding were forced to reduce levels of coverage and benefits, leaving the poor vulnerable and unable to afford essential health services and medications.

Elise's summary of establishing self-sustained healthcare programs in resource-poor nations is indicative of the logistical hurdles that delay measurable success and equitable access to care. Development of balanced, people-centered economic infrastructures across developing nations shows patterns of struggle which are eerily similar to the ones debated in the US. The discourse of HP+, developed to address the health inequality of developing nations, is sadly just as relevant to the US. Why, despite the health care reforms and services of the 1960s, and despite being one of the richest nations of the world, are we just as far from achieving health equity as countries like Ethiopia relying on aid to build a health care system out of nothing?

A Guide for Advocating for Respectful Maternity Care, developed by the White Ribbon Alliance in collaboration with others like HP+, is written for anyone who wants to improve the standard of midwifery care and seeks the tools to mobilize their community (Windau-Melmer 2013). The document language is supportive of distributing knowledge and power to all, in the same way that a midwife distributes knowledge and "re-skills" her client (Daviss 2006). The promotion of midwifery and improving maternal and infant health is a natural by-product of establishing health equity. To each of these organizations, to address one issue of human rights is to address another. These coalitions work to weave midwifery and natural physiologic birth within the basic structure of healthcare and economic infrastructure, rather than integrating it into an already broken system which operates on a basis of profit over providing equitable health services.

Coalitions, as interagency advocates, are the most advantageous structures for public and global health progress. Interprofessional membership of individuals and organizations enhance the credibility of their agenda. Their breadth and depth of knowledge, combined with pooling resources, creates a much bigger beast to work against the corporations that benefit from oppressive policies (Kotch 2005). Together, they understand "the importance of looking at the big picture, and the possibilities of all of the social movements working together to make large-scale cultural change" (Daviss 2006:435). Their stakeholders commonly include midwifery groups like the AABC, ACNM, MANA, ACOG, and NACPM, but the human rights and single-payer healthcare systems that are advocated for in the coalitions do not consistently trickle down to the work of their stakeholders or individual members.

One positive example comes from the ACNM digital news site, *Quickening*, which recently put out an open-access article that discussed racial disparities and the rise of maternal mortality in the US. The piece was a collaborative effort to address the causes and effects of racial disparities, to support active federal legislation, bring attention to obstetric and structural violence, and to introduce the types of needed legislative reforms. The piece did not suggest specific policy proposals but stated: "The racial inequality impacting black mothers and people of color continues to grow despite ongoing research and frequent calls to take measured steps to address disparities and improve care. While causes are complex and include health insurance coverage gaps, uneven access to services, social determinants of health, and other factors, it is clear that the maternal mortality crisis is rooted in racism and the marginalization of black women and their birth practices. For most black women, that means being exposed to multiple forms of discrimination and institutional barriers to quality care. There is also evidence that the chronic effects of the stress of racism, along with the feeling of

not being heard when health concerns are raised, are factors in black maternal mortality and poor maternal health outcomes" (ACNM 2020). Similarly to TMA, ACNM post did not include sources. However, the post was strongly focused on the issues rather than discussing the threats from other organizations.

CHAPTER 5:
Concluding Analysis and Policy Recommendations

In addition to its other purpose—the study of midwifery advocacy in all its complexities—my study also follows how Houston midwives perceive and choose to participate in advocacy. Though there are disagreements within their professions on the details and methods of implementing change, they agree that all women should have access to their choice of birth attendant and setting. It is also agreed that the success of midwives relies on changing public perceptions through education and media presence, and that success on Capitol Hill, or in every state, cannot be achieved without collaboration among midwives and the grassroots support of their consumer base. This agenda is CMA in practice; it's a testament to the strength of midwives who challenge the social order that has been shaped by medical authoritative knowledge as well.

The midwives showed themselves capable of assessing problems and solutions within the Texas medical system and were up to date on the policies that would improve their day to day functions. These fulfill the criteria for system-correcting praxis because the current policies in the Texas midwifery agenda are focused on bureaucratic matters. The problems and solutions are well-articulated and focused throughout their online resources and are

generally easily accessible by the public. The majority of midwives could identify the major social actors and collaborative stakeholders in their community but did not vocalize a connection between their professional organization and the coalitions that reached into global maternal and child health.

Overall, the midwives showed a limited understanding of the strategies needed to achieve their policy goals and relegated most of the activity to the local prominent advocacy figures like Lori and Wendy through MANA, ACNM, CTCNM, and AABC. While this was ultimately a matter of personal identity and choice, it was consistent with the pitfalls of the ABM as a successful social movement because of low levels of involvement. The system-challenging praxis, which is the practical side of my theoretical viewpoints and the ultimate factor of success in this thesis, fell quite short of expectations but remains a source of potential strategy for future policy reform. Additionally, the variety of coalitions with midwifery organizations as stakeholders was high and indicated that the midwifery model of care and healthcare as a human right were capable of high visibility and influence.

Factors of a plural medical system may still exist in the US, but functionally the reality is that ruling elites like physicians—not individuals—control the direction of the medical system. Until social movements for structural change are part of mainstream ideology and persist on the ground, the reforms discussed by midwives and public health activists will have a low impact. Structural changes carry high risks, and it is common to feel that immediate costs outweigh the benefits that may not even occur in our lifetime. The policy priorities expressed from midwives are only part of the solution to improving MCH. The capitalist system in which these policies operate leaves the poor and other minorities exposed to systemic oppression. Though some midwives like Jaime choose to work within the limited

Medicaid system, the majority of midwives have clients who can afford to navigate the US healthcare system by paying out of pocket or by benefiting from their religious affiliation, leaving the most vulnerable groups hardly any better off than before. For midwifery to effectively reduce maternal and infant mortality and morbidity, such as those affected by PPD and racial disparities, "changing individual and health provider behaviors" through training and resource mobilization social movements "is a necessary but insufficient strategy to close the health gap. Eliminating health inequities will require a national resolve to state, community, as well as individual levels" (Kotch 2005:333). While the struggles of midwifery over their scope of practice, legal status, and cultural and medical authority are deeply entrenched in issues of gender, capitalism, religion, and authority in healthcare from an analytical and anthropological perspective, the criticism from midwives is focused on the projection of physician authority (regardless of gender or cultural origin) over healthcare and the threats their authority has on the professionalization of midwifery within Texas.

"Policy for the future"— the ideal transformation of birth care under a single-payer healthcare system—has arrived (Lazarus 1997:152). If the moment was apparent in 1997, it can only be more apparent now. The desire to experience revolutionary change through recent history has also left us stuck in the liminal stage where "for the future" never transitions into "for now." But the perfect circumstances for structural change will never exist, just like no amount of parenting books or classes can make you ready for the struggles of parenthood. Small changes are of course better than no change at all. But I challenge midwives, whether their passion to serve women includes policy or they just can't get far away enough from it, to never become complacent with small changes. Even small successes require relentless questioning. Here are few such questions that were raised during interviews but had unclear

answers: Are the methods for educating the public and bringing the midwifery agenda into focus truly successful? Are multimedia resources being used to their full potential? Are the priorities of professionalization hindering progress of human rights legislation? Are we taking advantage of individuals, local communities, and the unique talents they can provide? In *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, Paul Farmer reminds us that in all matters of health and equity: "Arguing that nominal civil and political rights are the best we can hope for means that members of the healing professions will have their hands tied, forced to stand by as the rights and dignity of the poor and marginalized undergo further sustained and deadly assault in what is essentially an undeclared war on the poor. Because it is undeclared, we need to declare against whom, for whose benefit, and how it is being waged" (2005:245).

Therefore, it is my goal to amplify the voices of midwives, who have the power to support all women, especially the vulnerable and marginalized, so that women can feel free in exercising authority over their own health even within national policymaking. Results of this freedom are projected to reduce maternal and infant mortality rates, reduce unnecessary interventions, reduce NICU admissions, and save America billions of dollars in healthcare costs (Anderson, Daviss, and Johnson, in press; Health Management Associates 2007). It's even more important to recognize that as massive as the political and corporate biases against midwives are, they are only a portion of those affected by the corporate greed that preys on the poor and contributes to the global health crisis. It behooves us to take this understanding and apply it critically and publicly to not just assess what the perceived cost of structural change would be individually, but also to assess what the cost of defending the status quo means for the most vulnerable of us.

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