Article

Midwifery and Antenatal Care for Black Women: A Narrative Review

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Abstract

Non-Hispanic Black mothers are 2.3 times more likely than White mothers to receive delayed or no prenatal care. Black women possess a long history of midwifery-led care, but there is a recent absence in the literature about the role of midwifery in this population. This systematic review elucidates the state-of-the-science regarding Black women's experience of antenatal care, including the role of midwives. Sixteen articles identified through CINAHL and PubMed databases were included using specific parameters. Three themes were used to identify Black Women's antenatal care perceptions: (a) care disparities, (b) perceptions of antenatal care, and (c) midwifery-led care. Major literature gaps include Black women's perception of midwifery as an antenatal care option and the experience and practice of Black midwives today. Understanding Black women's views of midwifery will enable providers to deliver antenatal care options that facilitate improved outcomes for Black women and their neonates.

Keywords

Black midwives, midwifery, antenatal care, prenatal care, African American, women

It is well established that Black women are at greater risk for preterm birth (PTB) and infant mortality than other race/ethnicities in the United States, particularly in the south. Evidence exists supporting the effects of adequate prenatal care to significantly reduce the risk of PTB among this vulnerable population (Debiec, Paul, Mitchell, & Hitti, 2010; Picklesimer, Billings, Hale, Blackhurst, & Covington-Kolb, 2012). However, Black mothers are 2.3 times more likely than White mothers to receive prenatal care late, or not at all (Office of Minority Health [OMH], 2015). Rationale for this trend remains unclear. The purpose of this article is to examine how current literature addresses Black women's experience of antenatal care, including the role that midwives may have in that care. A brief history of Black midwives and their role as the major health care providers for Black women, as well as the current trends in midwifery, will provide background and offer a point of reference. While much of the literature focuses on birth outcomes, provider qualities, and situational life factors in conjunction with the prenatal care received by Black women, very few investigate the effects that historical underpinnings may have played in Black women's current reception of prenatal care. The history of Black women's health care and the prominent role that midwifery played is all but forgotten.

Throughout this review, the term *Black* is used rather than *African American* as birth certificate data and much of the early demographic data use the term *Black* as a racial indicator.

Background

Antenatal care for Black women was historically provided by Black midwives from the 1600s to the mid-1900s (Robinson, 1984; Tunc, 2010). These midwives were the primary health care providers to Black women and were often called on to assist White women in the south during birth (Tunc, 2010). Approximately 50% of all U.S. births in 1900s were attended by midwives (Devitt, 1979). By 1935, 12.5% of all births in the United States were attended by midwives, while more than half of all Black births were still attended by midwives (Tandy, 1937). The decline of midwifery among the Black population was precipitated by the Sheppard–Towner Act of 1921, resulting in widespread regulation of the Black midwives in the South who, by this time, were the largest percentage of active midwives (Devitt, 1979; Tandy, 1937). Furthermore, in 1948, there was a push to standardize medicine and eliminate lay healers, which gained momentum around the time the American Medical Association (AMA) was formed (Robinson, 1984). Many women during this period of transition switched their method of antenatal

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care from midwives to physicians (Tunc, 2010). This trend, along with the subsequent regulation from the Sheppard–Towner Act, resulted in the gradual elimination of many Black midwives. By 1972, only 1% of all births in the United States were attended by midwives (Devitt, 1979).

Interest in midwifery-attended birth is resurging, as recently noted by the American College of Nurse-Midwives (ACNM). AACNM (2014) report titled "CNM/CM-Attended Birth Statistics in the United States" stated that 12.1% of all vaginal births in the United States were attended by certified nurse-midwives (CNMs) and certified midwives (CMs). ACNM's numbers do not reflect the practice of certified professional midwives, so the actual percentage of midwife assisted births may be slightly higher. Despite Black women's significant heritage surrounding midwifery, the trend toward midwife-attended births today is higher among Non-Hispanic White women. In 2014, 11% of all White, live births were attended by CNMs/CMs, whereas 8% of Black, live births were attended by CNMs/CMs (HealthData.gov, 2014). This is a sharp contrast to the mid-1900s when nearly 50% of all Black births were attended by midwives.

The demographic characteristics of members of the ACNM also mirror this trend. In all, 88% of the CNMs, CMs, and students enrolled in ACNM certified programs are White, and 3.6% are Black (Schuiling, Sipe, & Fullerton, 2005). The capacity for enrollment into nurse accredited nurse-midwifery programs remained stable since 2013, according to a 2015 report from ACNM; however, graduates from these programs continued to grow, reaching nearly 600 in 2014 at a growth rate of 5.6%. This increase saw an increase in diversity of nurse-midwives in all races ranging from 16.1% in Hispanic/Latino to 250% in Native Hawaiian/Other Pacific Islanders. There was an 18.1% rise in the increase of Black midwifery students (ACNM, 2015). The upward trend in the number of practicing midwives as well as the increase in diversity among midwives is encouraging; however, there is still a notable gap, both in the literature and in practice, regarding Black women and current use of midwives.

Method

Searches for both qualitative and quantitative research published in peer reviewed journals were conducted through CINAHL and PubMed databases using combinations of search terms "infant mortality," "preterm birth," "antenatal," "prenatal," "midwife," "black midwife," "granny midwife," "African American OR Black women," and "preferences." Publications selected for final review included a broad range of research designs including experimental, case controlled, phenomenological, cross-sectional, and ethnographic studies meeting four inclusion criteria: (a) published between 2006 and 2017, (b) conducted in the United States, (c) included a minimum of 13% participation by Black women, and (d) addressed antenatal care. Research conducted outside the United States or conducted within the United States among immigrant Black women was excluded because of the cultural differences between U.S. born Black women and Black women born outside of the United States. The threshold of 13% Black women was selected to ensure the data adequately represented the perceptions and experiences of Black women. This percentage is the national average of women who identify as Black. Preliminary analysis indicated a lack of research focused primarily on midwives and Black women; therefore, final analysis was conducted on research addressing Black women's antenatal care, regardless of provider type. In all, 18 studies were identified using these search criteria; however, two studies were not included in the analysis because they were based on data collected from the late 1900s. These were "Disparity in Prenatal Care Among Women of Colour in the USA" by Park, Vincent, and Hastings-Tolsma and "Women's Narratives on Quality in Prenatal Care: A Multicultural Perspective" by Wheatley, Kelley, Peacock, and Delgado. Final analysis was conducted on 16 studies.

Results

Eight of the 16 articles gathered for review were quantitative research. Of these eight, three sampled Black women exclusively, two sampled both Black and Latino women, and three sampled White, Black, and Latino women. Four of these studies addressed the role of midwives in prenatal care. The remaining eight studies were qualitative research. Six of the qualitative studies enrolled an exclusively Black population, and the remaining two sampled multiple races. Three specifically addressed midwife involvement in prenatal care. There was some geographic diversity among the studies ranging from locations in the Southeast, Northeast, Northwest, and Midwest, with a few utilizing data from multiple sites across the United States.

Quantitative research used well-defined study design and analytics. One quantitative study used data from two separate randomized controlled trials, five were case controlled studies, and two utilized cross-sectional design. Of the eight qualitative studies, four were phenomenological and the remaining four were ethnographic, grounded theory, comparative case study, and narrative, respectively. Three main themes specific to Black women's experience of antenatal care were identified throughout the literature: (1) care disparities that affect quality and frequency of antenatal care for Black women, including subthemes (a) discrimination and (b) other influences; (2) Black women's perceptions and preferences related to their antenatal care; and (3) midwifery-led care for Black women. These themes were identified through careful perusal of the publication provided data and conclusions, focusing on the aspects of antenatal care that affected or had the potential to affect Black women's experience of that care. Many of the studies had overlapping purposes; for example, several of the qualitative interview studies addressed prenatal care preferences, care disparities,

and discrimination within the same study. In addition, although discrimination is correlated with disparity in care, it was identified as an individual subtheme of importance because it also appeared to correlate with satisfaction and antenatal health.

Care Disparities

The literature suggests discrimination as a primary factor affecting the quality of antenatal care, in addition to other stressful life events, limited access to care, drug and alcohol use (linked to stress), and late initiation of prenatal care. These care disparities correlated with adverse birth outcomes such as preterm and stillbirths.

Discrimination. Racial discrimination, affecting the quality of prenatal care, is found in both the health care system and everyday encounters. Two qualitative studies performed in two separate communities in Florida linked racial discrimination in the health care system to fewer prenatal visits (Close, Suther, Foster, El-Amin, & Battle, 2013; Salm Ward, Mazul, Ngui, Bridgewater, & Harley, 2013). Research participants described negative preconceptions held by health care as a deterrent to care, such as assuming they used illicit drugs because they were Black (Ward et al., 2013). Participants also reported the perception of receiving a different, lower quality of care than White women received (Close et al., 2013). Nearly all the Black women mentioned long waiting periods, occasionally 3 to 4 hr after arriving at a clinic. A few felt that White patients waited shorter periods of time for care (Close et al., 2013; Daniels, Noe, & Mayberry, 2006; Savage, Anthony, Lee, Kappesser, & Rose, 2007). Each of these studies was conducted with few participants in specific communities, which does not allow for strong external validity per each individual study. However, examining the common experiences of these Black women over all the studies together, and given the geographic diversity—two in Florida, one in Georgia, and one in Ohio—the similarities suggest that the experiences of these women may not be limited to their individual communities. Another qualitative study among compared differences between two groups of Black women of low socioeconomic status—late and early initiators of prenatal care—noting perceptions of discrimination or insensitivity in the clinic were most common among late initiators (Daniels et al., 2006). Across all these studies, discrimination in the clinics coincides with reduced desire to return regularly.

The stress of discrimination is also linked with an increased incidence of PTB (Rankin, David, & Collins, 2011; Ward et al., 2013). This stress was succinctly expressed by a female participant: " . . . it's been like this forever. You learn to go last. No matter how much people talk about it, it is the same . . ." (Ward et al., 2013, p. 1757). A case control study surveying 277 Black women delivering at a hospital in Chicago found that those who delivered preterm were more likely to report daily incidents of discrimination than women who delivered full term. Interestingly, the research suggested that subtle forms of discrimination such as being talked down to or hearing surprise expressed over one's intelligence or industriousness was more strongly related to PTB than other forms (Rankin et al., 2011). This finding may be attributed to the possibility that these "subtle" forms of discrimination are more frequent because they are not as easily recognized as such by the majority culture.

Environment and negative health behaviors. Environmental factors such as stressful life events and access to care were also addressed as affecting both birth outcome and regular prenatal care. Per Hogue et al. (2013), in a population case control study, Black women were more likely than White women to have financial, emotional, and partner-related stressors, and women experiencing financial and partner-related stressors were at increased odds for stillbirths. This was an extensive study collecting data from 59 community academic hospitals from several different states (Hogue et al., 2013). Transportation and access to care were identified stressors noted by participants as the second most frequent barrier to receiving prenatal care (Close et al., 2013). Transportation barriers identified by participants in an ethnographic study located in Ohio ranged from inability to afford a car to long and inconvenient bus schedules (Savage et al., 2007). Participants stated that the few clinics located near their homes were often busy, and traveling to a hospital or more accessible clinic was time intensive (Close et al., 2013; Savage et al., 2007). The negative outcomes of these stressors coupled with the effects of discrimination already discussed above suggest a significant burden of disparity that Black women face to have a healthy pregnancy.

A health behavior addressed in several studies that affects birth outcomes of Black women was drug and alcohol use. It is well documented that use of drugs and alcohol during the prenatal period increases incidents of adverse birth outcomes (National Institute of Health, 2012). Among three qualitative studies that interviewed Black women concerning their thoughts on prenatal care, drug and alcohol use was a recurring theme (Close et al., 2013; Daniels et al., 2006; Savage et al., 2007). Participants in the Savage et al. (2007) ethnographic study described knowing other Black women in their neighborhood who used drugs and alcohol during pregnancy, although none of the Black women interviewed admitted to drug use. Drug and alcohol use appeared to be a greater problem among pregnant teens and women who were under significant stress (Close et al., 2013).

Perceptions of Antenatal Care

Most of the qualitative studies identified Black women's perceptions about their antenatal care, provider experiences, and view on pregnancy. These perceptions often defined how they experienced antenatal care.

Knowledge deficit, or the perception that prenatal care was unnecessary, was not cited as a major issue. Most Black women reported their awareness of the value of prenatal care, even if they did not receive regular prenatal care themselves. Some voiced frustration that although they understood how to appropriately care for themselves and regularly attended prenatal visits, their infants still were born with complications (Close et al., 2013). There were a few study participants, however, who mentioned lack of knowledge as a deterrent of prenatal care for other women they knew (Daniels et al., 2006). In addition, a study conducted by Tucker Edmonds, Mogul, and Shea (2015) found that the use of ultrasounds increased the perception of value of prenatal care by low-income Black women.

Perception of providers was another theme noted in the literature. A study interviewing low-income Black women in Philadelphia found that the women perceived lack of personal relationships and discontinuity of care with their physicians, while appreciating the relationships they formed with the nursing staff they saw on a repeated basis (Tucker Edmonds et al., 2015). Conversely, a study implemented in Detroit among a sample of Black women failed to find that trust in providers differed significantly between CNMs and physicians (Peters, Benkert, Templin, & Cassidy-Bushrow, 2014).

How Black women perceived their pregnancy played a significant role in how they approached prenatal care. Women who reported feeling disinterested, depressed, or devastated about their pregnancy were more likely to initiate prenatal care late, or not at all (Daniels et al., 2006; Tucker Edmonds et al., 2015). Several studies suggest that an unplanned or unwanted pregnancy may have a negative effect on a Black woman's pursuit of antenatal care (Daniels et al., 2006; Savage et al., 2007; Tucker Edmonds et al., 2015). Savage et al. (2007), in their ethnographic study, mentioned that unplanned pregnancies could be felt by Black mothers to be an interruption to future plans, such as higher education. A closely related study conducted in a predominantly Black Florida community recorded participant's views suggesting that the tendency for Blacks within the community to place less importance on planning pregnancies than White women was related to a difference in cultural mentality—dealing with events as they happen (Close et al., 2013). The effect of an unwanted pregnancy had the propensity to cause such significant distress that the woman might intentionally avoid prenatal care (Savage et al., 2007).

The findings from the literature substantially point toward numerous factors that lead to decreased prenatal care for Black women. Women acknowledged that late prenatal care was a problem in their communities, and cited discrimination, inaccessibility to clinics, mistrust of medical providers, and unplanned or unwanted pregnancies as main reasons they or other women might initiate late prenatal care. Besides affecting incidences of PTB, late or no prenatal care can also affect the postpartum health of the mother and child, as it is correlated with decreased incidences of postnatal and well-child visits. A retrospective/prospective urban study that followed a sample of low-income Black women after delivery for a year found that women who attended prenatal visits were more statistically more likely to attend postnatal visits and well-child checkups. About 50% of the women who did not attend prenatal care visits also did not attend their postnatal or well-child visits (York, Tulman, & Brown, 2000). Skipping these important health visits could contribute to decreased health screening for both the mother and child.

Midwifery-Led Care

Less than half of all reviewed studies discussing antenatal care for Black women specifically addressed midwifery-led care among Black women; only one of these seven mentioned Black midwives. The single study by Guerra-Reyes and Hamilton from Indiana University Bloomington was of interest; it presented how Black midwives and doulas articulate or present their role to the broader community. They noted the nearly complete lack of topic-related peer reviewed literature and utilized the web to locate sites run by self-identified midwives and doulas. The researchers gathered qualitative data from the sites by looking at the demographics, stories, and narratives written by the Black midwives or doulas. One third of the noted sites were devoted to advocacy and activism; the remaining two thirds offered services and advocacy. Main thematic areas were (a) a strong link to tradition, (b) providers identifying with more than one role (i.e., activist and doula), and (c) a sense of urgency in linking their practice to the future. This study had several limitations, including the potential for outdated information, inability to interact with the website owners, exclusion of providers who do not have websites, or whose websites are not picked up by the search engines, and nondistinction between midwives and doulas. However, it shed some light on the perceptions of Black midwives and doulas today (Guerra-Reyes & Hamilton, 2016).

The predominant theme that ran through many of the remaining studies was CenteringPregnancy, a prenatal care model started by a midwife that provides group care to women who are near the same due date (Centering Healthcare Institute, n.d.). Program benefits include (a) support from the group, (b) more time for educating, (c) less waiting time at the clinic, (d) enhanced relationships with their providers, and (e) improved rates of healthy practices (Klima, Norr, Vonderheid, & Handler, 2009; Trotman et al., 2015). This model was introduced in several clinics serving predominantly Black populations. Despite concerns regarding lessened individual time with each mother, which might limit the midwife's ability to address deeper issues with the women, the results were overwhelmingly positive (Benatar, Garrett, Howell, & Palmer, 2013; Earnshaw et al., 2015; Klima et al., 2009; Palmer, Cook, & Courtot, 2010; Trotman et al., 2015). Two studies focused on the effect of CenteringPregnancy care with adolescent to young women, primarily Black (Earnshaw et al., 2015; Trotman et al., 2015). Both studies

were performed in urban hospitals that served low-income women. The women who experienced CenteringPregnancy care attended more prenatal visits and were more involved in their care than those who used a standard model of prenatal care (Earnshaw et al., 2015; Trotman et al., 2015). Earnshaw et al. (2015) purposely crafted groups composed of a range of ages, and one of the most interesting results of her study is that women tended to be more engaged in groups that were more diverse in age. Some additional benefits that CenteringPregnancy had among Trotman et al.'s (2015) adolescent population was an increase in breastfeeding, adequate weight gain, and use of birth control methods as compared with teens who used a traditional prenatal care model.

Four studies specifically compared the differences between midwife-led prenatal care and physician-led prenatal care. One focus identified in these studies was the number of health topics reviewed during prenatal care sessions that were not directly related to clinical care, such as nutrition, breastfeeding, and family planning, and provider type. Women participating in midwifery-led care reported discussing a higher number of health topics than those who received physician-led care (Palmer et al., 2010; Vonderheid, Norr, & Handler, 2007). The comparison of health behavior outcomes related to provider type was closely related. One study failed to find an association between provider type and health behaviors; however, patients who used CNMs did report more encouragement to engage in healthy behavior than patients who were cared for by MDs (Vonderheid et al., 2007). These results contradicted the study on adolescent health behaviors that saw an increase in positive health behaviors such as increased breastfeeding rates and adequate weight gain in the group of primarily Black adolescents receiving midwifery care (Trotman et al., 2015). However, this difference might be partially attributed to the difference in midwifery care models where Vonderheid et al. used a more traditional midwifery one-on-one care model and Trotman et al. utilized the CenteringPregnancy model.

Two additional variables compared in studies that investigated midwife versus physician-led antenatal care were (a) the variance in C-section and PTB rate based on provider type and (b) the length of time spent with provider during prenatal visits. Women receiving prenatal care at a birthing center staffed by midwives were less likely to have a C-section (Benatar et al., 2013; Palmer et al., 2010) and less likely to deliver preterm than those who received standard prenatal care at a hospital or clinic. A significant difference was noted in the average amount of patient/provider time spent in prenatal care sessions. Centers utilizing CenteringPregnancy model hold, on average, 2-hr prenatal sessions with each group (Centering Healthcare Institute, n.d.). However, even among providers who do not utilize CenteringPregnancy, a study in Washington, D.C., comparing average prenatal visit times between obstetricians at a clinic and CNMs at a birthing center found that the length of time spent with the provider was often twice as long at the birthing center than at the clinics. First time visits at the birthing center could last nearly 2 hr, whereas first time visits at the clinics ranged from 25 to 35 min. Follow-up visits at the birthing center ranged from 20 to 90 min, depending on the need, whereas follow-up visits at the clinics usually were 20 to 30 min (Palmer et al., 2010).

Few of the studies focused on Black women's perception of midwives; however, some address it in passing (Klima et al., 2009; Palmer et al., 2010; Tucker Edmonds et al., 2015). Participants from a predominantly Black community who were involved in a study that evaluated the introduction of CenteringPregnancy in a public health clinic were asked what they thought of the care. The women expressed that being heard and making friends in the group were positive aspects of CenteringPregnancy. Overall, there was an increased satisfaction in prenatal care with this particular midwifery model (Klima et al., 2009). Another woman voiced appreciation for the personal interest and care that a CNM in a birthing center showed her by personally calling to check up on her (Palmer et al., 2010). A study that did specifically examine Black women's preferences in provider care found that women described feeling more in control and empowered when they used a midwife for prenatal care (Tucker Edmonds et al., 2015).

Discussion

This review notes that there are three principal areas of experience that the literature covers regarding Black women's antenatal care. These are (a) care disparities, (b) perceptions of antenatal care, and (c) midwifery-led care.

Examining the care disparities that have an impact on Black women's antenatal care shows that there are many factors beyond their control, such as discrimination and access to care. Discrimination is a particularly pervasive factor, as it is shown to be an issue both within the health care system and on a day-to-day basis. The stress of daily discrimination adds to the number of stressful life situations that Black women are already at a higher risk of facing, such as access to care and transportation issues. Stress is strongly correlated with higher rates of alcohol and drug use, and the studies reviewed noted an increase in negative birth outcome for both substance use and stressful life events. This historical connection is not difficult to see in the case of discrimination, particularly on a health care level. It was not until the Civil Rights Act of 1964 that federally funded hospitals were not allowed to deny care based on race, ethnicity, or income level, and even then, segregation remained an issue (Friedman, 2014). During the mid-1900s while Black midwives were being phased out, there was significant stigma attached to being or receiving care from an "uneducated" midwife, and it is very likely that there were some Black women who felt ashamed of the stigma involved with using a midwife, and yet were excluded from care at hospitals. This frustration associated with a lack of options may still color the Black woman's perception of midwifery use today; however, there is no research that addresses this question.

The limited information offered in these studies about Black women's perceptions of antenatal care shows two predominant themes of frustration, and desire for personalized, respectful care. A frustration component, according to the Close et al. (2013) study, is that women do not always see positive birth effects even when they do attend prenatal care regularly. Participants cited discrimination and disrespectful encounters as deterrents to care. Unplanned pregnancies were also a source of stress that could negatively affect Black women's perception of obtaining prenatal care. Some of these frustrations could be addressed through meeting the prenatal care desires mentioned by participants, particularly personalized care, continuity of provider, respect, and to be listened to. These are desires of most women when it comes to health care; however, considering the history of discriminatory health treatment that Black women faced in the not-so-distant past, it is sobering to realize that these basic needs for respect often remain unmet. Overall, Black women's perception of a desirable prenatal care experience coincides well with midwifery-led care, which tends to be more personalized and holistic. However, the percentage of Black women who use midwives is only 12% of the total number of CNM/CM-attended live births in the United States (HealthData.gov, 2014).

The studies addressing Black women's experience of antenatal care in relation to midwifery-led care focused predominantly on CenteringPregnancy, a midwifery model that uses a group approach to care. Participants had mostly positive responses to this model, particularly the group aspect. The sessions were longer, on average, than traditional prenatal appointments, and there was more time for the midwife to engage in patient teaching. Women specifically mentioned feeling more in control and empowered in prenatal sessions with midwives. It appears that midwifery could be a good method of care to offer Black women; however, there is not enough research on Black women's perception of the desirability of this option. The studies included in the review focused primarily on positive health outcomes because of implementing CenteringPregnancy or midwifery-led care.

A single study addressed the practice of Black midwives today. This study by Guerra-Reyes and Hamilton (2016), provided valuable information despite many limitations. Black midwives and doulas were noted to be focused on advocacy. All of the Black midwives and doula websites that the researchers found and analyzed included an advocacy-related arm—some focused solely on educating the public and lobbying for Black midwives, whereas others offered doula or midwifery services as well. It was also noteworthy that most of these midwives and doulas based inspiration for their practice on the history of the Black midwives. The limitations of this study suggest that some information was outdated. There was also an inability to interact with the website owners and a potential exclusion of providers who did not have websites, or whose websites were not picked up by the search engines. These limitations indicate an urgent need for more research exploring the role of Black midwives today.

Major gaps in the literature noted in this review are (a) Black women's perception of midwifery as an antenatal care option and (b) experience and practice of Black midwives today. A further geographical gap is a lack of studies looking at how Black women in the south view midwives and their role in prenatal care. Most of the CenteringPregnancy studies took place in the North.

Conclusion

Epidemiological data clearly indicate the high propensity for adverse events associated with pregnancy in Black women. The effect of stress, discrimination, and limited access to care suggest implications of late or no prenatal care. There is a paucity of literature surrounding Black women's experience of antenatal care. In the past 10 years, 18 studies were found pertaining to this topic, and two were not included in the analysis because they were secondary analyses of late 1990s data. Seven of the remaining 16 articles addressed midwifery care directly, and one of the seven investigated the role of Black midwives. Considering the long history of midwifery among Black women well into the 1960s, this gap in the literature is significant.

Further research is essential to address the gaps related to the antenatal needs of Black women and the perception that Black women hold concerning midwifery as an option for antenatal care, particularly in the south. Examining the literature, it appears that midwifery has the potential to address the lower prenatal care rates that Black women experience, as an option that is favorably considered, has good outcomes, and may better accommodate Black women's desires for prenatal care—attentive provider, continuity of care, and woman empowering. However, there has been no research investigating Black women's perceptions and desires surrounding changes to the antenatal care available to them, or the role that midwives might play; this is where the literature falls short. The gap, as noted, is significant. Researchers must meet, consult with, and listen to Black women and hear their stories to understand the significance of midwifery to them. Only then, in partnership with, and based on suggestions for change from Black women themselves, can health care providers and researchers begin to make changes in the health care system to facilitate improved antenatal care for Black women and their neonates.

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References

American College of Nurse-Midwives. (2014). *CNM/CM-attended birth statistics in the United States*. Retrieved from http://www.midwife.org/CNM/CM-attended-Birth-Statistics

American College of Nurse-Midwives. (2015). *Midwifery educational trends report: 2015*. Retrieved from http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005752/ACNMMidwiferyEdTrend2015-10.28.15.pdf

Benatar, S., Garrett, A. B., Howell, E., & Palmer, A. (2013). Midwifery care at a freestanding birth center: A safe and effective alternative to conventional maternity care. *Health Services Research*, *48*, 1750-1768. doi:10.1111/1475-6773.12061

Centering Healthcare Institute. (n.d.). *Centering pregnancy*. Retrieved from https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

Close, F. T., Suther, S., Foster, A., El-Amin, S., & Battle, A. M. (2013). Community perceptions of Black infant mortality: A qualitative inquiry. *Journal of Health Care for the Poor and Underserved*, *24*, 1089-1101. doi:10.1353/hpu.2013.0118

Daniels, P., Noe, G. F., & Mayberry, R. (2006). Barriers to prenatal care among Black women of low socioeconomic status. *American Journal of Health Behavior*, *30*, 188-198. doi:10.5555/ajhb.2006.30.2.188

Debiec, K. E., Paul, K. J., Mitchell, C. M., & Hitti, J. E. (2010). Inadequate prenatal care and risk of preterm delivery among adolescents: A retrospective study over 10 years. *American Journal of Obstetrics & Gynecology*, *203*, 122.e1-122.e6. doi:10.1016/j.ajog.2010.03.001

Devitt, N. (1979). The statistical case for elimination of the midwife: Fact versus prejudice, 1890-1935 (Part I). *Women & Health*, *4*, 81-96.

Earnshaw, V. A., Rosenthal, L., Cunningham, S. D., Kershaw, T., Lewis, J., Rising, S. S., . . . Ickovics, J. R. (2015). Exploring group composition among young, urban women of color in prenatal care: Implications for satisfaction, engagement, and group attendance. *Women's Health Issues*, *26*, 110-115. doi:10.1016/j.whi.2015.09.011

Friedman, E. (2014). *U.S. Hospitals and the Civil Rights Act of 1964*. Hospital & Health Networks, American Hospital Association. Retrieved from http://www.hhnmag.com/articles/4179-u-s-hospitals-and-the-civil-rights-act-of-1964

Guerra-Reyes, L., & Hamilton, L. J. (2016). Racial disparities in birth care: Exploring the perceived role of African-American women providing midwifery care and birth support in the United States. *Women and Birth: Journal of the Australian College of Midwives*, *30*, e9-e16. doi:10.1016/j.wombi.2016.06.004

HealthData.gov. (2014). *Vital statistics live birth summary beginning 2008*. Retrieved from https://health.data.ny.gov/api/views/gnvg-m62r/rows.csv?accessType=DOWNLOAD

Hogue, C. J., Parker, C. B., Willinger, M., Temple, J. R., Bann, C. M., Silver, R. M., . . . Goldenberg, R. L. (2013). A population-based case-control study of stillbirth: The relationship of significant life events to the racial disparity for African Americans. *American Journal of Epidemiology*, *177*, 755-767. doi:10.1093/aje/kws381

Klima, C., Norr, K., Vonderheid, S., & Handler, A. (2009). Introduction of CenteringPregnancy in a public health clinic. *Journal of Midwifery & Women's Health*, *54*, 27-34. doi:10.1016/j.jmwh.2008.05.008

National Institute of Health. (2012). *Alcohol & drug-related birth defects research at the NICHD*. Retrieved from https://www.nichd.nih.gov/news/resources/spotlight/Pages/062712-alcohol-drug-related-birth-defects.aspx

Office of Minority Health. (2015). *Infant mortality and African Americans*. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4

Palmer, L., Cook, A., & Courtot, B. (2010). Comparing models of maternity care serving women at risk of poor birth outcomes in Washington, DC. *Alternative Therapies*, *16*(5), 48-55.

Peters, R. M., Benkert, R., Templin, T. N., & Cassidy-Bushrow, A. E. (2014). Measuring African American women's trust in provider during pregnancy. *Research in Nursing & Health*, *37*, 144-154. doi:10.1002/nur.21581

Picklesimer, A. H., Billings, D., Hale, N., Blackhurst, D., & Covington-Kolb, S. (2012). The effect of CenteringPregnancy group prenatal care on preterm birth in a low-income population. *American Journal of Obstetrics & Gynecology*, *206*, 415e1-415e7. doi:10.1016/j.ajog.2012.01.040

Rankin, K. M., David, R. J., & Collins, J. W. (2011). African American women's exposure to interpersonal racial discriminatioin in public settings and preterm birth: The effect of coping behaviors. *Ethnicity & Disease*, *21*, 370-376.

Robinson, S. A. (1984). A historical development of midwifery in the Black community: 1600-1940. *Journal of Nurse-Midwifery*, *29*, 247-250.

Salm Ward, T. C., Mazul, M., Ngui, E. M., Bridgewater, F. D., & Harley, A. E. (2013). "You learn to go last": Perceptions of prenatal care experiences among African-American women with limited incomes. *Maternal and Child Health Journal*, *17*, 1753-1759. doi:10.1007/s10995-012-1194-5

Savage, C. L., Anthony, J., Lee, R., Kappesser, M. L., & Rose, B. (2007). The culture of pregnancy and infant care in African American women: An ethnographic study. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *18*, 215-223. doi:10.1177/1043659607301294

Schuiling, K. D., Sipe, T. A., & Fullerton, J. (2005). Findings from the analysis of the American college of Nurse-Midwives' membership surveys: 2000–2003. *Journal of Midwifery & Women's Health*, *50*(1), 8-15. doi:10.1016/j.jmwh.2004.08.025

Tandy, C. E. (1937). *Infant and maternal mortality among Negros* (Bureau Publication no. 243). Washington, DC: U.S. Government Printing Office.

Trotman, G., Chhatre, G., Darolia, R., Tefera, E., Damle, L., & Gomez-Lobo, V. (2015). The effect of centering pregnancy versus traditional prenatal care models on improved adolescent health behaviors in the perinatal period. *Journal of Pediatric & Adolescent Gynecology*, *28*, 395-401. doi:10.1016/j.jpag.2014.12.003

Tucker Edmonds, B., Mogul, M., & Shea, J. A. (2015). Understanding low-income African American women's expectations, preferences, and priorities in prenatal care. *Family & Community Health*, *38*, 149-157. doi:10.1097/FCH.0000000000000066

Tunc, T. E. (2010). The mistress, the midwife, and the medical doctor: Pregnancy and childbirth on the plantations of the antebellum American South, 1800-1860. *Women's History Review*, *19*, 395-419. doi:10.1080/09612025.2010.489348

Vonderheid, S. C., Norr, K. F., & Handler, A. S. (2007). Prenatal health promotion content and health behaviors. *Western Journal of Nursing Research*, *29*, 258-276. doi:10.1177/0193945906296568

York, R., Tulman, L., & Brown, K. (2000). Postnatal care in low-income urban African American women: Relationship to level of prenatal care sought. *Journal of Perinatology*, *1*, 34-40.

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