Birth work as justice work: Exploring the untapped potential of midwifery care in addressing maternal health disparities

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Background: Maternal Health

- **46** countries have a lower maternal mortality rate than the US \(^1\)-\(^2\)
- **28.3** deaths per 100,000 is a two fold INCREASE between 2003-2013 \(^3\)
- Black infants are **2x** more likely to die in infancy \(^4\)
- Black, non-Hispanic women in NYC are **8** times more likely to die from childbirth related complications \(^5\)
- **13** billion dollars in spending \(^6\)-\(^7\)
• 12% of all US births with midwives; 60% of these births are billed to Medicaid 

• Midwifery ethos: relationally driven, shared decision making, self-determination 

• History of serving the needs of poor and vulnerable communities
Ethos of midwifery care

- Pregnancy as an essentially healthy process
- Midwives view birth as physiologic and social process
- Value the physical, emotional, spiritual, and mental aspects of health
- Focus on decision making, autonomy, trust, and culture
Cochrane Reviews showed that midwife led care 15-16:
- < preterm birth
- < use of pain medication
- < miscarriage before 24 weeks
- > satisfaction

Increasing focus in midwifery care 17-18:
- High quality
- High value
- Enhanced experience
- Intersectional feminist praxis
• Definition of quality care is evolving to prioritize the experience of care for patients and providers

• Understanding of midwifery care in public health settings limited

• Lack understanding of the experience of providing maternity care to historically disenfranchised people

• Relationship-centered care centers affective & social dimensions of health as we struggle to address the social determinants of health
Orienting theories

- Critical feminist theory: 19-26:
  - Black feminist theory: Davis, b. hooks, Hill-Collins
  - Post-colonial or Third-world feminism: Mohanty, Spivack, Anzaldua,
  - Intersectionality: Crenshaw, Hill-Collins, Ross

- Reproductive Justice / Birth Justice

- Relationship Centered Care Framework

- Healthcare as a social relationship requiring a fusion of patient and practitioner perspectives: 28
  - Experience shapes quality and Quality shapes experience
Reproductive Justice: Feminist Praxis

Black Feminist theory

Intersectionality

Reproductive Justice

M. Niles
Considering the ‘Quadruple’ Aim

Benefits:
- Improves employee satisfaction and turnover, improves patient satisfaction and reduces workplace injuries.
- Reduced Spending for Workers’ Compensation Claims, Employee Injuries, Medical Error Litigation, Lost Productivity, Reduced Readmission Expense

Benefits:
- Less Patient Suffering through reduced Medical Errors, HAIs and injuries
- Reduced Readmission, Reduced Error Related Complications

IHI’s Quadruple Aim
Fig. 1. WHO framework for the quality of maternal and newborn health care

Experience shapes quality

Quality shapes experience

Health system

Quality of Care

PROVISION OF CARE
1. Evidence-based practices for routine care and management of complications
2. Actionable information systems
3. Functional referral systems

EXPERIENCE OF CARE
4. Effective communication
5. Respect and preservation of dignity
6. Emotional support

7. Competent, motivated human resources
8. Essential physical resources available

Individual and facility-level outcomes

Coverage of key practices | People-centred outcomes

Health outcomes
Research Aims

- Examine practices, values, and challenges of midwives caring for publicly insured women in building relationships

- Identify the occupational health factors that facilitate or impede the development of therapeutic relationships between midwives and women/pregnant-parenting people
How do overlapping social, political and gendered vulnerabilities influence healthcare relationships?

What organizational forces (personal, professional and organizational) impact relationships of care?

How are the knowledge, skills, values, and health of midwives influenced by their work environment?

How do interprofessional relationships impact perceptions of healthcare quality?
Design & Methods:
Qualitative Exploratory Design

• Qualitative exploratory design guided by feminist theory

• Data collection
  • Intensive, in-depth interviews recorded and transcribed
  • Average length of each interview: 82 minutes, with 20 practicing midwives

• Qualitative methods\textsuperscript{30} produce:
  • rich data on perceptions, beliefs, experiences, and behaviors
  • understanding of local care contexts
  • in-depth understanding of women’s narratives \textsuperscript{31}
More than 1.2 million New Yorkers received care

Network: 11 acute care hospitals, five long term care facilities, network of community based clinics

Care for one in five inpatient New Yorkers in 2014

Takes care of “newest New Yorkers”

NYC H +H provides three times greater share of care to the uninsured than other NYC hospitals

Of the 11 hospitals, seven have integrated midwifery services
### Setting: Demographics

#### Table 2: Perinatal Outcomes by hospital

<table>
<thead>
<tr>
<th>Perinatal outcomes (by percent)</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>NYC</th>
<th>NYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature birth</td>
<td>11.7</td>
<td>11.3</td>
<td>11.8</td>
<td>10.4</td>
<td>10.5</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>9.9</td>
<td>8.7</td>
<td>9.1</td>
<td>8.1</td>
<td>7.8</td>
</tr>
<tr>
<td>Late or no prenatal care</td>
<td>9.9</td>
<td>7.4</td>
<td>10.8</td>
<td>6.7</td>
<td>5.4</td>
</tr>
<tr>
<td>Medicaid / Self-pay</td>
<td>69.8</td>
<td>68.0</td>
<td>81.6</td>
<td>60.4</td>
<td>52.7</td>
</tr>
<tr>
<td>Adolescent birth rate (per 1,000)</td>
<td>19.1</td>
<td>19.5</td>
<td>26.6</td>
<td>16.0</td>
<td>13.9</td>
</tr>
<tr>
<td>Infant death rate (per 1,000)</td>
<td>4.9</td>
<td>4.7</td>
<td>5.1</td>
<td>4.0</td>
<td>4.6</td>
</tr>
</tbody>
</table>
Sample: Participant Demographics

- All self-identified as **women**
  - Pronouns: she, her, hers

- Attend **>80% of all NSVB**

### Race identification
- 35% Black
- 65% White

### Language proficiency (clinical)
- English, Spanish, or French

### Years of midwifery practice (mean)
- 13.45 years
- Most years of practice: 33 years
- Least years of practice: <1 year

### Years at NYC H+H facility (mean)
- 8.25 years

### Boroughs served
- Bronx
- Brooklyn
- Queens

### Specialty Care
- Termination Counseling
- Gestational Diabetes
- Antenatal Testing Unit
- Adolescent Clinic
- First Assist, Circumcision
Data Analysis: Thematic Approach

• Iterative and inductive process
• Emergence themes and concepts through data harmonization
  • Transcripts (focus group and interviews)
  • Field notes (site visit observations)
  • Reflective Memos
• Using thematic analytic approach for guidance with analysis:
  • Coding
  • Theme generation
• Data integration: merging disparate data to find significant patterns and themes through interpretation and abstraction
Findings

Navigating boundaries

Fluid autonomy

Caring for the social body

*Kairos* care in a *Chronos* world
• Professional boundaries
• Physicians – Midwives – Nurses:
  » Distinct & Interdependent
• Values mis/alignment
• Helping clients navigate large institutionalized care
“I don't think we always see eye to eye. It's interesting there was a conversation, with two doctors and me. We were talking about how to handle something. I can't remember what the clinical picture was but all three of us saw a completely different story and thought what the right thing to do was completely different. It was just fascinating how different this management can be and how people come at these things with these different ideas.”

-Nina, (Hospital B)
Findings: Fluid Autonomy

- Autonomy is driven by clients’ needs
- Understanding autonomy as interdependent on contexts
- Midwives derive job satisfaction when they are practicing authentically
“I can't always promise women prenatally what their birth experience will be like. A lot of time they want concrete ideas of how things are going to go or will people let them do this? ... because it's different approach by all these different people. You can't paint a solid picture for them. It could change in a minute or from person to person. One person can say ‘we need to break your water’, or ‘no, we don't need to break your water right now - we can wait’. You have to be so open ended because it's going to be out of my hands and that's really hard.”

-Faye (Hospital A)
Findings: Caring for the social body

- Language as soluble barrier
- Integrated care: the social as clinical
- Un/shared experiences
- Family dynamics
- Immigrant realities
“Oftentimes, I see that ... this woman is here for migraines or something but she also lives in a shelter and she's hungry and she came into triage because she wanted to get some rest. There are instances, where I'll go present the patient and tell them what she's here for and they’ll say, "Well, did you give her this for nausea? Did you try Fioricet? ... and I say, "Well, she just really needed some rest and as I mentioned maybe some IV hydration or some PO hydration even." We don't have to intervene in huge ways all the time or think about everything as a medical problem. Sometimes she just needs to be cared for or about.”

- Melissa, (Hospital A)
Findings: Kairos care in a Chronos World

- Change is progress
- Normalizing pathologies – Reorienting risk
- Guarding the birth experience as special and potentially transformative
"I think having midwives and having midwifery care, it helps to attenuate risk. It doesn't mean that the risk goes away, and we can say - "you're not getting preeclampsia now. I'm the real preventer, not aspirin." But we know that people can be really stressed out by interactions with their healthcare providers, and I think that we don't produce that stress. I think that patients leave smiling, they leave even-even if it's like, "You're diabetic, I'm really sorry. I want you to see the nurse and start finger sticks." ... the patients will still leave feeling like, "okay, I'm not well, but will I get to see you again?" I think there's something about that, that our interactions are therapeutic in themselves. That helps to attenuate risk for that person ... they don't leave driven by cortisol, they leave with some sense of well-being, probably a little bit of cortisol, catecholamines et cetera, but I think that's one thing about working with this population that makes a difference.

-Angela, (Hospital A)
Implications for practice & policy

• Increase and integrate midwifery workforce as primary providers of maternity care
• Provide justice-oriented trainings for all provider types
• Build-in provider work satisfaction scales into healthcare improvement strategies
• Continue to identify and celebrate exemplar models of care
• Adaptation to contexts is essential when applying and evaluating quality improvement initiatives
• More data and data aggregation to clearly evaluate midwifery related outcomes
• Midwifery care is well-suited for care of historically disenfranchised communities

• Maternal health disparities are rooted in social determinants of health – so care of the social ‘body’ is integral to overall health

• Lack of integrated social services means we are not adequately addressing the comprehensive needs of disenfranchised people

• Job satisfaction is derived from high quality healthcare relationships that center connection, communication, and mutual respect

• Collaborative practice requires time, training, attention, and centering our collective purpose of healthy peoples and families
Questions/Comments

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References

References


Limitations

- **Site specific** – not generalizable; specific to place and context of care

- **Response bias** – only captures view and perspectives of willing research participants

- **Personal Bias** – as a clinician -midwife working in the H+H system, as an immigrant woman, as a woman of color (the value of *reflexivity*)