As Mississipians cope with a lack of obstetric services in over half of counties in the state, an increasing number of women desire to have less-medicalized births outside of a typical hospital setting. The number of planned births that occurred outside of a hospital in Mississippi grew by 68 percent between 2007 and 2017 as did births attended by midwives. Midwifery care is being explored across the country as a way to alleviate workforce shortages and offer safe, community-based care in low-risk pregnancies.

Midwives are trained professionals who help healthy women during pregnancy, labor and delivery, and after birth. Research indicates that integration of midwifery care in a health system and better access to midwives are associated with higher rates of vaginal delivery, vaginal delivery after prior cesarean (c-section), and breastfeeding as well as lower rates of premature births, low birth-weights, and neonatal death. While most births that occur in Mississippi are uncomplicated, just over two percent of pregnancies and births are managed by midwives annually, and few women have access to safe, non-medicalized birth options.

Midwives have been instrumental in providing uncomplicated pregnancy-related care in previous times of provider shortages and poor birth outcomes in Mississippi. (See sidebar.) Mississippi is currently experiencing a shortage of obstetric providers; women in forty-six Mississippi counties must drive an hour or more to see an obstetrician (OBGYN) for prenatal, delivery, and post-partum care. From 2015 to 2017 Mississippi had the highest rates of cesarean deliveries, pre-term births, and low birth weight in the nation. In response to similar shortages and poor birth outcomes, several states have broadened access to maternity care through midwives and birth centers for women with uncomplicated pregnancies.

**KEY POINTS**

- Midwives and birth centers provide a model of maternity care that research shows can be appropriate for low-risk pregnancies and deliveries with similar or better outcomes as typical obstetric care with lower healthcare costs.

- Certified Nurse Midwives currently practice in Mississippi hospitals, while Certified Professional Midwives and Direct Entry Midwives legally practice unregulated in homes and community settings.

- Birth centers provide midwifery care and operate independently from hospitals. These providers are currently licensable, but none currently operate in Mississippi.
Three types of midwives are known to practice in Mississippi. **Certified Nurse Midwives** (CNMs or nurse-midwives), 29 of whom are currently licensed to practice and attend over 800 births (or two percent) annually across the state. Other types of midwives in the state include **Certified Professional Midwives** (CPMs) and **Direct Entry Midwives** (or lay midwives). In Mississippi, CPMs and lay midwives practice legally but unregulated, and the number of these practitioners active in the state is unknown. These midwives are available for women who wish to give birth in home-like settings, but no state-level oversight exists.

**TABLE 1. A COMPARISON OF TYPES OF MIDWIVES CURRENTLY PRACTICING IN MISSISSIPPI**

<table>
<thead>
<tr>
<th>Currently Licensable</th>
<th>Certified Nurse Midwife</th>
<th>Certified Professional Midwife</th>
<th>Direct Entry Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed by State Board of Nursing</td>
<td>Not currently, but licensed in 35 states</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Registered nurse training with advanced practice degree in midwifery</td>
<td>National certification* after 3-5 years of apprenticeship including at least 2 years of clinical education and observing 55 or more births</td>
<td>None required</td>
</tr>
<tr>
<td>Site of Practice</td>
<td>Primarily hospitals and birth centers</td>
<td>Home and community settings</td>
<td>Home and Community</td>
</tr>
<tr>
<td>Payment</td>
<td>Reimbursable via Medicaid and commercial insurers</td>
<td>Mostly self-pay; reimbursable by some commercial insurance plans; Medishare</td>
<td>Self-pay; No known insurance coverage; Medishare</td>
</tr>
</tbody>
</table>

Nurse midwives practice in all 50 states, and CPMs are licensed to practice in 37 states including Tennessee, Louisiana, Arkansas, Alabama, and Florida. Lawmakers in Florida have formally recognized the role of midwives in reducing a shortage of providers of prenatal and delivery services and have provided for Medicaid reimbursement for CPMs in addition to nurse midwives.

**Birth centers offer another option for uncomplicated deliveries.**

Birth centers operate according to the midwife model of care and are an option for pregnant women at low risk of complications who want a non-medical delivery but not at home. Medicaid and commercial insurers cover birth center services, which have significantly lower costs due to fewer medical interventions and less expensive staff. Because midwife-managed care limits intervention and allows for normal progression of labor, data show the risk of some birth-related injuries is less, although risk of shoulder dystocia may be higher. (See sidebar.) Studies indicate that fewer than 10 percent of births initiated in birth centers require transfer to medical care during labor. State law requires that birth centers maintain written agreements with acute care facilities for transfer of laboring women in case of emergency. Birth centers currently operate in Tennessee, Arkansas, and Louisiana. **There are no birth centers that meet the state minimum standards currently providing this care in the state.**
Key Differences in Midwifery Model of Maternity Care

Midwives in any setting practice what is known as the Midwifery Model of Care, which views pregnancy and birth as normal, healthy physiologic processes. Midwives support women throughout pregnancy, delivery, and post-partum periods. Midwife-managed prenatal care includes pregnancy assessment as well as lifestyle and behavioral interventions, and emotional support. In case of complications at any point in the pregnancy or delivery, women are referred to a physician’s care. Induction, artificially accelerated labor, c-section deliveries, anesthesia, and intensive electronic monitoring are avoided under midwives’ care but may be provided by medical clinicians as necessary. Midwives may order lab tests and medication as credentials allow and medical necessity requires.

Midwifery offers comparable or better outcomes and cost savings.

Research shows that in any setting of care, midwife-managed births result in significantly lower rates of induced labor and c-sections which negatively impact maternal health, and poor outcomes like pre-term births and low birth weight that endanger infant health. Prenatal and postnatal care are more comprehensive than typical medical maternity care and supports improved outcomes like breastfeeding and postpartum contraception use, both of which contribute to long-term health of mothers and infants.

Research also shows that costs improve under a model of care that promotes minimal intervention and the natural progression of labor and birth via vaginal delivery. In 2018, the average total charge to Mississippi Medicaid for an uncomplicated cesarean delivery was $27,510 while the average total charge for an uncomplicated vaginal delivery was $15,854 (inclusive of pre-and postnatal care and infant care). Approximately 70 percent of Medicaid deliveries billed that year were uncomplicated.


Mississippi may benefit from greater integration of midwifery.

Mississippi mothers with low risk for complications deliver via c-section at the highest rate in the country (Figure 1.). They also attempt vaginal delivery after prior c-section at half the national rate. Rates of uncomplicated c-sections can vary widely across hospital systems (from 15 to 37 percent in Mississippi hospitals) which suggests clinical practice patterns and limitations on time, staffing, and labor rooms may play a role rather than population-level health risks. Births initiated under midwifery care are very likely to be delivered vaginally (as many as 93 percent of births in one study). Greater utilization of midwifery would reduce unnecessary c-sections, as well as risk to maternal and infant health and costs of care.
Discussion

The United States is grappling with a host of reversals in decades-long health and public health gains in maternal and child health. Avoidable pregnancy-related deaths and illnesses have increased for all mothers and infants, but especially black women and their children. The burden is heaviest among states in the Southeast, including Mississippi where obstetric providers are in short supply. It is unlikely that Mississippi will attract enough OBGYNs to meet recommended coverage levels in the near future. However, as many states and other highly developed nations have demonstrated in numerous studies, midwifery care is sufficient and beneficial for many pregnancies. The midwifery model of care has been integrated into national and state-level initiatives to reduce perinatal death and illness as well as racial health disparities in maternal and child health.

Use of birth centers and midwifery care in Mississippi has lagged behind other states despite existing enabling policies, such as Medicaid reimbursement for nurse-midwives and licensure of birth centers. Additional policy options that would foster greater integration of midwifery into the existing maternity care system in Mississippi include:

- Licensure and regulation of Certified Professional Midwives currently practicing without regulation in the state
- Promoting collaboration between medical and non-clinical maternity care providers within medical systems, including both midwives and birth centers
- Creation of in-state training programs for Certified Nurse Midwives to expand the maternity care workforce for low risk pregnancies

Studies have shown that integration of midwifery in medical settings yields more favorable outcomes for low-risk pregnancies than medical settings that do not include midwifery—even in deliveries that are not ultimately managed by a midwife. Greater inclusion of midwifery would benefit the uncomplicated pregnancies midwives manage as well as relieve strain on obstetric providers to care for high risk pregnancies

Sources

Files/FILENAME/000000000680/FINAL-ComparisonChart-Oct2017.pdf