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Alternative prenatal care interventions to alleviate Black–White maternal/infant health disparities

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Abstract

This paper attempts to forward the maternal health literature that critiques standard prenatal care in the United States by drawing on intersectionality, medicalization, and fundamental causation theories. We argue that these theories deepen our understanding of the maternal health experiences of Black women and can help explain why alternative prenatal care interventions have value for Black pregnant women. Alternative models of prenatal care, which include the use of midwives, doulas, and group prenatal care, are associated with equal or better health outcomes for infants and mothers compared to the standard prenatal model in the United States. We begin by drawing on these sociological perspectives to identify gaps in the maternal health literature that is critical of standard biomedical maternal health approaches. We then go on to describe select alternative methods of prenatal care and then provide a summary of the epidemiological literature as it relates to sociodemographic trends in usage and the relative effectiveness of alternative models compared to standard care. We conclude by arguing that a joint, critical application of these three theories can help scholars explain the utility of alternative interventions for African American maternal/infant health and can inform policies that aim to alleviate Black–White maternal/infant health disparities.

1 | INTRODUCTION

The US ranks behind 25 OECD countries for infant mortality (MacDorman, Matthews, Mohangoo, & Zeitlin, 2014) and has a maternal mortality rate that is higher than any other developed nation (Kassebaum et al., 2014). Women complain of long waits, rushed visits, and mechanistic, impersonal care (Novick, 2009). In a context of high socioeconomic and racial health disparities, low-income and racial/ethnic minority women are even more vulnerable to the ill effects of suboptimal care. African American women are particularly vulnerable, as they experience approximately twice the infant mortality rate (Kochanek, Murphy, Xu, & Tejada-Vera, 2016) and close to four times the maternal mortality rate of non-Hispanic women (Creanga et al., 2014). In a thorough review of racial/ethnic disparities in obstetric outcomes, Bryant, Worjolah, Caughey, and Washington (2010) found that non-Hispanic Black women had

consistently worse pregnancy and maternal outcomes along various measures, such as fetal death, preterm birth, maternal mortality, and maternal morbidity, than both non-Hispanic Whites and other racial/ethnic minorities. The authors concluded that prenatal care and social circumstances appear to be the strongest contributors to maternal mortality. In her overview of trends in infant mortality, fetal mortality, and preterm birth, MacDorman (2011) determined that non-Hispanic Black women are at the highest risk for these unfavorable birth outcomes. Moreover, Tucker, Berg, Callaghan, and Hsia (2007) discovered that although there were no differences between Black and White women in the prevalence of five specific pregnancy complications (preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum hemorrhage), Blacks were two to three times more likely than Whites to die from them. Given that the US has the highest prenatal care costs in the world and is the most expensive place to give birth (iFHP, 2015), its subpar maternal and infant health outcomes and high socioeconomic and racial maternal/infant health disparities are striking.

As a response to low quality prenatal care, women (primarily White) are increasingly utilizing alternative models of prenatal care as an adjunct to or replacement for traditional prenatal care. We define *alternative models of prenatal care* as comprehensive methods of childbirth preparation that go beyond the standard model of prenatal care, which involves regular one-on-one visits with an obstetrician at consistent, frequent intervals and culminates with a birth in a hospital setting. Our definition encompasses methods that are comprehensive in scope—i.e., methods that focus on the entire care experience for prenatal women. There are fewer comprehensive alternative strategies, such as hypnobirthing, prenatal yoga, and meditation, that have become popular in recent years to aid women in various aspects of the pregnancy experience. While many of these strategies are valuable techniques with demonstrated benefits, our focus is on methods that involve the delivery of physical and/or emotional care throughout the pregnancy process. We do not review the literature on birth centers as they represent a site of birth rather than a prenatal care approach. While patients who choose to deliver in a birth center may use the comprehensive alternative models discussed here, some may opt for a more traditional prenatal care approach that may involve, for example, standard prenatal care visits with an obstetrician.

This paper draws on key sociological theories to argue that the prenatal care structure in the US disadvantages pregnant women, particularly African Americans. It contends that alternative prenatal care interventions have greater value for Black pregnant women than the standard prenatal care model. We begin by drawing on intersectionality theory, medicalization theory, and fundamental causation theory to identify gaps in the maternal health literature critical of standard biomedical maternal health approaches. Thereafter, we describe select alternative methods of prenatal care and then provide a summary of the epidemiological literature as it relates to sociodemographic trends in usage and the relative effectiveness of alternative models compared to standard care. In doing so, we identify two primary dimensions by which alternative methods of prenatal care vary: caregiver type and one-on-one vs. group-based care. We regard midwives and doulas as two of the most important types of alternative caregivers that can help reduce Black-White health disparities. We conclude by arguing that a joint, critical application of these three theories can help scholars explain the utility of alternative interventions for minority women, particularly African Americans, and can inform policies that aim to alleviate many observed racial maternal/infant health disparities.

2 | SOCIOLOGICAL APPROACHES FOR THE STUDY OF AFRICAN AMERICAN MATERNAL HEALTH

2.1 | Intersectionality: Understanding the multilayered maternal health experiences of African American women

Intersectionality theory (Collins, 2002; Crenshaw, 1991), which recognizes that social constructs such as race, gender, and class cannot be considered in isolation but rather cohere to reproduce social inequality, serves as an important analytical tool for understanding African American women's multilayered maternal health experiences. The dominant

feminist perspectives (Lupton, 2012; Martin, 2001; Rothman, 1984) in the critical maternal health literature have acknowledged that the maternal health care system operates in a larger society that continues to situate men and women in a hierarchical paradigm, socially and biologically. These scholars (e.g., Lupton, 2012) have argued that medical discourse constructs women's bodies as treacherous territory, presenting pregnancy and birth as medical dilemmas.

While many maternal health scholars critical of standard care (Roberts, 2014; Rothman, 1984) recognize that race and class play an important role in shaping women's experience, by centrally focusing on gender, the literature has largely failed to systematically examine the simultaneous effects of various social determinants of health on women. While the dominant prenatal care model in the US fails to meet the needs of all women, minority women are particularly vulnerable to negative experiences in maternal care. Racial discrimination has been proffered as a major contributor to Black-White health disparities and has been shown to be associated with an increased risk for adverse infant and maternal health outcomes (Collins, David, Handler, Wall, & Andes, 2004; Collins et al., 2000; Giscombé & Lobel, 2005; Giurgescu, McFarlin, Lomax, Craddock, & Albrecht, 2011; Mustillo et al., 2004; Rosenberg, Palmer, Wise, Horton, & Corwin, 2002). There are three ways in which racial discrimination contributes to Black-White maternal health disparities. First, racial discrimination often arises in the clinical prenatal care encounter. The third wave of the *Listening to Mothers* survey, a national U.S. survey of women's childbearing experiences, (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013) revealed that about one in five Black and Hispanic women reported poor treatment from hospital staff due to their race, ethnicity, cultural background, and/or language. Second, racial discrimination affects pregnant women outside of the clinical encounter. Based on data from maternal perceptions of exposure to racial discrimination during pregnancy, Collins et al. (2004) concluded that racial discrimination could potentially lead to very low birth weight among African American infants. Finally, as Lu and Halfon (2003) noted, racial disparities in birth outcomes are not solely a consequence of differential exposure to racial discrimination during pregnancy. Rather, they are the effects of differential exposures that occur throughout the life course.

Because legacies of discrimination endure, in order to identify the most appropriate health care for African American women, it is necessary to situate African American women's maternal health experiences into a broader sociohistorical context. Historically, portrayals of African American women in the broader society have been and continue to be largely negative, involving pejorative images of Black women such as the "the mammy" figure, "the jezebel," and the "welfare-queen" (Collins, 2002). The "welfare queen," for example, is the hyper-image of a Black woman who refuses to work and illegally steals money from the government to live off the welfare system. The Reagan Administration used this image to disparage those who utilized welfare (Gilliam, 1999). Thus, gender stratification, racial discrimination, and low socioeconomic status oppress low-income minority women, rendering them disempowered in the overall U.S. healthcare system.

2.2 | Resisting medicalization ... or not: alternative prenatal care interventions to alleviate Black-White maternal health disparities

Numerous scholars have documented the historical development of the medicalization of pregnancy and childbirth (e.g., Barker, 1998; Oakley, 1980; Oakley, 1984). Major themes in analyses of medicalized birth concentrate on issues of control over women's reproductive choices, the site of birth, and the use of medical technologies (Brubaker & Dillaway, 2009). Feminists' critiques of medicalization (Davis-Floyd, 2004; Leavitt, 1986; Martin, 2001; Oakley, 1984; Probyn, 1993) have noted that medicalization has involved a shift in approach from viewing pregnancy as a natural process to framing it as a highly specialized and interventionist issue. Bringing pregnancy under the purview of biomedical logic has translated into the removal of the social and personal experience of pregnancy that fails to address the unique preferences of women (Oakley, 1984).

Maternal health scholars (Scamell, 2014) have identified risk discourse as an engine of the medicalization of pregnancy. As Scamell (2014) noted, risk discourse has played a critical role in the conceptualization of childbearing and childbirth in modern society. Medical professionals and the public at large treat risk designations and pregnancy

diagnoses as taken-for-granted, and the birthing options for women diagnosed as high-risk are restricted to medical interventions performed by obstetricians (Simonds, Rothman, & Norman, 2007). With an emphasis on and an expansion of risk terminology, birthing is constructed as pathological—a logic that is counter to the midwifery philosophy of care, which conceives pregnancy and birth as a natural life process. However, as Rose (1981) famously argued, pursuing a high-risk strategy of prevention can result in the medical community's medical surveillance of an increasing number of patients. A high degree of monitoring during pregnancy and birth is more likely to result in medical intervention (Welch, Schwartz, & Woloshin, 2011). Low-income women on Medicaid, a joint federal and state-sponsored program in the US that helps low-income individuals pay for health care costs, are particularly susceptible to such monitoring, as Medicaid does not typically cover alternative methods.

While maternal health scholars have contributed greatly to the understanding of the ways in which medicalization has affected pregnant and birthing women, they have tended to portray natural childbirth as best for all women, have understated the degree to which medicalization benefits women, and have neglected the ways in which women may embrace elements of a traditional biomedical approach to pregnancy and childbirth. According to Brubaker and Dillaway (2009), a strict adherence to the natural versus medical dichotomy fails to account for the complex variations in women's pregnancy and birth experiences, and Brubaker (2007) has shown in her research on African American teens' reproductive experiences that African Americans can embrace some facets of prenatal care while simultaneously resisting others. Women's preferences for their active involvement in pregnancy care decisions vary widely, with some women preferring to be highly involved and others preferring a more passive role (Harrison, Kushner, Benzie, Rempel, & Kimak, 2003). While an overemphasis in the US on risk and diagnosis may lead to the failure to consider the many other ways in which physicians should tailor their treatment to their patients, it is not clear that abandoning a risk-based perspective would improve maternal and infant health. A natural childbirth with low medical supervision and few medical interventions may not be best for some pregnant women, such as women who are pregnant with more than one child and those with severe health conditions. Thus, the degree to which women will resist the dominant prenatal care model will vary depending on their preferences and physical, familial, and social situations.

2.3 | Fundamental causation as an explanation for changing trends in the usage of alternative models

Numerous studies on the social determinants of health have identified socioeconomic status and race as fundamental causes for preventable health problems (Carpiano, Link, & Phelan, 2008; Link & Phelan, 1995; Phelan, Link, & Tehranifar, 2010). The fundamental cause thesis, proffered by medical sociologists Link and Phelan (1995), argues that health inequalities in mortality and morbidity are due to the unequal distribution of important resources, including money, power, and knowledge, that are vital for maintaining and improving health. When new knowledge, technologies, and interventions related to the causes and effective treatment of disease become available, more privileged individuals draw on their resources to avoid risk factors, take advantage of protective factors, and invest in treatments to sustain or improve their health advantage (Link & Phelan, 1995). Less advantaged populations face resource barriers that prevent them from acting in health enhancing ways. Multiple tests of the fundamental cause thesis have yielded support for the theory (Chang & Lauderdale, 2009; Link, Northridge, Phelan, & Ganz, 1998; Phelan, Link, Diez-Roux, Kawachi, & Levin, 2004; Polonijo & Carpiano, 2013; Rubin, Colen, & Link, 2010; Wang, Clouston, Rubin, Colen, & Link, 2012).

Maternal health scholars investigating alternative care methods have largely failed to engage with the fundamental cause perspective. As a result, they may succumb to narrowly focusing on gender, racial, or health care inequalities and, thus, risk devising down- or mid-stream solutions that fail to focus on the multidimensional needs of women, which include the biological, psychological, emotional, and social needs of pregnant and birthing women. Addressing these multifaceted needs is even more important for low-status individuals facing multiple types of resource disparities. As Lutfey and Freese (2005) demonstrated in their study of two diabetes clinics with different sociodemographic profiles, the resources that could be considered compensatory are typically made available to those who need them

the least (p. 1363). For example, the low rates of the use of midwives and doulas among African American women reflect the constrained socioeconomic, cultural, and social choices that they face (Rieker & Bird, 2000). Except for midwifery services, Medicaid and most private insurance plans do not typically support the cost of alternative health care services, thus making them prohibitive for low-income minorities. The cost of private practice doulas, for example, can range anywhere from \$300 to \$1,800 (Campbell, Lake, Falk, & Backstrand, 2006). A fundamental cause approach to maternal health acknowledges that women's choices are constrained and can identify the upstream determinants that affect these choices.

3 | ALTERNATIVE CAREGIVERS: THE ROLE OF MIDWIVES AND DOULAS IN PROVIDING PRENATAL CARE SUPPORT TO PREGNANT WOMEN

3.1 | The use of midwives to address the multidimensional needs of African American women

For much of American history, midwives—professionals trained to assist women in pregnancy, childbirth, and postpartum—attended births. This began to change in the 19th century due to the professionalization of obstetrics-gynecology, an effort involving doctors campaigning against the knowledge systems of midwives, which were informal and involved the use of homeopathic remedies and traditions. This resulted in a steep drop in the use of midwives, from approximately half of all births in 1900 to 15% in 1935 (Rooks, 2007, p. 24). Midwives follow a holistic model of care which goes beyond a sole focus on the physical needs of women to address their emotional and psychosocial needs (MANA, 2008).

African American midwives, termed “granny midwives” by some, played a dominant role in early midwifery and served the Black and White communities (Lee, 1996; Mongeau, Smith, & Maney, 1961; Robinson, 1984; Schwartz, 2006; Smith & Holmes, 1996). The medicalization of obstetrics-gynecology led to a decline in African American midwives serving both White and non-White communities (Fraser, 2009). Today, Black midwives represent only 3–4% of all midwives (Schuiling, Sipe, & Fullerton, 2013; Sipe, Fullerton, & Schuiling, 2009). While there appear to be no racial disparities in women's use of CNMs, Whites predominately use “other midwives” (Declercq, 2015), which results in higher rates in overall usage of midwives among Whites.

Midwifery's multifaceted view of the needs of women contrasts with the biomedical model, which focuses solely on the physical needs of women and is intervention-based. There is a large body of literature that supports midwifery care both in and out of the hospital as a safe and viable option. Among low-risk and moderate-risk mothers, midwives are associated with lower rates of medical interventions that produce outcomes equivalent to or better than conventional care with obstetricians (Cragin & Kennedy, 2006; Johnson & Daviss, 2005). In a systematic review of 11 studies comparing the outcomes of CNMs and physicians' care during labor and delivery, Johantgen et al. (2012) found that CNMs achieve similar or even better outcomes than physicians despite not using technological interventions during delivery. Several scholars (Benatar, Garrett, Howell, & Palmer, 2013; Johnson & Daviss, 2005; Stapleton, Osborne, & Illuzzi, 2013; Wax et al., 2010) have discovered that low-risk women delivering outside of hospitals experience fewer interventions and similar intrapartum fetal mortality and neonatal mortality rates compared to their counterparts delivering in hospitals.

3.2 | Doulas: Social support during pregnancy and birth

Doulas, or labor support professionals, provide various forms of support to pregnant mothers, including providing educational information during the last trimester of pregnancy, offering words of support in the last stages of pregnancy and during delivery, giving advice about birthing positions and breathing techniques during delivery, and providing other forms of emotional and social support during delivery (Klaus, Kennell, & Klaus, 2012; Simkin, 1995; Thornton & Lilford, 1994). Doulas can work in hospitals, birth centers, communities, or home settings. We include

doulas as an alternative caregiver for two reasons. First, their philosophy of care is similar to that of midwives in that they emphasize the overall well-being of women rather than focus solely on the biological needs of birthing women. Second, doulas constitute atypical care professionals for pregnant women in the US. While their philosophy is similar to that of midwives, doulas are different in that they do not deliver clinical care but instead focus on the non-clinical care needs of pregnant women (Thornton & Lilford, 1994; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1996).

Doulas have been on the rise in the US and other Western contexts in recent decades (Pascali-Bonaro & Kroeger, 2004; Steel, Frawley, Adams, & Diezel, 2015). Many countries, such as the United Kingdom, Switzerland, and Canada, have professional doula associations; those without such professional associations instead have an informal base of less-organized doula workers. Results from the second and third waves of the *Listening to Mothers* survey showed an increase in the use of doulas in the US from 3% in 2006 to 6% in 2012 (Declercq, Sakala, Corry, & Applebaum, 2006; Declercq et al., 2013). While the use of doulas has increased, it has not increased uniformly across groups. A U.S. cross-sectional national survey of over 600 doulas showed that while the vast majority (93.8%) of doulas were White, only 6% of their clients were African American (Lantz, Low, Varkey, & Watson, 2005). In addition, only 2.6% of doulas identified as African American (Lantz et al., 2005).

In a review of 22 randomized controlled trials conducted in 16 countries that examined continuous labor support for women giving birth, Hodnett, Gates, Hofmeyr, and Sakala (2012) found that women with continuous labor support were more likely to give birth without the aid of medical interventions, such as vacuum or forceps-assisted births and Caesarean sections, less likely to use pain medications, and more likely to be satisfied with their birth compared to usual care without any adverse effects. Research on women's perceptions of doulas has also supported doula use, as women who use continuous labor support report positive birth experiences (Campero et al., 1998; Deitrick & Draves, 2008; Gentry, Nolte, Gonzalez, Pearson, & Ivey, 2010; Koumouitzes-Douvia & Carr, 2006). There is some evidence that doulas can serve an important role for low-income minority women by helping them overcome barriers to quality care and by enhancing their personal agency (Kozhimannil, Vogelsang, Hardeman, & Prasad, 2016). Women's more positive birth experiences with doulas may be due to doulas' woman-centered motivations, which may result in fewer institutional preoccupations compared to other maternal health professionals (Campbell-Voytal, McComish, Visger, Rowland, & Kelleher, 2011; Hardeman & Kozhimannil, 2016). Like midwives, minority doulas express a desire to support their racial/ethnic communities through their work (Hardeman & Kozhimannil, 2016). The benefits of doulas for pregnant women exist despite their degree of marginalization in the formal health care system relative to doctors, midwives, or even lactation consultants (Torres, 2013).

4 | GROUP-BASED CARE: SOCIAL CAPITAL FOR AFRICAN AMERICAN WOMEN DURING PREGNANCY

We regard group prenatal care philosophy as an alternative form of care because it deviates in scope from the traditional prenatal care model in the US. Group prenatal care aims to educate women about pregnancy and childbirth in a group setting, with the goal of empowering patients to take control of their own health. Women are educated and supported not only by a health professional but also by other women, which makes this form of prenatal care distinctive. One of the most popular forms of group prenatal care is Centering Pregnancy (Rising, 1998; Rising, Kennedy, & Klima, 2004). In this form of group-based care, women attend approximately 10 sessions with a group of women (approximately 8–12) of similar gestational age (Rising et al., 2004). Each session involves a physical with a provider, which is followed by a group discussion with the provider (Rising et al., 2004).

Existing literature reviews on the relative effectiveness of group prenatal care compared to standard care have shown that group care is equal or superior to traditional prenatal care in terms of perinatal outcomes (Ruiz-Mirazo, Lopez-Yarto, & McDonald, 2012; Thielen, 2012). Research on the effects of group prenatal care have primarily focused on high-risk groups and have demonstrated benefits for these populations, including lower rates of preterm birth (Ickovics et al., 2007; Picklesimer, Billings, Hale, Blackhurst, & Covington-Kolb, 2012), improved health care

utilization (Tandon, Cluxton-Keller, Colon, Vega, & Alonso, 2013; Trudnak, Arboleda, Kirby, & Perrin, 2013), greater levels of personal engagement in care (Novick et al., 2010; Tandon et al., 2013; Trudnak et al., 2013), and the delivery of social support (McNeil et al., 2012; Novick et al., 2010) compared to standard care. Social support has been discussed as a key aspect of group prenatal care that can reduce stress levels among pregnant women and provide them with a more positive pregnancy experience (Rising et al., 2004). Research has shown that various forms of stress, including racism-induced stress, among pregnant African American women are high and that these stress levels negatively affect African American women's birth outcomes (Collins et al., 1998; Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008; Dominguez, Schetter, Mancuso, Rini, & Hobel, 2005; Giurgescu et al., 2012). Therefore, social support is an important benefit for African Americans.

Unlike other alternative models of prenatal care, African Americans and Hispanic women are more likely than White women to participate in-group prenatal care (Declercq et al., 2013). A reason for this higher participation may be minorities' history of reliance on their in-group for various types of needs, including health-related needs. Research suggests that racial socialization and racial identity can promote resilience among African Americans (Brown, 2008; Miller, 1999; Miller & MacIntosh, 1999; Neblett, Philip, Cogburn, & Sellers, 2006). Therefore, group-based care may benefit racial minorities by contributing to a sense of collective identity grounded in a common racial heritage. By taking advantage of group-based care, minorities, low-income women, and other marginalized groups who may feel uncomfortable asking questions and expressing their concerns about pregnancy with an obstetrician (who, typically, is a White male) may be more comfortable in a setting with women of similar gestational age and socioeconomic/racial status.

5 | ALTERNATIVE PRENATAL CARE MODELS: A WAY FORWARD FOR IMPROVED AFRICAN AMERICAN MATERNAL AND INFANT HEALTH

When applied to maternal health, insights from the intersectionality, medicalization, and fundamental causes literatures make sense of the epidemiological research showing that alternative prenatal care models can benefit pregnant African American women more so than the standard approach to prenatal care. Intersectionality is a broad framework through which to examine how the multiple vulnerabilities African American women face cohere to construct a uniquely disadvantaged pregnancy experience. Other racial groups experience many of these vulnerabilities. For example, American Indians and Alaska Natives have worse outcomes along multiple measures of maternal and infant health compared to Whites, although in general, these outcomes are slightly better than those faced by African Americans (Bryant et al., 2010). What differentiates African Americans from other minorities is that research (Lee & Bean, 2007; Lee & Bean, 2010; Massey & Denton, 1993; Oliver & Shapiro, 1995; Parisi, Lichter, & Taquino, 2011; Quillian & Campbell, 2003) in the areas of income and wealth inequality, residential segregation, social networks, and interracial relationships has shown that Blacks have been slower to integrate into American society compared to other minorities. Race scholars refer to this as "Black exceptionalism" (Gans, 2005; Lee & Bean, 2007; Lee & Bean, 2010; Parisi et al., 2011), which pertains to how racial boundaries are fading more rapidly for non-Black minorities compared to Blacks.

There are two public health policy implications of Black exceptionalism for African Americans. First, they need to be viewed as a priority in policy changes concerning maternal health care. Second, policymakers should avoid a "one-size-fits-all" policy approach and instead tailor strategies for the needs of African American women. We argue that in devising maternal health policies geared toward African Americans, policymakers should take a holistic perspective that recognizes that the multiple disadvantages that African Americans face are tightly interwoven and require a multipronged approach. The biomedical model is narrow and assumes that most women have similar needs; because of this, women go through a highly similar monitoring process. This may have negative consequences for African Americans, as research (Ting-Toomey et al., 2000) has demonstrated that African Americans maintain a strong cultural connection to their community, which may lead to culturally-specific maternal health needs. Because not all aspects of

the biomedical model have adverse maternal health impacts for African American women, health policies need not abandon biomedical solutions entirely but instead should offer women a range of options.

Phelan et al. (2010) discussed three types of policies that can be used to effectively combat health inequalities: the reduction of resource inequities, contextualizing risk factors, and creating interventions that can benefit people at any level of socioeconomic status (p. S37). While policies involving alternative maternal health interventions cannot eliminate resource inequities, we argue that such policies can take the form of the latter two strategies to resist fundamental cause processes. Policies that contextualize risk factors intervene to address the factors that put people "at risk of risks" (Phelan et al., 2010, p. S37). By giving minority women a voice and targeting their multifaceted health needs, alternative maternal health interventions make it more likely that minority women will stay committed to their prenatal care. Alternative interventions can be used to accomplish the third strategy through legislation, which will in turn permit reimbursement for services that have been demonstrated to have positive effects on maternal/infant health. In addition, other federal-level policies, such as programs to support the training of Black midwives and doulas, should be developed to facilitate the delivery of alternative services for needy communities. We do not argue that these types of policies can break the links between status, race, and maternal health; however, we do believe they can weaken them.

Sword (1999) constructed a multifaceted socio-ecological model for conceptualizing the barriers to prenatal care for vulnerable women. This framework recognizes patient utilization as a product of "two interacting systems": individual-level behavior, which is affected by personal and situational attributes, and the characteristics of health services and programs, which are influenced by various agency-level and contextual influences (Sword, 1999, p. 1173). Social networks, community factors, and public policies concerning maternal and infant health shape both systems (Sword, 1999). Policies that incorporate the use of alternative prenatal care methods have the potential to address the broader external factors that affect the way pregnant women navigate pregnancy and the way agencies offer prenatal services. For example, national-level policies that seek to educate African American women about group-based care and provide financial support for the use of these services can give women the social support they may be lacking.

6 | CONCLUSION

In this paper, we proposed three sociological bodies of literature that can improve critical analyses of standard prenatal care and help scholars understand the utility of alternative models of prenatal care for African American women. Intersectionality, in particular, allows us to position African American women in the broader socio-historical institutional milieu to understand how their marginalization may affect their pregnancy and childbirth experiences. While intersectionality has been used to study a wide variety of topics, few scholars have investigated how the intersections of gender, race, and class contribute to African American women's maternal health (Roberts, 2014).

More research is needed to explore the reasons why minority women fail to use alternative caregivers, investigating barriers such as unfamiliarity with alternatives to obstetricians, financial constraints, a lack of access to alternative caregivers in their geographical area, and a lack of access to minority alternative caregivers, among others. Research should also investigate the professional challenges facing minority doulas and midwives, as these challenges may prevent minority women from utilizing alternative caregivers, which in turn may affect the maternal and infant health benefits discussed in this paper associated with the use of midwives and doulas.

We believe these models have added value—specifically for African Americans—and, as such, can contribute to the narrowing of Black-White maternal/infant health disparities. Although our discussion focused on applying these theories to African Americans, future research and theorizing should investigate how the theories discussed here can apply to the maternal health situation of different ethnic groups. Hispanics, for example, have maternal/infant health outcomes similar to Whites (Bryant et al., 2010). However, as the immigrant health paradox has demonstrated, their maternal/infant health declines the longer they reside in the US. We stress that all racial/ethnic groups in the US are

disadvantaged by the prenatal care system; thus, alternative interventions should be promoted to all populations. Other countries facing socioeconomic and/or racial maternal/infant health disparities can utilize our proposed framework to forward sociological research in maternal health in their respective countries. Finally, we cannot conclude from the literature that alternative methods can work for women considered high-risk from a biomedical perspective, as there is sparse research on the benefits of alternative models for this population. Future research should be conducted to determine the value of these methods for high-risk women with the goal of providing recommendations for the best services for these women.

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