Framing Black Infant and Maternal Mortality

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Abstract: This article looks to the past to consider how government officials, health professionals, and legal authorities have historically framed racial disparities in birth and the lasting impact these explanations have had on Black birthing experiences and outcomes.

In the U.S., black mothers and infants die at two to three times the rate of their white counterparts.[1] Since government reports from the late 19th century first took note of the excess deaths, these racial inequities have persisted.[2] This article explores two historical eras that have had a lasting impact on how government officials, medical experts, and legal actors have explained the disparate outcomes and the ways their explanations have shaped black birthing experiences. Part I explores narratives of individualized blame: that is, the blaming of black midwives for maternal and infant deaths and the campaign waged by health and government officials in the early twentieth century to regulate, and criminalize, Black midwives. At a time when midwives provided critical maternity and neonatal care in Black communities, legal measures to push midwives out of practice left expectant mothers with fewer options for care and meant Black mothers and babies disproportionately suffered. Part II examines how these inequities endured despite progressive social welfare and legal developments in the 1960s, including federal mandates to desegregate hospitals and expand health care access. Though more Black mothers gave birth in hospitals, increased access to health care institutions did not eliminate racial disparities in birth outcomes or experiences of discrimination. In analyzing these historical efforts to regulate attendants and access, this article argues that policy responses to the death of Black mothers and infants depend on the way medical and legal authorities frame the issue — whether as a legal problem, racial injustice, or more persistently, as individual failure. Drawing on government reports, historical accounts, and, notably, Black women's first-hand perspectives, it demonstrates the importance of looking to the past in order to explore new ways of

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thinking about the role of law and policy in combatting racial inequities in birth today.

Part I

Recent studies show that midwives are associated with improved birth outcomes, lower rates of infant death, and that Black pregnant women in the U.S. report greater satisfaction with the care they receive from midwives than from physicians.[3] One hundred years ago, however, attitudes towards midwives were very different. Doctors and health officials blamed midwives for maternal and infant deaths, and considered mothers who relied on Black midwives to be uninformed and negligent.[4] This early 20th century framing of midwife attendants as the cause of maternal and infant mortality was a key argument that health professionals wielded to bring midwives under state supervision and regulation. Yet, listening to Black women's first-hand accounts of this era challenges these assertions and instead highlights how Black mothers navigated limited options for having a safe birth, and how Black midwives struggled to provide desperately needed care in their communities. Centering Black women's experiences of the early 20th century campaign to eliminate midwives reveals the ways government and physicians' efforts to restrict midwifery critically limited Black families' ability to have safe and healthy births.

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During the era of Jim Crow racial segregation when Black Americans had unequal access to health care, Black midwives were the main providers of maternal and infant care in their communities. Into the 1940s midwives attended to more than half of all Black births, and in the rural South Black families called on midwives eight times out of ten.[5] Even as roughly six million Black Americans moved north and west as part of the Great Migration of the early to mid 20th century, most Black births and infant deaths took place in the South and at home. The reliance on midwives looked very different for white women, who were more likely to have a physician attend to them whether they gave birth at home or in a hospital.[6]

Black women preferred to have a midwife by their side through pregnancy, birth, and the postpartum period for several reasons. Midwives were valued for their expertise and skills providing physical and emotional support to women. A 1924 survey of white, Black, and Latina mothers found that many believed midwives "took more pains" than doctors to assist during labor and the initial days after birth. One of the Black mothers interviewed had such a traumatic delivery experience when attended by a doctor that she swore to never "have him again." For any future pregnancies, she would only call on a midwife as she explained: "Granny helps in your misery."[7]

Compared to the holistic care women received from midwives, Black women were more likely to endure humiliating, painful, and even deadly experiences when attended by physicians. Doctors were less willing to serve poor Black families. Dr. Halle Tanner Dillon Johnson, one of the first Black women physicians to practice in Alabama, noted that in the area where she practiced, white doctors charged for each mile they had to travel to reach patients, and that he "must be assured of his money before coming, often demanding cash" before agreeing to visit.[8] For Black sharecropping families with little access to cash, hiring a physician was out of the question. In contrast, midwives were more willing to accept alternate forms of payment, including crops, livestock, and other goods and services. For Black women who had the financial resources to hire a physician, the ability to pay did not ensure that they would have a favorable experience, or even survive. A 1937 study found that physicians' errors were 50 percent more frequent in Black obstetrical cases.[9] Renowned physicians such as John Whitridge Williams at Johns Hopkins Hospital justified their use of risky, "last resort" procedures like Caesarean sections on Black women, arguing that because of biological differences (deformed pelvises and nutritional deficiencies were chief among the reasons cited), "blacks require radical interference much more frequently than whites."[10] White physicians' beliefs in racial biological difference undergirded their use of high-risk obstetric interventions that, ultimately, contributed to higher morbidity and mortality rates among Black mothers and babies.

Yet when health officials in the early 20th century tried to explain why Black maternal and infant death rates in the U.S. were higher than found among other racial and ethnic groups, they barely acknowledged

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the role that physicians played. Instead they directed their attention to the South, the region with the highest death tolls and largest concentration of midwives.[11] Behind tuberculosis and heart disease, the diseases and complications of birth were the third leading cause of death for Black residents of the South.[12] Rather than recognizing midwives as indispensable health care providers in this region, doctors and nurses regarded midwives as incompetent practitioners who posed "a serious menace to infant life and the lives of mothers."[13] From the 1910s through to the 1950s, many health professionals argued that eliminating Black midwives was the key to reducing Black maternal and infant death rates. As one nurse commented, "if the problem of infant mortality is to be solved … it would certainly simplify matters if we could remove from our midst the midwife."[14]

At the turn of the 20th century, doctors worked to reframe birth as a dangerous event that could only be properly managed by those with an accredited medical education. Physicians argued that midwives, who lacked formal training in obstetrics and bacteriology, needed to be closely supervised if they were to attend any deliveries, and they lobbied state legislatures and boards of health to establish licensing requirements for midwives.[15] Up until this point, most midwives worked without legal oversight.[16] The few southern states that had pre-existing laws, like Louisiana, actually allowed Black midwives to practice unsupervised since health authorities viewed "the so-called midwife of rural districts and plantation practice" as a lay healer who was not "practicing midwifery as a profession."[17] This exemption from regulation was based on the state's narrow definition that practitioners who accepted non-monetary compensation were not true "professionals," a framing that disavowed Black women's skilled labor.

Swayed by arguments that midwives were untrained and posed a grave threat to mothers and newborns, local legislatures enacted laws requiring midwives to be trained, tested, and licensed in order to practice.[18] Midwifery regulation intensified with the passing of the 1921 Sheppard Towner Act, which provided federal aid for maternal and infant health programs, particularly in rural areas. Many states, especially in the South, allocated a portion of the funding to create midwife classes run by local health officials and state-employed nurses.[19] Through the classes, midwives learned of the new laws governing what they could and could not do when attending a birth. To ensure compliance, nurses closely surveilled midwives through administering tests, inspecting the equipment midwives carried, and conducting investigations and surprise home visits.

Midwives who resisted these measures and state requirements to register for a license faced criminal prosecution, including monetary fines of up to $500, license revocation, and imprisonment.[20] Mary Willingham, a Black nurse practicing in Georgia in the 1930s, recalled the fear that these penalties provoked, "It used to be anybody could wait on a 'oman havin' a baby … Now, that's all changed. If you don't have that 'stificate they'll put you in the penitentiary for life."[21] She was not alone in being alarmed by the increasing government surveillance surrounding childbirth. Margaret Charles Smith, a midwife practicing in Alabama, understood perfectly that Black midwives had become the government's primary targets of blame, remarking, "if anything happens bad to the mother, they're calling you in."[22]

In this medical-legal climate of intensifying regulation, midwives faced an ethical dilemma, caught between demands to comply with new laws and a responsibility to provide the care their clients requested and needed.[23] Many midwives resisted regulation, well aware that the limited care they could legally provide would be of little comfort to women. One midwife, exasperated by the restrictions she faced, informed her supervising nurse that she would resign. She stood firm in insisting, "You don't know how it goes. Rubbing helps and teas help. If I can't give them some hot teas which I know will help, I just well ought to give up."[24] While midwives traditionally relied on herbal remedies to relieve labor pains and control bleeding, health authorities viewed such therapies as unscientific, with some alleging that midwives used herbal remedies not to promote healthy births, but to induce abortions.[25] Public health nurses issued stern warnings to midwives that "they better not catch nobody giving nobody no tea of no kind. If they do, she was going to jail and from there to the pen."[26] In struggling to work in such a threatening and punitive environment, midwives found that state laws erected in the name of reducing maternal and infant deaths actually left them little room to utilize their community-valued skills to protect the wellbeing of mothers and babies.

As a result of state efforts to restrict midwifery practice through licensing, surveillance, and intimidation, the number of midwives drastically declined. This was as many doctors had hoped, writing in their professional journals that midwives "must be eliminated… and placed under state control."[27] In 1925, over 9,000 midwives practiced in Georgia, and by 1950 that number had decreased to 1,322.[28] Similar declines occurred across the South.[29] Yet federal reports showed that even with national infant mortality rates falling, Black mothers and babies continued to die at twice the rate

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of whites, raising the question of whether midwives were actually to blame.[30] In this sense, physicians' claims that midwives were responsible for the country's maternal and infant deaths served more as a tactic to remove unwanted competition than to address the root causes of deaths surrounding birth. With midwives largely eliminated and overall infant death tolls declining, health officials paid less attention to the disparity between Black and white infant survival. Still, as one Mississippi health official raised, "who is to care for these women…some one must serve. The midwife can not be taken away even though she is not capable, until a better service is available to these mothers."[31] The official's comment exposed one racialized consequence of the government campaign to eliminate Black midwives — it left Black mothers and babies in a health care void, vulnerable to complications and premature death that could be prevented with accessible and equitable care.

Part II

Whereas health officials in the first half of the 20th century framed Black infant and maternal deaths as the fault of midwives, by the early 1960s a growing number of activists, lawmakers, and health professionals argued that the unequal access Blacks had to medical services explained their poorer health outcomes. Through lawsuits, civil complaints, and legislation, a range of reformers fought to transform the nation's "separate but equal" medical system into one that ensured health care access for more Americans, regardless of race, age, or ability to pay.[32] Such efforts had a sweeping impact on the nation's health care landscape, and some were optimistic that the progressive social policy reforms to expand access would reduce the nation's stark health disparities.[33]

The stakes were particularly high for Black women as the government's elimination of midwives left Black women with fewer options for having a safe birth at home. Compared to the 27 percent of Black babies delivered in hospitals in 1940, by 1960 85 percent of Black births took place in a hospital.[34] Yet even as more Black mothers gave birth in hospitals, their restricted access to these segregated spaces meant they experienced multiple forms of discrimination and inferior medical care. In a 1963 report by the United States Commission on Civil Rights, 85 percent of Southern hospitals surveyed admitted to practicing some form of racial segregation or exclusion.[35] Hospitals such as St. Dominic-Jackson Memorial Hospital in Mississippi placed laboring Black women with all other Black patients instead of in the obstetrical ward, and confined Black newborns to a segregated section of the nursery. Black fathers were not allowed to be with their partners during delivery and could not visit their newborns.[36] In cities like Chicago that witnessed a significant rise in its Black population during the Great Migration, Black women could only deliver in two of the city's hospitals — Cook County and Provident Hospital — regardless of their ability to pay or proximity to other hospitals.[37] Both hospitals handled such a high volume of obstetrical cases that mothers were sent home with their babies "the evening of the first day after delivery if they were able to get out of bed."[38] Black women reported that they dreaded giving birth at Cook County, where "long labor lines … often stretch across the entire fifth floor."[39]

By the mid 1960s, lawsuits filed by Black patients and physicians, as well as new federal legislation, worked to expand health care access for Black Americans. Following the landmark 1963 decision in *Simkins v. Moses H. Cone Memorial Hospital* as well as the passage of the 1964 Civil Rights Act, hospitals that received federal funds and sought to participate in Medicare could no longer discriminate on the basis of race.[40] To comply with the new laws, more hospitals began to admit Black patients and remove structural markers of segregation such as separate entrances, waiting rooms, and wards.[41] More federal dollars went to fund maternal-child health programs, especially in urban, low-income areas. And through Medicaid, poor Americans who fell into certain categories — children, pregnant women, seniors, and people with disabilities — were now eligible for public health insurance.

Such legislative efforts to reduce racial, geographic, and economic barriers to health care offered good reason to be hopeful that racial disparities in health would disappear. Increased hospital access meant that when complications during childbirth arose, Black mothers and newborns could benefit from lifesaving therapies and medical technologies. One Black mother valued her decision to give birth at Philadelphia's Temple University Hospital when she had a difficult delivery in the 1960s. As she explained, "I knew they could revive the baby so long as they was getting a heartbeat." She recounted how the hospital staff worked to save her newborn, "First they cleared its mouth and nose of mucous, then they slapped it and tied the cord. When it wasn't crying by that time they sent for a respirator and did mouth-to-mouth respiration on it, and then it began to cry."[42] Health professionals shared in the mother's optimism that infants who a generation before would have likely died, now stood a good chance of surviving if delivered at a hospital.

Yet the expansions in health care access did not guarantee equal treatment or high-quality care for Black mothers and babies. Medicaid's eligibility restrictions left many without coverage, particularly in the rural

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South where poverty was most concentrated.[43] In addition, several hospitals were reluctant to do away with their practices of segregation, and attempted to circumvent federal mandates. One county hospital in Mississippi had long used a curtain to separate Black and white babies in its nursery. Even after the hospital was mandated to desegregate, the curtain remained, albeit it now separated "difficult" babies from other newborns. In response to complaints filed by patients and practitioners, investigators from the Office of Equal Health Opportunity responsible for ensuring compliance with federal law visited the hospital and found the "difficult" babies were almost always Black.[44] The health care landscape was not much better in the North, where municipal hospitals that served Black communities were often overcrowded, understaffed, and under-funded. In the 1960s, thousands of poor Black women in Chicago were redirected from the city's overloaded public hospitals to private ones, where the care they received was primarily to "provide added teaching experience for interns and residents."[45] Such an arrangement perpetuated a longer history of Black women's access to health care being predicated on physicians having access to their bodies for educational and experimental purposes.[46]

Throughout the 1960s era of progressive social policy reforms, racial disparities in maternal and infant health narrowed slightly in some areas but still endured.[47] The persistence of these disparities, despite sweeping measures to restructure health care, highlighted the limits to interventions focused solely on access. Indeed, Black mothers have continued to receive poorer and discriminatory health care. State investigations of New York hospitals in the 1990s found that white maternity patients were placed in wards separate from Black and Hispanic mothers, many of whom were on Medicaid. Hospital administrators asserted that segregating maternity patients based on insurance type allowed for "more efficient care," yet Black mothers placed in the 'Medicaid wards' testified that they received no information on breastfeeding and infant care, and were treated only by doctors in training, not senior physicians.[48] One Black mother shared that "the whole experience was devastating … I was very depressed."[49]

Since the 1990s, studies have shown that Black women have the highest rates of C-sections, which places them and their babies at greater risk for severe postnatal complications and death.[50] C-sections are routinely justified on grounds that Black women's pregnancies are high-risk due to pre-existing conditions like obesity or the circumstances of labor such as "failure to progress."[51] Such risk assessments are rooted in older, clinical views about Black women's behavior and biology, and can lead to charges that Black women are to blame for their pregnancy outcomes. Yet these clinical practices make it more likely for health care providers to fatally intervene in Black births.

As Black women and their babies have navigated health care institutions, they have been disproportionately subjected to mistreatment and discrimination in ways that threaten their livelihoods. In this sense, Black women's access to health care was, and continues to be, double-edged. While increased health care regulation and access has been framed as improving options and outcomes, such access has been tenuous, making Black women more vulnerable to medical and legal interventions — including disproportionate rates of C-sections, sterilization, and criminalization — that jeopardize their health and the health of their babies.[52]

Conclusion

Today's profound racial inequities in maternal and infant health have historical roots. Examining past efforts to address these inequities — through campaigns to regulate midwifery and health care access — reveals the power of frameworks to shape health care interventions. Indeed, the questions underlying these past campaigns — who is best equipped to manage birth and where can Black mothers safely give birth — continue to be debated in ways that highlight the importance of understanding the historic roots of these concerns and the need for new frames in efforts to improve the Black birthing experiences.

Note

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