Increasing the Racial and Ethnic Diversity of Direct-Entry Midwives:

Exploratory Interviews with Black Midwives and Educators

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Prologue: Positioning Myself in Relation to My Research

The post-structuralist turn in the social sciences has pointed out the need for increased acknowledgement of how an individual researcher's background and biases might affect their research. To honor this call for increased reflexivity I want to begin my Master's Thesis by positioning myself in relationship to my research topic.

In my experience of midwifery school, discussions of race and racism were uncomfortable at best, extremely upsetting at worst. In the first quarter, my cohort took an epidemiology class. In the research studies we read, being black and having low socioeconomic status were consistently associated with worse clinical outcomes, yet the reasons for this were not discussed in that class. Racist statements made by my white classmates usually went unchallenged unless I, as one of the few women of color[1], spoke up, even during our cultural competence class. I watched two of the four women of color in my cohort leave the program in the first year. I hungered to read about midwifery in non-white communities – Japanese, African American, Mexican – it didn't matter. I especially wanted to talk to midwives of color. I could not clearly articulate why this was important until I started analyzing the data from my thesis research. I realized that the research participants were modeling a practice of midwifery that I did not learn in midwifery school – a paradigm of culturally affirming midwifery care and education, made affordable and accessible to those who could benefit most from it. This aligned with my

[1] In this paper, being "of color" refers to being African American, black, of the African Diaspora, Asian, South Asian, West Asian, Arab, Pacific Islander, First Nations, Alaskan Native, Chicano, Latino, Native American, multiracial or mixed race. Many people from these communities refer to themselves as being "people of color" and do not refer to themselves as minorities because in their own racial and/or ethnic communities they are not in the minority. When "minority" was used in the literature it was left as it appeared in direct quotations or changed to "student of color" or the race or ethnicity mentioned. The term "underrepresented minority" or "URM" was also used in the literature and was used as it appeared since it typically refers to fewer races and ethnicities than "of color." The American Association of Medical Colleges defines "underrepresented minority groups" as "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" (U.S.DHHS, 2006, p. 5) These populations typically include African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans (p. 2).

values of social justice and liberation more than the entrepreneurial model I learned in my overwhelmingly white-centric program. I would have loved to interview Japanese American direct-entry midwives but did not know of any. I chose to interview black midwives because I knew of at least one black midwifery program, I knew of a couple black midwives working on health disparities and I felt I could make a compelling argument for black women needing midwives from their own communities because of their disproportionate risk of health disparities (Institute of Medicine, 2003; National Center for Health Statistics, 2011). I also believed that improving midwifery education for African American students would help other students of color by shifting the current educational model away from a white perspective and toward a multicultural model.

Introduction

Clear perinatal and maternal health disparities exist between black and white women in the U.S. The National Center for Health Statistics (2011) reported that maternal mortality for black women in 2007 was 23.8 deaths per 100,000 live births compared to 8.1 deaths for white women. Black women had more than twice the rate of low birth weight babies than white women (15.6% vs. 7.7%). Only 57% percent of black women began prenatal care in the first trimester compared to 69.5% of white women, and 12.6% of black women began prenatal care in the third trimester or had no prenatal care at all, compared to 7.6% of white women. The reasons for these disparities are complex and include "mistrust among African Americans of the U.S. health care system" for reasons that are discussed later (Institute of Medicine, 2001, p. 81). Evidence shows that having a racially concordant health care provider increases utilization of health care and satisfaction among ethnic minority patients (Bodenheimer & Grumbach, 2009, p. 85; U.S.

Department of Health & Human Services, 2006). Indeed, black patients treated by black physicians were more likely to report that they felt respected, their concerns were heard and the care was accessible (IOM, 2001, p. 81). One strategy that has been suggested to reduce health disparities for people of color is to increase the numbers of providers of color (IOM, 2001, p. 78), which would require raising the numbers of students of color in health professions programs.

Nursing and medical educators have attempted to increase enrollment of students of color and have encountered challenges in recruiting, retaining and graduating students of color that ranged from the individual level to the institutional level (Barton & Swider, 2009; Beacham, Askew, & Williams, 2009; Childs, Jones, Nugent, & Cook, 2004; Liebschutz, et al. 2006). The challenges faced by nursing and medical educators include too few qualified applicants of color (Beacham et al., 2009, p. 70), students from underrepresented racial minority (URM) groups not considering health care professions as a career, requisite training and education among students of color (Barton & Swider, 2009, p. 5), and perceived discrimination, financial barriers, and social isolation in the academic setting (Childs et al., 2004). Nursing and medical educators have examined the experiences of students and residents of color (Liebschutz et al., 2006; Maton et al., 2011), but to date, no such research on the experiences of direct-entry student midwives has been published. Nursing and medical educators have also developed strategies to improve recruitment, retention and graduation of students of color (Barton & Swider, 2009; Childs et al., 2009; Gardner, 2005; Giddens, 2008; Priest & Ginwright, 2006; Stanley, Capers, & Berlin, 2007; Sutherland, Hamilton, & Goodman, 2007; Terrell, 2006) that may enhance the efforts of direct-entry midwifery educators to achieve the same goal. Given that direct-entry midwifery schools are less numerous than nursing and medical schools and there are only three direct-entry

midwifery schools that grant Master's level degrees (MEAC, 2011a), it is not surprising that there is virtually no peer-reviewed research on direct-entry midwifery education that addresses the concerns of African American students.

In this study, semi-structured qualitative interviews were conducted with midwives and midwifery educators who identified as black or African American[2] to record their experiences with direct-entry midwifery training and/or as preceptors. The social, cultural, and structural barriers they faced in pursuit of midwifery training were explored. Additionally, respondents were asked to suggest strategies for increasing completion rates of midwifery education programs. The interviews were analyzed for common themes, and a summary of issues and strategies for improving direct-entry midwifery training, recruitment, retention and graduation of African American students were compiled.

Specific Aims

The aims were the following:

- Document the experiences of black midwives with direct-entry midwifery education.
- Explore the social, cultural and structural barriers facing black women in pursuit of midwifery training.
- Develop a summary of themes and issues to guide midwifery educators on improving their recruitment, retention, and graduation of black students.

[2] The terms "African American" and "black" are used respectfully and interchangeably in this paper to refer to individuals and communities from the African diaspora in the U.S.. Participants referred to themselves using both terms, although one midwife stated a preference for "African American." "Black" was used in the title of this project in order to attract people of the African diaspora who have significant experience with midwifery or midwifery education in the U.S. but may not identify with the term "African American" because they were not born in the U.S.. The researcher felt strongly that any such individuals who wanted to participate in the study should not be re-marginalized because of their place of birth.

Semi-structured qualitative interviews were conducted with African American midwives and midwifery educators to record their experiences with direct-entry midwifery education and/or educating African American student midwives[3]. As African American women in a predominantly white field, they were uniquely positioned to discuss whether midwifery education programs (MEPs) are or are not meeting the needs of black students and where midwifery educators can improve. The interviews were audio recorded, transcribed and analyzed for themes.

Literature Review

The Institute of Medicine (2001) noted that "mistrust among African Americans of the U.S. health care system" stems from racism and abuse in research trials, among other factors (p. 81). Exploitation of African Americans by medical researchers can be traced back to the antebellum South, when white doctors performed gruesome experiments and surgeries on enslaved black individuals (Gamble, 1997). "This lack of trust contributes to the underutilization of medical and social services by blacks and makes it even more imperative that medical professionals as well as others concerned with the health of blacks be willing to meet them halfway" (Grayson, 1999, p. 138). Understanding the roots of this mistrust is significant when one considers that 12.6% of black women begin prenatal care in the third trimester compared to 7.6% of white women (National Center for Health Statistics, 2011). Additionally, when blacks access health care services there is evidence of racial and ethnic disparities not only in their health status but also in the quality of care they receive (Institute of Medicine, 2003).

[3] "Students," "student midwives" and "apprentices" are used in this paper to refer to individuals in a formal teacher/learner relationship with a midwife or midwifery educator. They are used interchangeably in this paper because some midwives taught their students in a classroom setting in addition to training them in a preceptorship or apprenticeship.

One proposed way to address inequities in the health care system is increasing diversity among health care professionals. Diversity among health professionals improves utilization of health care services and satisfaction among people of color (Bodenheimer & Grumbach, 2009, p. 85). The U.S. Department of Health and Human Services has determined that "health professionals, particularly physicians," of underrepresented minority (URM) groups, "disproportionately serve minority and medically underserved populations; minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity" (U.S. DHHS, 2006, p. 3). Declercq et al. (2001) found that there was an observable relationship "between a CNMs race and ethnicity and the characteristics of women served, even when controlling for practice setting (eg, urban or non-urban)" (p. 13); indeed, DeClercq et al. found that "42% of the women served by black CNMs were black, compared to 18% for white CNMs" (p. 13). The National Advisory Council on Nurse Education and Practice (NACNEP) (as cited in Stanley et al., 2007, p. 254) concluded that:

> a culturally diverse nursing workforce is essential to meeting the health care needs of the nation's population and that despite their small numbers, minority nurses are significant contributors to the provision of health care services in this country and are leaders in the development of models of care that address the unique needs of minority populations.

A number of organizations have endorsed the goal of "[a]chieving a health care workforce that reflects the diversity of the U.S" (U.S. DHHS, 2006, p. 5) and have implemented tools and programs to achieve this objective. The Association of American Medical Colleges (AAMC) recognizes the need to track demographic information of applicants, matriculants and graduates to evaluate whether or not efforts to increase student diversity are achieving the goal of

producing more providers from URM groups (AAMC, 2010). Nursing educators are increasingly concerned with helping students of color succeed and graduate (Stanley et al., 2007; Gardner, 2005; Sutherland et al., 2007; Ackerman-Barger, 2010). The Health Professions Partnership Initiative (HPPI), a project of the AAMC, was designed to enhance students' academic performance, to increase the enrollment of racial and ethnic minority students and was implemented at 26 sites across the U.S. (Terrell, 2006, p. S2). Other organizations working toward the goal of workforce diversity include the American Medical Association (Nelson, 2003), the Institute of Medicine (2001, 2004), and NACNEP (Stanley et al., 2007). The federal government also recognizes the importance of health care workforce diversity by sponsoring programs such as: the Health Careers Opportunity Program, Centers of Excellence and Minority Faculty Fellowship Programs (U.S. DHHS, 2006).

One of the barriers to greater diversity in the health professions is that URM students are usually first-generation college students. This means they do not have the experiences of their family to draw from when preparing for college and tend to need additional support (Sullivan Commission, 2004, p. 76). Students of color face other barriers to nursing education, which may include: past discrimination of ethnic minorities; financial problems; difficulties with academic and social adjustments which often lead to feelings of isolation, loneliness and frustration; a lack of academic preparedness; the image of nursing; and the availability of other career options (Childs et al., 2004). Other possible factors are the appearance of rigidity in education policies and a dearth of nurse and faculty role models of color (Ackerman-Barger, 2010; Barton & Swider, 2009).

As far as recruiting and admitting students to meet the goal of workforce diversity, nursing schools "have found the pool of qualified applicants to be dismally small" (Beacham et

al., 2009, p. 70). Nonetheless, the Sullivan Commission (2004) put the onus on educators to improve admissions procedures to "ensure a diverse student body with enhanced language competency and cultural competency for all students" and to "enhance and increase the pool of minority applicants" (p. 8). To that end, admissions committees should look at broader criteria when considering applications. For example, the Morehouse School of Medicine considers "motivation/goals; maturity/emotional stability/social support structure; educational readiness/self-discipline; leadership experience; and honesty/ethical dimensions" (p. 79). The process of increasing student diversity requires educational institutions to make a long term commitment, to institute accountability mechanisms and to conduct periodic evaluation and revision of policies and practices (Barton & Swider, 2009). The result may improve "cross-cultural training and cultural competencies of *all* trainees" by "help[ing] students challenge assumptions and broaden perspectives regarding racial, ethnic, and cultural differences" (Cohen, 2003; Whitla et al., 2003; both as cited in Institute of Medicine, 2004, p. 6).

Fortunately, there are a number of strategies that faculty and universities can use to mitigate educational disparities, but they must be instituted and evaluated in a methodic, sustainable and self-reflective way in order to address the underlying problems (Ackerman-Barger, 2010, p. 680). The Sullivan Commission recommended institutions use their mission statement, which should clearly state the institution's commitment to cultural diversity, to evaluate their progress toward achieving that goal (2004). Table 1 lists organizations and researchers that have examined strategies to increase diversity in the health professions (redundant recommendations were only included once).

Table 1 Recommendations for improving diversity in the health professions

Organization	**Recommendations**

(NACNEP, as cited in Stanley 2007)	• increasing recruitment, retention, and graduation of minority students; • developing minority nurse leadership; • developing practice environments that promote diversity; • preparing all nurses to provide culturally competent care
(AACN, 2001)	• presenting an inclusive image, • reaching out to diverse student populations, • making connections at the middle/high school level, • supporting students through the application process, • mentoring as the key to retention, • facilitating student success • launching coordinated outreach campaigns
(U.S. DHHS, 2006)	• "provid[ing] [recruits] with preparatory training, counseling, mentoring, and exposure to community-based primary health care," • "improvements in academic and clinical training opportunities, and stipends to minority students"
(Peter, 2005)	• study skills workshops

	• study groups • peer tutors • faculty coaches
(Gardner, 2005)	• hiring a retention coordinator • community building strategies that involved students' families • support groups • outreach to students
(Sullivan Commission, 2004)	• "shifting from student loans to scholarships," • "reducing dependency on standardized tests for admission," • "enhancing the role of two year colleges"

There are a number of success stories in the literature. By instituting evidence-based interventions, a small college in Michigan was able to increase the percentage of nursing applications from students of color to 8.9% of the total applicant pool, despite previously graduating only one minority nursing student (Barton & Swider, 2009, p. 2, 9). A three-year project in Texas involved three nursing schools and the Texas Medical Center (Igbo et al., 2011). The project implemented best practices to "enhance the success of students identified by federal criteria as being at risk" (p. 375) and achieved an "overall average completion rate of 76.8 percent for the three-year period [which] exceed[ed] the state average of 69 percent" (THECB, 2006, as cited in Igbo et al., 2011, p. 378). The Medical College of Georgia School of Nursing was able to achieve 100% retention rates in the two cohorts that had benefited from its Mentorship Model for Retention of Minority Students (Nugent, Childs, Jones & Cook, 2004, p.

93). A nursing department at a historically black university increased student enrollment by 20%, retention by 25% and the NCLEX pass rate by 14% by initiating a program to "increase the enrollment and success of minority/disadvantaged students" (Brown & Marshall, 2008, p. 21).

A wealth of strategies may increase the diversity of students in the health professions, but which are appropriate for the education of direct-entry midwives? Unfortunately, there is a dearth of peer-reviewed literature on direct-entry midwives (DEMs) education. Indeed, even finding research that names DEMs is difficult.[4] The only peer-reviewed article found that mentioned direct-entry midwifery education was Myers-Ciecko (1999) which gave an overview of DEM education, regulation and practice at the time and did not specifically address the concerns of African American students. Part of the difficulty in finding research about direct-entry midwives stems from the fact that midwives themselves are not always easy to find. Some midwives, white and non-white, practice in states where direct-entry midwifery is not legal or is strictly regulated. Because of their tenuous legal position (MANA, 2011), it is difficult to obtain a true count of the numbers of African American midwives and all midwives practicing in the U.S. (J. Joseph, personal communication, October 3, 2011). Therefore, the number of black midwives in the U.S. is unknown.

Fortunately, we have some data on midwifery schools and students. A number of programs and schools offer education in out-of-hospital midwifery. The education consists of the didactic work and clinical training in maternity care, including attendance at births. It is beyond the scope of this paper to survey and describe all direct-entry midwifery schools, so this discussion will focus on programs accredited by the Midwifery Education Accreditation Council

[4] The following terms retrieved zero (0) entries when keyed into the PubMed MeSH database: direct-entry midwifery, direct entry midwifery, direct-entry midwives, direct entry midwives, direct-entry midwife, direct entry midwife, certified professional midwife, CPM, licensed midwife and licensed midwives. The search term "certified nurse midwife" returned "Nurse Midwives," "midwife" and "Midwifery."

(MEAC) for three reasons. First, to be accredited means these schools have embraced standardization similar to the nursing and medical schools mentioned in the literature review. Secondly, some aggregated data was available for these programs. Lastly, these schools are eligible for federal financial aid, and financial aid was cited in the literature as an important tool to make higher education more accessible to students of color (Barton & Swider, 2009; Grumbach et al., 2003, p. 4).

MEAC is recognized by the U.S. Secretary of Education (MEAC, 2011b) and accredits ten programs to date. The number of students enrolled in all MEAC-accredited programs was over 500 in 2009 (MEAC, 2009). Accredited programs tend to cost between several thousand dollars and several tens of thousands of dollars (MEAC, 2011a) and offer resources and infrastructure for student support in addition to a standardized midwifery curriculum (MEAC, 2011b). Accredited programs are eligible to participate in federal financial aid programs to help students cover tuition and living expenses, although most do not participate (MEAC, 2011b). Additionally, some programs offer scholarships. Graduating from an accredited program streamlines a midwife's application for certified professional midwife (CPM) certification (North American Registry of Midwives, 2011a) which may be required or helpful for state licensure (NARM, 2011b; Midwives' Association of Washington, 2011).

To gather background information for this project I contacted the ten accredited schools listed on the MEAC website to ask if they would share any data they had regarding African American enrollment and graduation rates at their institution. . To date, only 3 of the 10 schools contacted have responded. One had enrolled 2 African American students in almost 20 years. Of these students, one did not graduate; the other was currently enrolled. The second program had an optional field for race on their application and reported the number of black or African

American graduates as "unknown" out of 299 total graduates. The third school had not tracked the race or ethnicity of students until recent years but reported one African American graduated out of an unknown number of total graduates.

Another pathway to becoming a midwife is the apprenticeship model. In this model a student learns through hands-on work with a midwife or midwives and self-study, and may also attend skills workshops (Steiger, 1987). Aspiring midwives choose the apprenticeship route for a variety of reasons: lower cost compared to attending school, flexibility to accommodate other obligations such as work and family or a preference for one-on-one teaching (Steiger, 1987, p. 2). Black students may choose this route for those reasons; however, the apprenticeship model may present challenges similar to formal education: social isolation, financial barriers and perceived discrimination. A midwife trained via the apprenticeship route is eligible for certification as a CPM and may be eligible for licensure at the state level, depending on the jurisdiction.

Traditional African American midwives, also known respectfully as "grand midwives" (Chester, 1997), were trained under the apprenticeship model. They attended the majority of births in the African American community up until midwifery was regulated under the Sheppard-Towner Maternity and Infancy Protection Act of 1921 (Graninger, 1996). This regulation eventually led to licensure or certification in some states which allowed those states to force retirement on midwives whom officials deemed unfit to practice (Graninger, 1996; Susie, 1998). The "racist campaign" to eliminate traditional black midwives was based on the "now discredited theory of eugenics" (Dawley, 2003, p. 87). Under the auspices of the Sheppard-Towner Act, the state-sanctioned nurse-midwife, which originated among public health nurses, supervised and then accelerated the decline in the numbers of traditional African American

midwives (Dawley, 2003; Graninger, 1996). Despite this legal hurdle, some African American midwives took their midwifery practices underground, and midwifery survived in certain communities (Clark & Logan, 1989; Fraser, 1998). Additionally, black patients who could afford hospital birth forsook midwives and had their babies in the hospital for the rise in social and economic status it represented (Graninger, 1996).

In spite of this history, contemporary black women sometimes choose midwifery care (Palmer, Cook, & Courtot, 2010; Declercq et al., 2001), which results in high satisfaction among black clients (Palmer et al., 2010). Black certified nurse-midwives (CNMs) are more likely to serve women of color, including black women, than non-Hispanic white CNMs (Declercq et al., 2001). Some African American women choose out of hospital birth, although white women are overrepresented among home births (MacDorman, Menacker & Declercq, 2010). Midwifery care has been shown to result in lower rates of intrapartum intervention among low-risk pregnant women compared to obstetricians and family practice physicians (Rosenblatt et al, 1997); this result has also been found in a client population comprised heavily of African American women (Palmer et al., 2001). Therefore, an increase in the numbers of African American midwives may result in increased access to the midwives' model of care for underserved black communities.

Most published research on non-nurse African American midwives is comprised of interviews and oral histories with traditional grand midwives (Clark & Logan, 1989; Lee, 1996; Smith & Holmes, 1996; Susie, 1988). *Sisters on a Journey: Portraits of American Midwives* is a collection of interviews with contemporary midwives, including several African American midwives: Gladys Milton, Shafia Monroe and Jo-Anna Rorie, certified nurse-midwife (Chester, 1997). The most famous of The Farm Midwives, Ina May Gaskin interviewed Makeda Kamara, a black CNM who was originally from Panama but has lived in the U.S. since the 1960s (Gaskin,

1992). All these interviews focused on how the subject became a midwife and her personal story. However, none of these publications provide insights into how African American midwives experience the formal midwifery education programs that are common today.

Midwifery educators realize that more needs to be done to increase the numbers of midwives of color. The Association of Midwifery Educators (AME) and the National Association for Certified Professional Midwives (NACPM), a professional organization for direct-entry midwives, held a joint symposium in March 2012 to address the role of Certified Professional Midwives (CPMs) in the future of maternity care in the U.S. Among other issues, the symposium addressed the need to "create diversity in the CPM workforce that reflects the diversity of our country" and CPMs' role in "addressing disparities in birth outcomes" (CPM Symposium, 2011). Nursing educators have determined that they need minority faculty members "to teach students, serve as role models, interface with patients, and conduct research relevant to health care needs of minority underserved populations" (Stanley et al., 2007, p. 254, 255). Suzy Myers, Department of Midwifery Chair at Bastyr University, noted the "chicken or the egg" conundrum that challenges DEM diversity: in order to "make midwifery education accessible to women from underserved communities," the midwifery profession needs to reflect those women (Pérez, 2009). In sum, midwifery education may not attract students of color if students do not seem themselves reflected among midwives and among the faculty of midwifery programs.

Midwifery schools have made efforts to address diversity. The predominantly white administration and faculty of Seattle Midwifery School realized they needed more information about why the school was failing to be a culturally competent institution. The school appointed a task force which found that "[a]ll students of color and several of the white women concluded in

some way that they were being trained to only serve white women" (Seattle Midwifery School, 2010, p. 5). This is not surprising given that the administration and instructors of this school were predominantly white, and "[e]vidence shows that minority nursing faculty and practitioners are more 'knowing' about the health care issues and needs of minority groups and individuals" (Stanley et al., 2007, p. 255-256). The Institute of Medicine (2004) recommended increasing the racial and ethnic diversity among faculty as one critical way to remedy this deficit (p. 158). Offering scholarships to students committed to working in underserved communities is another strategy schools have implemented to increase diversity in their student body (Bastyr University, n.d.; Birthwise Midwifery School, 2010; Maternidad La Luz, 2009).

Methods

The researcher approached this study using critical race theory (CRT). According to Parker and Lynn (2002), the purpose of CRT is to give voice to the perspectives of people of color, which often run counter to mainstream narratives. CRT also argues against race oppression while at the same time acknowledging that race is a social construct (as cited in Creswell, 2007, p. 28). So it was from the standpoint of critical race theory that the research topic was selected and the interview questions were written in order to uncover experiences of discrimination and acts of resistance. In the tradition of critical race theory, the author acknowledges her relative power (Madison, 2005, as cited in Creswell, 2007, p. 27) as the researcher who analyzed the data and framed the presentation of the participants' words. A CRT standpoint was combined with a modified advocacy/participatory model. This allowed the researcher to advance an agenda to reform midwifery education without requiring her to go so far as to attempt to "change the lives of participants" (Creswell, 2007, p. 21). Instead, the

interviews were designed to find out how the participants were changing the lives of others in resistance to racism. This aligns with the goals of the advocacy/participatory paradigm, which is used to study issues such as oppression, alienation and hegemony (p. 21).

As a woman of color, the researcher was likely to be "more 'knowing'" about the concerns of communities of color (Stanley et al., 2007, p. 256), which inspired the research topic in the first place. Throughout the research process, the author had to balance her perspectives as an insider (as a woman of color) and an outsider (as a non-African American). The researcher attempted to "bracket out," or set aside (Creswell, 2007, p. 59-60), her experiences as a student midwife of color through journaling and discussing her own experiences with family and friends. This reflexivity was meant to allow her to examine the phenomenon under study, African American women and midwifery education, from a new angle (Creswell, 2007, p. 59-60). However, the researcher also mentioned her experiences in public forums in order to position herself as an ally to African American women in order to interest potential participants in her study. Following Charmaz's approach to grounded theory procedure (2005), "the researcher… [brought] questions to the data, and advance[d] personal values, experiences, and priorities" (as cited in Creswell, 2007, p. 66).

IRB Process

The researcher wrote a thesis proposal, recruitment letter and consent form. These documents along with an IRB application were submitted to the Bastyr University Institutional Review Board. The IRB requested further security measures to protect the data and personal information of the participants as well as clarification on the participant criteria. The proposal and relevant documents were revised to comply with the IRB, and the project was approved.

Population / Sample / Recruitment

The criteria for inclusion in the interview process were the following:

- be between the ages of 18 and 65
- identify as African American or Black
- currently practice as a direct-entry midwife or be a recently retired direct-entry midwife and have practiced for at least 5 years in the U.S.

OR

- be a currently practicing or recently retired direct-entry midwifery educator or preceptor to black direct-entry midwifery students and have at least 5 years of experience in the U.S.

The researcher found African American midwives and midwifery educators via internet searches, a listserv for midwives of color and at midwifery conferences. After the researcher interviewed several midwives, these midwives gave her names of other midwives to contact. These potential participants were quite responsive after learning a black midwife they knew had given the researcher their names. The recruitment letter and/or the consent form, explaining the purpose of the study and risks and benefits, was given to potential participants in person or electronically. A total of 9 midwives participated. This met the minimum recruitment goal originally proposed. Two nurse-midwives and one student midwife contacted the researcher about participating but did not meet the study criteria. One individual who expressed interest in participating did not respond when the researcher followed up by email. Another midwife who had agreed to participate later declined for unspecified reasons. One other individual who agreed

to participate did not return her signed consent form. Participants were screened in person or over the phone. They were recruited and consented using an IRB-approved letter and consent form. All questions were reviewed and answered at that time or during the consent process at the beginning of the interview.

Validation was determined by criteria native to qualitative research, which was, in this case, thematic saturation (Creswell, 2007). Saturation was defined as the point at which continued questioning produces no new answers from participants (Baker & Edwards, 2012, pp. 3-4). Morse et al. (2002) recommend interviewing participants more than once to ensure saturation (as cited in Bowen, 2008, p. 141); unfortunately, practicality and the resources of a student researcher precluded this approach. Guest, Bunce, & Johnson's 2006 article "How Many Interviews Are Enough?" represents possibly the only evidence for when saturation occurs in purposive sampling. Guest et al. showed that saturation occurred within the first twelve interviews, and "basic elements for metathemes were present as early as six interviews" (p. 59). Therefore, the nine interviews used in the present study elicited most of the themes that might have emerged within this group of participants. Additional efforts to ensure validation are described in the coding process outlined in the data analysis section of this paper.

To preserve the confidentiality of the participants, any potentially identifying information has been obscured or removed including place names and names of organizations. These measures were necessary due to how small the national midwifery community is and, in some cases, how few African American midwives reside in a single community.

Data analysis

The interviews were designed to elicit the subject's experience and opinions on what challenges black students face and how direct-entry midwifery education can better serve them (see Appendix A for interview questions). Phenomenology attempts to understand the subjects' personal experiences (Moran, 2000; Starks & Trinidad, 2006), and in this case, the phenomenon under study was the experiences of black midwives, mentors and preceptors to black students and as former students or apprentice midwives. It is "important to understand these common experiences in order to develop practices or policies" (Creswell, 2007, p. 60) that will enhance the success of student midwives of color. Modified grounded theory was also employed to allow for exploration of ideas that emerged during each interview (Corbin & Strauss, 2008; Creswell, 1998; Starks & Trinidad, 2006). In the present study, grounded theory procedure was followed as far as open coding and also during axial coding when the themes were collapsed, but additional interviews were not conducted to test the strength of the themes, which differs from standard grounded theory (Creswell, 2007, p. 68).

Purposive sampling was used to recruit participants who had experienced "the phenomenon under study" (Starks & Trinidad, 2006, p. 1374), which was black women and direct-entry midwifery education. Because some participants did not attend a formal MEP but worked with students who had, participants were asked to comment on the experiences of students they knew. When this data was used in the analysis, it is described as secondhand accounts related by the participant. The interviews lasted approximately 45-60 minutes. The interviews were conducted by phone or at a mutually agreed upon location and were digitally audio-recorded after obtaining the participant's consent. No compensation was offered. Audio files were transmitted via a secure file transfer protocol (FTP) website to a transcriptionist. The first two transcripts were closely coded, using Atlas.ti 7, a qualitative software program. Some of

the codes were prefigured because of the focus of the interview questions on midwifery training and education; the majority of the codes emerged from the data. A list of over 200 codes was created. The researcher debriefed with the thesis committee chairperson, a qualitative researcher, and determined that the codes should be consolidated. The codes were examined for clusters of meaning and were consolidated. The first two transcripts were re-coded with the collapsed list of codes and reviewed by the chairperson. The codes were further consolidated down to about 50 codes during the process of coding the rest of the transcripts. Codes were examined for patterns, reintegrated, organized and reduced "around central themes drawn across all the cases" (Starks & Trinidad, 2006, p. 1374). A coding memo was developed in which codes were defined and illustrative quotes were identified. The researcher again debriefed with the committee chairperson and refined the coding memo.

The initial literature review conducted for the proposal was supplemented by additional searches. Other relevant literature was found through a keyword search in PubMed using the following keywords: African Americans, home childbirth and minority groups. The following combinations of words were also used: "education, nursing, graduate," "education, medical," "education, nursing, baccalaureate" and "students, nursing, nurse-midwives." No articles were found about African American students in nurse-midwifery education. The references of relevant articles were examined for further resources.

Findings

All of the participants were practicing midwives, although two currently attended births intermittently. Of these two, one was semi-retired, and the other was involved in other birth-related endeavors. All participants had at least five years of experience in the U.S. as midwives.

Four of the participants had between 5 and 10 years of experience as midwives, one had about 15 years of experience, and the rest (n=4) had 20 to 30 years of experience. Participants' ages ranged from early 30's to 60's. All participants identified as African American or black but were not asked about their ethnic backgrounds. Two were currently teaching student midwives in a formal setting. All but one of the 9 respondents had been preceptors for African American student midwives, and all respondents had mentored African American students in formal and informal ways. The participants had experience during their training or as midwives in the following geographic areas in the U.S.: the West Coast, the East Coast, the South, including Texas, and the Northeast. Two had training from outside the U.S. and had significant experience in the U.S. as midwives. Six of the participants went through a formal MEP; one of these women also did an apprenticeship after completing her midwifery program. Three were apprentice-trained. In addition to their school or apprenticeship, some participants also gained midwifery skills at workshops or study groups. Four of the participants had bachelor's degrees; one midwife had two advanced degrees. One midwife dropped out of nursing school to pursue midwifery, and another left nursing school just shy of graduation after becoming pregnant. Another midwife went to school to become a medical assistant prior to becoming a midwife. One midwife did not mention any college education aside from her midwifery school.

Interviews resulted in rich data and addressed a wide variety of issues related to the experience of becoming, being and training midwives of color. This paper focuses on four key areas: 1) Experience of becoming/being a black midwife, 2) factors that facilitated becoming a midwife 3) challenges to completion of training and 4) recommended strategies and/or areas for improvement.

Experience of becoming/being a black midwife

The respondents in this study were asked about their experiences as African American women pursuing education in a white-dominated profession and about their efforts to train the next generation of black midwives. The "core phenomenon" (Creswell, 2007, p. 64) that emerged from the data was: *Racism significantly impacts black women in the midwifery profession.* Race and racism played a major role in shaping the respondents' experiences as students, as midwives and/or as educators of student midwives. Participants were usually racial and ethnic minorities in the schools or midwifery communities where they pursued their training, except for one midwife who was trained by an African American midwife in a predominantly black community. The effects of racism on African American communities influenced most of the participants to emphasize accessibility in their midwifery practices.

Racism. The impact of societal racism on their communities influenced many, if not all, of the respondents to become midwives. Examples of racism at the societal level reported by respondents included the fact that black men are disproportionately incarcerated and black communities experience disproportionately higher rates of unemployment. As one midwife stated, "Unemployment, as you saw in [the film] *When the Bough Breaks*, has always been hard for black people. They never hire us." This contributes to a disproportionate lack of accumulated wealth among blacks compared to whites. A respondent noted, "And we don't have old money. We don't have… inheritance… I hear a lot, 'Well… white students have the same problem,' but it's still not the same. Because no matter what… even if you're a low income white, you're still white and you get a different treatment." All of these factors impacted the lives of African American clients served by the participants. Because decreased socioeconomic status is linked to worse outcomes and midwifery care is linked to good outcomes, respondents viewed bringing

midwifery care to affected communities as a way to improve health and access. For example, a participant talked about her work with pregnant women experiencing homelessness:

> "And so you get a homeless mom who's at a shelter, pregnant, who's getting taxi vouchers to come to the birth center that's in the hood, word is going to spread. And when she has her birth at the birth center with her friends and is given emergency housing because she now has an infant and gets put straight into an apartment… and talks about how she had this empowering birth in the midst of the most humiliating time in her life, being homeless, being without support, that's huge. You change the community in that little tiny way… This woman no longer feels like her life is a waste… because she had this amazing birth, that she had the power. She made the choices. She was educated and informed, and she can now go and teach and train other people in the community."

This example illustrates the positive influence accessible, culturally competent midwifery care can have on a community. Before they could offer this kind of care, participants had to learn midwifery.

Midwifery education. Midwives reported learning midwifery-related skills in a variety of ways: as apprentices, through MEP's, in allied health professions school, as a doula, being a childbirth educator, at workshops and conferences. About five of the participants received their clinical training primarily from white midwives, two were trained primarily by black midwives, and one participant had an apprenticeship with a black midwife but completed her training among primarily white midwives. A few respondents reported taking workshops or learning with midwives of other races. When respondents learned under women of color, overall, they reported

positive experiences. When they were surrounded by white midwives and students in school or in their clinical training, sometimes participants had very positive experiences. More often, however, they reported less of a bond between themselves and their white instructors. They reported that important issues related to race were overlooked or they even experienced discrimination.

> "[T]here were racist jokes told in the classroom. And when I brought them to the administration's attention, I was being overly sensitive, I was misinterpreting their statements. And so that was a constant theme throughout the entire program… and that is what leads to the isolation, loneliness, frustration … feelings of being discriminated."

So racism or a lack of cultural sensitivity impacted their training experiences. Participants noted when students of color were unsupported by their schools (e.g. the administration refusing to address racism in the classroom), they were at greater risk of attrition. Thus, one participant charged schools with "mak[ing] it their business to put more students [of color] through."

Accessibility. Eight out of the nine respondents explicitly stated that they were motivated to serve their community as a midwife. One midwife stated, "I really reached out to the African American community and let them know that I was here and ready to practice." Several respondents felt obligated to make their care affordable in order to be accessible to the communities they had set out to serve in the first place. Two offered sliding scale fees. Two created low-income clinics, and two more had worked in such clinics. This concern for accessibility is a key feature of their approach to culturally competent midwifery care and education.

In addition to increasing access to midwifery care, seven out of nine participants stated specifically that they were working to decrease the rates of infant and maternal mortality and/or

morbidity among African Americans. Each of the participants felt compelled to practice midwifery in a way that was accessible to African Americans because they saw their communities as being underserved. They saw midwifery care as a way to address racial and ethnic health disparities. Several respondents noted that they served individuals that their white colleagues would never have considered as potential clients due to their socioeconomic status or social circumstances (e.g. sex workers). Several midwives expressed frustration that the majority of white midwives did not appear to experience the same motivation to reach underserved communities at greater risk for health disparities. "[Why] then…is it… okay that the majority of midwives who happen to be white are … aware of the statistics and the disparity, yet unaware or unable to do much about that."

Those participants who were also educators instilled this motivation to reduce health disparities in their students. "I know that each one of [my students] are going to go back to their communities and make a difference in somebody's life… keeping a baby inside a mommy longer, bringing a baby to full term… That is why I do it." Several respondents stated that, as educators, they were driven by communities of color needing midwives, not by the potential to earn money from teaching. "It can't be about money. It's just simply that there's a bigger picture here… we say, 'That's okay. I'd rather see you sitting here in the class and showing up than have a check [for tuition] from you.'" Similarly, they made their apprenticeships as accessible as possible to students of color, sometimes by taking on apprentices that white midwives had refused to teach or by finding ways to pay their apprentices for their work. They felt compelled to make midwifery education and training accessible and affordable for students of color to serve their communities and to build capacity.

Facilitators

Participants were asked about support, strategies and actions they took that helped them on their journey to becoming a midwife. The facilitators that emerged from the data included *motivations for becoming a midwife, family and social support, other midwives of color / finding peer support* and *advocacy / standing up for oneself*.

Motivations for becoming a midwife. A key facilitator of midwives completing their training was the ideological motivations that undergirded their desire to become a midwife. They saw midwifery as a career choice that would address critical social and health needs in their communities. Many participants were also motivated to train students of color in order to build capacity – to serve their communities, to reduce racial and ethnic health disparities, and to be preceptors to African American students. One midwife who was also an educator envisioned capacity building the following way:

> "I wish that I could clone myself and my partner and put us in all these different states… Or [get] into the schools that are already there and maybe do the little sidebar programs… [I]f you could just put five students of color through your program every year, what would that look like and how could that be supported? And what if you had a couple educators or one educator who was willing to work with these students?… [B]eing able to think outside of the box could get the goal happening… [I]f we had five happening in every single year and every single program, we could really get something done."

Participants spoke of their communities "needing" them. One midwife stated,

> "I have to do this for a whole entire community. I have to do this possibly for a whole entire state. I have the weight of a community and a state on me to like do this, do a good job, and then go home and do a good job."

Some of their preceptors voiced this concern: "My old preceptor would be like, '[Y]ou have to do [finish midwifery school]. We need you to do this because…I can't be the only midwife of color for all these years. I'm going to have to stop eventually.'" Another midwife discussed her motivation for becoming a midwife and training student midwives.

> "[Y]ou have to have an understanding and a bigger picture of what's happening out in our world. And when you say you want to be a midwife and you want to serve women, you need to look at who are the communities and populations out there who really could benefit from midwifery care."

The same midwife noted that her white preceptors "moved mountains" to help her succeed. Respondents' passion motivated them to pursue this career, but they also needed support along the way.

Family and social support. Respondents repeatedly mentioned aspiring midwives needing support, especially when they have children. All participants who had children while pursuing their training, except for two, were married. All of those married participants attributed their success to their spouses' financial support and willingness to do childcare. "I had a husband. He was supportive… Dropped me off. Ran and got supplies. Watched the children." One midwife who had children but no live-in partner relied on her family for support and childcare. Several participants also cited the urging of their mentors, some of whom were white, but most of whom were black, as being key in helping these midwives complete their training.

Other midwives of color / finding peer support. Given that some respondents reported difficulty relating to white midwives, being excluded by white women or even perceiving discrimination, it is no wonder that respondents who trained with midwives of color valued that experience so highly. One midwife described not feeling welcomed by the predominantly white

midwifery organization in her state and what it took for her to successfully complete her training as a midwife:

> "[T]here was an organization, the [State] Midwives Alliance…[T]hey were polite, but not really inviting in my opinion…[S]o I just kind of pushed to find black midwives in my community... I found midwives from Africa. I found a couple of [South Asian] midwives... and then I found the one that really topped it off was … [an] African American midwife…[S]he really helped me to get to the level where I could actually catch babies and do care on my own."

Another midwife described her relationship with her mentor, a traditional black midwife in the following way: "Like, it was really just very organic and a mothering almost. Like, I'm going to show you … I'm going to teach you how to be a midwife. In a really gentle, loving way." A third respondent observed that studying in a small, supportive group of like-minded peers helped her, and later, her students succeed. This kind of support was important for midwives who otherwise faced exclusion from white midwives.

Advocacy / Standing up for oneself. Midwives reported advocating for themselves and their students. *S*ometimes a participant self-advocated by inviting herself to meetings or study groups or starting her own group.

> "Being the only black midwife… within… any midwifery movement in [the state] where midwives were coming together, working, doing things, I was not necessarily included. I had to often invite myself. I had to really advocate for myself because, otherwise, I was nonexistent in their world… [T]hey were never on my side of town. I had to always go to them."

One midwife reported standing up for her students who were struggling in midwifery school and stated that she was ostracized among her professional peers for it. Another midwife reported that a colleague, who was also African American, wrote letters to challenge midwifery schools to be more accessible to students of color.

Challenges

The data were also examined for barriers and challenges that respondents encountered on their path to becoming a midwife, as well as challenges they faced as educators and preceptors. Many of the reported challenges revolved around being an outsider or "other"; these included the themes of *aloneness, overt racism from midwifery peers, lack of willing preceptors, financial challenges, lack of financial aid, single motherhood* and *organizational racism.*

Aloneness. Many of the respondents reported being the only black person in their program, at workshops, or in their local midwifery communities. This aloneness was often exacerbated by a perceived difference in demographics and life experiences between themselves and their white peers as well as perceived underrepresentations and misrepresentations of African American midwives. Participants stated they had expected to be the only black person in their program, but these other factors contributed to a sense of isolation. One midwife described her experience travelling to another state for her midwifery education:

> "[W]hen you have to travel out of your community and go into these programs…and there's all women who may not have any of the same experiences or references that you have, and… you know, people gravitate towards who they feel most comfortable with. So they're already in these little cliques. And it's awkward."

Another midwife described the impact of tokenization:

> "I think schools cannot bring, not just choose one person of color… because that's very isolating. And it's hard for the women of color in that situation to get through the program. Because they're constantly having to educate everybody else in the cohort. They're constantly having to listen to inappropriate things that people think are just fine to say."

Perceived differences in demographics and life experiences included race, socioeconomic status, having children and being a single mother.

> "[T]he demographics of women of color and the demographics of people who want to be midwives who are white is completely different. When I look around, the women who are studying to be midwives now are young white girls. They... aren't responsible for anybody else.... Or, if they have children, they have a husband working. And... that's not what women of color look like in America. The majority of black women over the age of 23 are single parents. Completely different demographic."

In addition to the obvious differences around experiences of race and racism, some midwives noted their white peers enjoyed relatively higher socioeconomic status. "So, I would go to the [midwifery] meetings. I would drive from [a low income neighborhood]… which is more of the black community, out to… a predominantly middle-class Caucasian environment."

Respondents also noted a lack of visibility of black midwives in midwifery education and at events produced by midwifery organizations that were not led by women of color. Participants noted when African American midwives were mentioned, it was usually as grand midwives of the 20th century; currently active black midwives were forgotten.

> "I've heard people say… 'Oh, I didn't know about [name of black midwife]. I didn't know what [name of another black midwife] is doing. I didn't know that [name of a third

> black midwife] is doing that. I've never heard of these people. How come our school never mentions them?'"

So not only were participants tokenized, but so were their predecessors. This experience was exacerbated by overtly racist encounters.

Overt racism from midwifery peers. Participants recounted their own experiences with racism in midwifery as well as the experiences students had shared with them. Several midwives discussed the negative impact that racist incidents had on them during their training and how experiencing racism compounded other challenges they or their students already faced. The same midwife who earlier recalled being ignored by her school's administration after bringing racist incidents to their attention, described the effects of institutional racism:

> "I think it's, the issues of, of race and culture that weigh your spirit down, right. Like even if you have the family support and you have the financial support… if you have those two worked out… you know, if you're constantly the butt of racist jokes, or you're constantly experiencing discrimination, the other two don't matter. You're not going to make it at that particular school or in that particular program… Like it just wears you down, it dings your soul, it breaks your spirit."

This sense of alienation was echoed in another participant's account of two of her apprentices.

> "[T]he two students that I took on definitely felt oppressed within their program…[O]ne of the white girls in her class said, 'Well, it's the black midwives own fault that they got themselves kind of weeded out of the system'… And my two students were appalled. And… they pretty much shut down and barely even spoke in the class because they felt like they didn't have a place, or that they were respected, or had a voice. And it would be

> time and time again of stupid comments like that out of ignorance and racism…they just felt like they didn't belong there."

Overt discrimination was sometimes discussed in combination with other challenges like a lack of willing preceptors.

Lack of willing preceptors. Almost all participants discussed the challenge black students face due to an apparent scarcity of willing preceptors. Respondents recalled accounts of black students they knew who had sought preceptorships with white midwives only to be turned away and then find out the midwife took on a white student. "[Black women] can't even get into the midwifery community, they can't find preceptors because they're students of color. Some of them have heard outright…'No, I don't want… the personal likes of you in my office.'" When a black student was able to find a preceptorship, respondents reported that she might be treated poorly and feel as though she could not leave due to the difficulty of obtaining a clinical placement. One midwife reported recently counseling a student facing this problem:

> "One student was completely in tears… She works in an all-white area… Her midwife, she said, would call her 'nigger'… And she says, 'I don't have a choice. I don't have anybody else that I can work with, and I want to become a midwife. And I don't have money to move to another state or anything.' So she had to put up with it… And she was having a breakdown about it."

Given the circulation of these stories of mistreatment, it is not surprising that African American students would seek out black preceptors. Unfortunately, one midwife noted that there is a shortage of black midwives available to be preceptors.

> "[Black students] have asked me do I know any black midwives who… could mentor them. And I try to give as many names as I can. The other challenge is that a lot of black

> midwives are no longer practicing… They shut down their birth center. Can't find clients. There's a lot of midwives that aren't practicing… They went and got jobs."

Because of societal racism affecting the socioeconomic status of black midwives and students, financial challenges stymied some women's pursuit of midwifery.

Financial challenges. Midwives noted financial challenges during the course of their training and relied on the financial support of their husbands and families. Midwives noted that financial hardship was a challenge for all aspiring midwives but perceived it as being more common among their African American students. One midwife talked about two students who had to leave school because they could not afford the tuition.

> "And after a year, it became so hard for [the students] to be able to keep up with the payments and everything to stay in [midwifery school], that they fell behind… And the school started becoming a little hard on them. And they basically got weeded out."

Two respondents stated that the most common question they were asked by black aspiring midwives was where to get financial aid to pay for midwifery school.

Lack of financial aid. Several respondents bemoaned the lack of financial aid available from direct-entry midwifery schools. "[T]here simply isn't enough financial aid in the schools for students to be able to get through. Not many of them, the direct-entry midwifery schools, have it available, which is really unfortunate." Two respondents stated they sometimes steered black students towards nurse midwifery because of the availability of financial aid for those programs. Many participants noted that a lack of financial aid makes midwifery education inaccessible for many African Americans; several noted that this barrier was particularly hard for single mothers.

Single motherhood. Raising their families alone, single mothers have an even greater challenge than other students with children. Several respondents noted that single motherhood was more common among African American women. One midwife stated, "[W]hen I look at the majority of the women who have expressed their interest… in apprenticing with me, the majority of them are single mothers." Another respondent discussed the difference between her needs as a single mother and the expectations of midwives with whom she had sought apprenticeships: "I am a single parent, I have a child that I have to raise, and I have to bring money into my house. So I am not a person who can follow you around tied to the back of your car 24 hours a day, going here, going there."

Organizational racism. Participants noted that most of the national midwifery organizations in this country were run predominantly by white women. One respondent had this to say about major organizations representing direct-entry midwives in the U.S.:

> "I do think they [national midwifery organizations] have an impact on the students of color… if students of color … don't necessarily feel included. They perhaps are feeling somewhat … not quite at the table. Not just students even, but midwives, as well … I don't know that student midwives of color or black student midwives would say that they feel an affinity and … that those organizations stand for their needs or understand even, what those needs are."

Another midwife echoed the sentiment while discussing her reason for avoiding midwifery politics.

> "I have friends, wonderful Caucasian midwives … who have actually *for years* [said], 'Why don't you be a part of this organization?'… I think I started to go to a conference

> once, and I looked at a brochure, and it was just all Caucasian women who would be speaking…I just didn't feel connected in any way, shape, or form."

When asked whether she thought the politics among midwifery organizations affected students of color, another midwife stated, "I think that it is set up to eliminate them." A different respondent noted that because most of the major midwifery organizations in this country often work together, policies that negatively impact women of color are coincidentally reinforced by the other organizations. For example, an experienced midwife recalled when the CPM credential was created.

> "It was typical for a white midwife to average, you know, maybe about 50 births per year; whereas, I might have been lucky to get 10 births a year. And so the way that NARM had it set up was that you have to not only pay to start the CPM process, but you also had to have a certain amount of births within this time frame."

This midwife primarily served African American families, who, she noted, were outnumbered by white couples among likely home birth clients. Her account illustrates the real concern, expressed by the respondents, about the ghettoization of African American midwives. One participant was concerned that young women of color who were inspired to serve in poor, underserved communities of color would stay as poor as their clients; whereas, white women were more likely to make a comfortable living serving white, middle-class families. Another respondent gave an account of two of her apprentices who experienced financial barriers and racism in their program. This respondent felt that the white midwives who ran the program were less sympathetic to her students because they could not relate to the barriers they faced. One respondent who maintained a diverse clientele noted that policy makers rely heavily on the

NARM but that model did not necessarily serve "other subcultures." She urged midwifery educators:

> "To be… more supportive… in the CPM process. I think that a lot of these state midwifery organizations use N.A.R.M.… for getting a midwifery license in their states… if that's going to be the norm and the only acceptable way to get your state to legalize licensed midwifery, then I think that N.A.R.M. needs to open up their scope more realistically and look at the other subcultures of this country other than their own."

Respondents have many more recommendations to address the challenges outlined in the preceding sections.

Recommendations

Respondents were asked to recommend strategies to address the challenges they encountered and/or to build on the facilitators identified. The data were examined for solutions and specific strategies that facilitated the process of becoming a midwife. Recommendations were to: *embrace multiculturalism and practice cultural competence, offer financial aid and scholarships, support student employment, conduct outreach to black students, recruit black students, implement retention strategies,* such as *promoting mentorship, fostering peer support* and *providing academic support*. Additionally respondents wanted midwifery educators to *encourage creative problem-solving and flexibility within the structure of midwifery programs, develop sustainable employment models, support the leadership of African American women* and *expand distance learning programs.* Many of the suggested strategies were meant to build capacity so that more black midwives would be available as mentors, faculty and leaders.

Embrace multiculturalism and practice cultural competence. Participants had a lot to say about cultural competence and the invisibility of black midwives and issues pertaining to African

American communities in the classroom and in midwifery circles. A few participants expressed frustration and exasperation with the apparent lack of concern among many white women regarding these issues. One midwife bemoaned the fact that when African American communities were mentioned in midwifery education and at conferences, emphasis was placed on depressing statistics rather than taking a positive, strengths-based approach to these issues. Despite these critiques, a couple of respondents noted white midwives who worked on racial and ethnic health disparities and cultural competence. One participant expressed gratitude to a white lesbian midwife who led a cultural competence workshop: “I loved her for that because she got it. She understood.”

Respondents noted that one way to improve a school’s ability to be culturally competent and to promote an anti-racist mission was to increase racial and ethnic diversity in the student body and staff. “[W]e need to have more black teachers… And more midwifery schools that have the integration of diversity at a tenure level… And the students want that. And… white students want it.” A couple of midwives stated that MEAC should require its accredited schools to have policies supporting diversity. Several midwives expressed the idea that cultural competence should be woven throughout the curriculum rather than be contained in a single course and would demonstrate "schools' commitment for diversity."

Offer financial aid and scholarships. Respondents expressed concern over the financial barriers that students experience and the importance of financial support. Participants noted the lack of financial aid creates an economic barrier particularly for African Americans, who experience disproportionately higher rates of unemployment and whose families are less likely to have accumulated wealth. As one midwife stated, “I didn’t have family or friends that could loan me, well, at the time I think... the going rate for midwifery school was, like, $20,000." One

midwife had the idea that MEP's should offer scholarships for women of color but require repayment if recipients did not finish the program, similar to the incentives some nursing programs offer. A related theme was the recommendation to support student employment.

Support student employment. Employment serves several purposes for aspiring midwives. Several participants reported working as allied health professionals, birth assistants or as administrative staff in midwifery clinics which helped them gain skills related to midwifery, as well as to support themselves and their families while pursuing their midwifery training. One participant noted the importance of employment for African American women who are more likely to be single mothers. She recalled being paid as an apprentice and continued to use that model today. She stated, "Because if I don't pay [apprentices], they'll go get a job and do something different because they have to feed themselves." Another midwife reported that she created paid positions for two of her students to help them get through school. Another participant, who trained outside the U.S., was paid a salary and given student housing by her program. A further recommendation was that aspiring midwives train as doulas, childbirth educators and/or breast-feeding counselors in order to support themselves during school. Understanding the challenges African American women face in their pursuit of midwifery led several of these women to conduct outreach to build capacity and create more interest in midwifery.

Conduct outreach to black students. Respondents referred to several strategies that are employed by mainstream colleges and universities to increase diversity in their student bodies -- outreach, recruitment and retention. An outreach strategy reflects the need for increased public awareness about childbirth options and midwifery as a profession, particularly in underserved communities. Midwives worked to meet this need by participating in Career Day in local

schools, by participating in cultural fairs, organizing conferences and speaking at colleges. One participant felt it was very important for MEP's to have a presence at midwifery conferences to reach aspiring midwives. Another midwife credited celebrities like Erykah Badu with raising awareness about natural options for childbirth. The next step after raising awareness is targeted recruitment.

Recruit African American students. Targeted recruitment of students of color reflects the understanding that certain underrepresented ethnic and racial communities are less likely to pursue higher education in the health professions and also that having more providers of color improves access for those communities. Participants noted that it is incumbent upon midwifery schools to target outreach and recruitment toward students of color as part of their commitment to a diverse student body and to build capacity to address issues pertinent to communities of color. Respondents suggested targeting recruitment efforts at historically black colleges and universities and from black doula and midwife organizations.

> "I think midwifery schools need to recruit students of color. They need to contact the organizations that represent women of color: black doula organizations, black midwife organizations, midwife of color organizations. They need to contact them and say, 'Do you have any women that are wanting to become students and are… having a hard time making that happen? We would love to interview them.'"

Respondents also noted that incentive such as financial aid and scholarships would aid recruitment efforts.

Implement retention strategies. Respondents noted that the current educational system does not do as good a job preparing African American students for higher education as it does their white peers. Midwives stated that a commitment to meeting the needs of underrepresented

students is required in order to increase retention rates. They identified three strategies to meet this need: *promote mentorship, foster peer support* and *provide academic support.*

(1) *Promote mentorship.* Midwives reported mentoring students in formal and informal ways, including offering moral support in online discussion groups and over the phone, teaching students midwifery theory and clinical skills, counseling on perceived discrimination in classes or clinical sites, bolstering their confidence, helping students to navigate school policies and to understand the professional credentialing process. One midwife described being challenged by the perceived unfairness of her mentees' preceptors and/or school, yet feeling compelled to advise students to persevere because of the community's need for more midwives. Another respondent suggested that midwifery programs should facilitate this mentorship:

> "I also think that every single student should be paired with a midwife of color to, like, be able to call while they're in school to say, 'Hey, I'm having a hard time… Can you talk me through this?'"

(2) *Foster peer support.* Peer support refers to students developing bonds and offering moral support to each other. "One of the main things that I see which keeps my students going, which also helped to keep me going when I was a student, is creating your own little community within the students." When this peer support was lacking during their training, participants felt isolated in their programs or communities. Respondents reported instances of students not feeling supported by their classmates or their school and withdrawing from the program.

(3) *Provide academic support.* When asked about academic support such as tutors and study groups most respondents agreed with the strategy. However, one midwife noted that if

a student did not have good preparation before entering higher education, they were unlikely to succeed even with academic support.

Encourage creative problem-solving and flexibility in the structure of midwifery programs. Participants discussed the need for new ways of thinking about midwifery education and creative, flexible solutions to meet the needs of African American students.

> "I would like to see that the midwifery community understands… the specific needs of midwives of color… I'm not looking for a lowering of the bar, but just a different approach to the education, the credentialing and so on."

Another participant echoed this idea and stated that African Americans did not want special treatment but wanted "sensitivity" to circumstances common among African American women, such as decreased economic resources and single motherhood. Respondents recounted ways their instructors or preceptors had shown flexibility to help them succeed, such as audio recording a class, allowing a student to come late due to childcare and travel issues, trading work hours for tuition, or allowing the student to write an essay instead of taking a standardized test. Respondents also encouraged creative thinking about the practice models for which students were being prepared.

Develop sustainable employment models. Several respondents pointed out that the entrepreneurial model of direct-entry midwifery today is not a feasible career choice for African American women who need an income to support their families. These women stated that it was disingenuous to try to attract women of color to midwifery education if there was no guarantee of a job after school.

> "I think the number one thing is job prospects. You know, you pay a lot of money to get through this program, and then you're not hirable…I mean there has to be some means of

> making back what you've invested, and the ability to provide for your family. And that doesn't happen really in direct-entry midwifery unless you own a birth center, own a practice and you're really busy, right?"

Respondents discussed the challenges of being a direct-entry midwife with a focus on women of color when it came to developing a solid client base. Many midwives lamented the lack of knowledge regarding birth options in the general public and particularly in black communities. "Just because I'm this color doesn't mean I can just walk in there, and they [African Americans] will all just follow me and have out of hospital, natural births." Two respondents mentioned a recent report that found that home births among whites increased significantly in recent years, but the rate for African Americans remained the same. Another midwife questioned the likelihood of white women choosing African American midwives: **"**What would we have to do to get middle-class white women to come to us …. where they're going to be sitting in the waiting rooms with round-the-way-girls?" The same midwife suggested partnering with business schools and tasking the students there to create a business plan to determine the right proportion of Medicaid, private insurance and cash pay clients to sustain a midwifery practice.

Participants had several other ideas to make direct-entry midwifery a sustainable profession for black women. One midwife recommended licensure in all 50 states, reasoning that more women would be attracted to a legal profession that was integrated into the health care system. Other suggestions were to encourage midwives to practice across their full scope of practice, including in STD and pregnancy outreach clinics, and even to pursue further training in order to apply for hospital privileges. Another suggestion was that MEP's should all grant master's degrees because the level of training warrants such a degree and would qualify midwives for a greater variety of positions beyond clinical practitioner. Another midwife was

interested in promoting public health midwifery in a clinic setting and also as a stepping stone to other health professions, such as advanced nurse practitioner or physician.

> "So, one of my ideas… is creating the clinic midwife. This is a woman who does 9 to 5 midwifery. She goes home at night to her children… She's employed. She gets benefits… But the focus and emphasis is on populating public health clinics with the clinic midwife. Then in that training -could also be if you want to go on to get into mainstream, you can do nursing. There's nurse midwifery, there's nurse practitioner, you could be a physician, you can carry on up the ladder."

This quote illustrates how midwives saw a sustainable career as a way to attract women of color to the profession and also as a way to address health disparities and increase access to care. These creative solutions demonstrate why black midwives' leadership deserves broader support.

Support leadership of African American women. A couple of participants discussed the need for more midwives of color in leadership positions and the need to have their leadership supported by white women. One midwife expressed a desire to partner with a larger organization with the resources to create an online midwifery school, but she also wanted to keep the leadership in order to recruit and retain black women.

> "[H]elp us get a good powerful school going, an online school. Work with us. Let us have the leadership in it. And we could recruit tons of black women and retain them. That's a dream I would love to see happen. We would love a school and… partnership with these large organizations that have much bigger budgets."

Another midwife observed that many midwifery organizations are led by women in their 50s and felt younger midwives with fresh ideas were "being roadblocked" by current leaders and not allowed to take on leadership.

Expand distance learning programs. Two midwives were using a distance learning format to teach students. In both cases, students met together with instructors for several days and worked on their own the rest of time. Some of the students traveled from several hours away. This allowed aspiring midwives the flexibility to learn with other students and have face-to-face contact with instructors without having to move their families.

Discussion

Considering that there is very little peer-reviewed research on direct-entry midwifery education and apparently none on women of color in direct-entry midwifery education, this study intended to fill that gap. The midwives in this study have been on the front lines of increasing access to midwifery care and reducing health disparities. This project aggregates in a formal way the concerns of black midwives regarding midwifery education as it exists today as well as suggestions for improvement.

Participants described their experiences with becoming and being a midwife. These experiences were shaped by racism and how they accessed midwifery education. These midwives felt compelled to make their care accessible and affordable to African American communities and other underserved groups. Facilitators that helped them complete their training included their motivations for becoming a midwife, family and social support, finding other midwives of color, peer support, advocacy and standing up for themselves. Participants reported a number of challenges black students face in midwifery training and also made recommendations to mitigate those challenges.

Participants who pursued their training primarily under white midwives typically experienced racism during that time. They reported hearing racist comments or experiencing

racist behavior in their midwifery programs and felt unsupported by their instructors or school administrators when they called out the problem. Once they had become midwives, almost all of the respondents had counseled black students facing perceived discrimination in MEP's, in practicum sites or while attempting to get clinical training. Respondents consistently reported that African American students faced a lack of willing preceptors, and there was a perception that white midwives were more likely to accept white students over black students. Several respondents discussed the fact that societal racism negatively impacted black women's socioeconomic status, and the majority of respondents noted that low socioeconomic status made it difficult for black women to pursue midwifery education and training. Several acknowledged that this financial challenge was often compounded by single motherhood, which, they noted, was more common among black women. Indeed, 2010 census data showed that 29.3% of black households are headed by unmarried women; whereas, only 9.6% of white households are headed by unmarried women (U.S. Census Bureau, (a) and (b)). Additionally, respondents noted that organizational racism, couched in the policies of midwifery organizations, negatively impacted black midwives and students.

Participants had a number of recommendations to increase the numbers of black midwives. In order to attract students of color and create a safe learning environment, participants recommended embracing multiculturalism and incorporating cultural competence throughout the curriculum. They felt this process would be facilitated by recruiting diverse instructors and students. Similar to the literature, midwives recommended financial aid and scholarships as well as employment to mitigate the financial barriers students of color face (Childs et al., 2004). Other strategies that were consistent with the literature included: targeted outreach, recruitment and retention of students of color (AACN, 2001; Gardner, 2005; Stanley,

et al., 2007). Several retention strategies included using mentors to counsel students on the challenges of midwifery school, fostering peer support among students and academic support (Gardner, 2005; Peter, 2005). Midwives discussed the need for creative and flexible solutions to educate and retain students. Significantly, several respondents were concerned about the sustainability of the current entrepreneurial model of direct-entry midwifery and the implications of attracting women from already economically-challenged communities to a profession that might not support their families. Respondents had several interesting suggestions for making midwifery a more sustainable career choice, which included licensure in all 50 states, practicing across the full scope of practice including in STD and pregnancy outreach clinics, applying for hospital privileges, accredited Master's degrees, and public health midwifery in a clinic setting. Participants urged midwifery educators to support the leadership of women of color on professional and institutional policies and objectives. Lastly, distance learning was considered a model that made midwifery education accessible to black students. The respondents offered new visions for the future of midwifery education and the profession, ideas which have the potential to increase the diversity of midwives across many demographics.

The findings of the present study were consistent with the literature review in many areas and differed in a few important ways. Barriers that students of color experienced in the literature review that were reflected in the present study included: discrimination against ethnic minorities, financial problems, difficulties with academic and social adjustments, isolation, loneliness, frustration, the image of the profession as a white profession (Childs et al, 2004), rigidity in education policies and a lack of role models of color (Ackerman-Barger, 2010; Barton & Swider, 2009). Being a first generation college student was not a problem overall for the participants in the study, but it is unknown if this affected the success of their students. The availability of other

career options (Childs et al., 2004) may be reflected in the recommendation by participants for developing sustainable employment models. Barriers that were not cited in the literature review but appeared in the present interviews included a lack of willing preceptors, lack of financial aid availability and the challenge of single motherhood.

Participants made many similar recommendations to those found in the literature: increase efforts to recruit, retain and graduate students of color, support the leadership of providers of color, develop practice environments that promote diversity, teach culturally competent care (NACNEP, as cited in Stanley 2007); present an inclusive image, reach out to diverse populations, promote mentorship (AACN, 2001); increase financial aid (U.S. DHHS, 2006); and support study groups and provide tutors (Peter, 2005). It is important to note that the research participants explicitly described racism as a barrier to the success of students of color and called on white midwives and educators to embrace multiculturalism, antiracism and cultural competence to counteract the effects of racism on students of color. Other recommendations that respondents made which did not appear in the literature included supporting student employment, encouraging creative problem-solving and flexibility within midwifery programs, developing sustainable employment models and expanding distance learning programs.

Strengths and Limitations

There were several limitations that may have affected the demographics of the respondents and the data gathered. The respondents volunteered to participate in the study, so there may have been self-selection bias of respondents. Respondents were selected based on self-identification as African American or black but were not asked about their ethnic background. Therefore, no themes regarding the role of ethnicity uncovered. Those who participated may

have been more likely to perceive racism in midwifery and believed DEM education as it exists today needs improvement as compared to those who did not participate. Those who did not perceive a need for improvement or had no experience with discrimination in midwifery education or as midwives may not have responded to the recruitment emails posted in online forums. The study design relied primarily on electronic forms of communication to reach potential participants, so individuals without internet access or with low computer literacy may not have been reached. The limited resources of a student researcher precluded interviewing participants more than once to test themes for saturation. Lastly, the researcher may not have been aware of or able to access forums or groups that were closed to non-African Americans.

There were also several strengths that contributed to the efficacy of the study. The researcher was able to access some forums for midwives and students of color because she is Japanese American. Additionally, speaking about her own experiences with racism in public forums may have inspired trust in some individuals who either chose to participate and/or who encouraged others to do so. Debriefing with and oversight by an experienced researcher strengthened the reliability of the findings.

Recommendations for Midwifery Education

The recommendations that seemed to underlie every statement made by participants were *embrace multiculturalism, practice cultural competence* and *increase the availability of financial aid and scholarships.* To paraphrase one participant, an MEP's mission should include a commitment to increasing diversity, and all faculty and staff need to embrace that mission. Hiring qualified African American faculty demonstrates that commitment. Committing financial aid resources and scholarships specifically for black students also shows that commitment;

however, the learning environment needs to be reformed to make black students feel safe, recognized and valued. Therefore, several participants recommended that cultural competence should be woven throughout the curriculum and not covered solely in a single course.

This researcher proposes to advance the following "agenda for change" as is appropriate to an advocacy/participatory study (Creswell, 2007, p. 22).

Recommendations:

- Embrace multiculturalism and practice cultural competence
- Increase financial aid and scholarship availability
- Support student employment
- Conduct outreach to black students
- Recruit black students
- Implement retention strategies, including:
    - Promote mentorship
    - Foster peer support
    - Provide academic support
- Encourage creative problem-solving and flexibility within midwifery programs
- Develop sustainable employment models
- Support the leadership of African American women
- Expand distance learning programs

Next Steps / Further Research

The body of research on direct-entry midwifery education lags far behind the research on nursing and medical education. Medical educators track the demographics of applicants,

matriculants and graduates (AAMC, 2010 & 2011b), but a lack of data collection for direct-entry midwifery schools hamstrings efforts to assess who applies to midwifery schools, who enrolls and who graduates. Further research needs to describe current efforts by MEP's to increase diversity in the applicants, student body and faculty and to assess the effectiveness of these efforts. An evidence-based model to increase diversity in a direct-entry program needs to be developed and evaluated after implementation in order to guide midwifery educators in their actions. Can an assessment tool be created to measure the cultural competence of the individuals in an institution? If so, does a high level of cultural competence correlate to greater retention of students of color? What challenges face students of other races and ethnicities, LGBT individuals, rural students, students for whom English is not a first language, students with disabilities and male students in midwifery school? Other basic questions about direct-entry midwifery remain unanswered – how many midwives are practicing in the U.S.? How do single mothers compare to their married counterparts in graduation rates? Do midwives of color serve proportionally more women of color than their white colleagues? The MANA Statistics project collects data, including race and ethnicity, from participating midwives and could be valuable in answering some of these questions. At any rate it is clear that more research is necessary to better understand the needs and concerns of students and midwives of color.

The urgency of this need is clear given that one stream of the modern midwifery movement advocates nationwide legalization and along with that, regulation and licensure. It is important to remember that regulation and licensure were used in the early 20th century to exclude black midwives in the South (Graninger, 1996), European immigrant midwives in the Northeast (Dawley, 2003, p. 87) and, in the late 20th century, rural Spanish-speaking *curandera-parteras* in the Southwest (Ortiz, 2005, p. 416) from practicing. As midwives fight for our right

to practice, how do we ensure that midwives of color, immigrants and midwives for whom English is not a first language are not criminalized? Clearly these midwives need to be involved in shaping the policies that may impact their ability to practice.

Conclusion

The original research question asked "what are the experiences of black women with midwifery education as students, midwives and educators of African American students?" The major objective of this project was to aggregate experiences with and opinions on midwifery education from African American midwives and educators. Participants' experiences of becoming and being midwives were shaped by societal racism, their route of midwifery education and valuing accessibility in midwifery care and education. Participants' recommended midwifery schools increase their accessibility to students of color. In order to attract and retain these students, midwifery schools should embrace multiculturalism, practice cultural competence, and provide greater financial support. However, midwives also noted that in order to make the profession attractive to students who are often single mothers and/or have financial challenges, sustainable employment models need to be developed and promoted during the training process. Additionally, they viewed accessible midwifery care as one important tool, among many, that would reduce racial and ethnic health disparities. They felt schools should reflect this goal in the education students receive. For midwifery schools which are typically small programs with limited budgets, the practicalities of implementing these recommendations may appear daunting. However, midwives of color have paved the way in many areas. They have created curricula that embrace multiculturalism and cultural competence. They have developed creative and flexible policies to help their students get through school, and they have created midwifery models that reduce health disparities. Further research needs to be done to assess the

efforts midwifery schools have already made in these areas and what resources and planning are required to make changes recommended here. Case studies of successful efforts would be particularly heartening to the midwifery community. This paper offers important insights into an ongoing conversation about improving midwifery education for students of color, increasing access to midwifery care and reducing health disparities.

Appendix A

Interview questions

- I'd like you to start by telling the story of how you became a midwife.

  PROBES:

  - When did you first learn about midwifery?
  - Why did you decide to become a midwife?

- Can you please describe your midwifery training/education for me?

  PROBES:

  - Which programs did you consider?
  - What were the pros and cons that you weighed?
  - What was your experience in your training?
  - Did your experience include any of the following: loneliness, frustration, a lack of social inclusion, or discrimination? Please expand on that.
  - Did your experience include any of the following: feelings of belonging, inclusion, respect, etc.?
  - Tell me about your faculty, preceptors, or mentors. How did they either support you and/or create barriers for you?

- What kinds of support systems did you have that helped you complete your training and education?
- Tell me about any experience you have with mentoring or training black students.
- What do you think would attract black students to the midwifery profession?
- What would help these students be successful in school and as practicing midwives?

PROBES

- What would you recommend to help black students complete their training and education?
- In your experience with students, what social barriers or challenges in their education prevented them from finishing?
  - Family support, financial reasons, feeling alienated, perceived discrimination

- What challenges do you face as a mentor or educator of African American students?
- As an African American midwife, what distinguishes your practice of midwifery from that of your white colleagues?
- Are there specific strategies that you would recommend for improving recruitment, retention and graduation of students of color?
- The literature on nursing and medical education recommends a number of strategies for improving recruitment, retention and graduation of students of color, I'm going to go through those on the list that you haven't already mentioned and ask you to reflect on the pros and cons of each of these strategies. The first is….

PROBES:

- Mentors – faculty, peers, community professionals
- Outreach to elementary, middle, high school, and community college students
- Scholarships
- Support groups
- Academic coaching

    - Which of these do you think would be helpful to black students in direct-entry midwifery education?

- Do you think politics in the national midwifery movement and large midwifery organization impacts students of color, and if so, how?
- Any final thoughts on improving direct-entry midwifery education to help recruit, retain, and graduate more black students?

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