Home Is Where the Birth Is: 
Race, Risk, and Labor During COVID-19

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On April 28, 2020, Dr. W. Spencer McClelland—an obstetrician at New York City’s Lenox Hill Hospital—published an editorial in The New York Times that announced, “If you planned on delivering in a New York City hospital, don’t change your plans.” McClelland’s plea was a response to an outpouring of news reports focused on pregnant people navigating a fundamentally changed medical landscape: COVID-19 had inaugurated new hospital rules barring birth partners and birth workers from delivery rooms and encouraging prenatal telemedicine.

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described by one journalist as creating a “DIY pregnancy.” The Centers for Disease Control and Prevention (CDC) had even recommended that mothers with “confirmed or suspected COVID-19” be “temporarily” separated from their newborns, even as it affirmed that “the ideal setting for care of a healthy, term newborn while in the hospital is in the mother’s room,” guidelines that were changed again by October 2020. McClelland was also responding to the particular crisis facing New York City as it struggled to “flatten the curve.” Namely, that the hospital—or what one journalist dubbed the “Covid hospital” came to be associated with a dire lack of protective equipment, leaving frontline workers and patients dangerously vulnerable.

That same month, news outlets reported that midwives were swamped with requests for home births, the very birthing practice that had previously been associated with risk and danger. The founder of Black Breastfeeding Week, Kimberly Sears Allers, noted, “Women across the country are panic shopping doulas and midwives for home births and desperately calling birthing centers, overwhelming people and systems that are built on relationship-building during the pregnancy period, not last minute additions.” Hospitals, in turn, began to

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5. For more on the term “flatten the curve” and its circulation, particularly in the United States in March and April 2020, see, for example, Siobhan Roberts, Flattening the Coronavirus Curve, N.Y. TIMES (Mar. 27, 2020), https://www.nytimes.com/article/flatten-curve-coronavirus.html [https://perma.cc/Q8P5-64RZ].


emphatically reassert their status as the safest place to deliver a baby.9 McClelland insisted, “While this is a world-shaking time, we will take the same care of you as we always have.”10

In the very moment that McClelland penned an editorial promising that the hospital would extend “care” to perinatal patients, New York City was coming to terms with a widely circulated and deeply tragic story of a Black pregnant woman’s death in the hospital. A few days before McClelland’s editorial was published, Amber Rose Isaac died at Montefiore Medical Center in the Bronx. Her pregnancy had been marked by complications and by medical neglect. In fact, a few days before the emergency C-section which led to her death, she had tweeted: “Can’t wait to write a tell all about my experience during my last two trimesters dealing with incompetent doctors at Montefiore.”11 Isaac’s case—alongside Sha-Asia Washington’s death at Woodhull Medical Center in Brooklyn in July and Cordielle Street’s death in March after complications from her delivery—are a testimony to the racial maternal health disparities the New York City Department of Health had found. Black women in New York City were eight times more likely than white women to die from pregnancy-related causes.12 In a moment in which new legal, medical, and popular attention turned to Black maternal death in the hospital, how might we critically engage McClelland’s insistence that the hospital can confer care and safety on its perinatal patients, particularly given the dual crises facing Black women—the

9. See generally Ayres-Brown, supra note 7 (“During the COVID-19 pandemic, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine have issued statements reassuring pregnant women that accredited hospitals are still secure spaces for giving birth.”); de Freytas-Tamura, supra note 6 (“N.Y. U. Langone [Hospital] . . . said it had adopted practices to keep pregnant women safe and has ‘continued to provide uninterrupted services to mothers scheduled to deliver at the hospital.’”).

10. The American Academy of Pediatrics also issued a formal statement on home birth urging doctors to remind families of “the factors that increase the risks of home birth” and reminding them that “[i]f a medical emergency does arise during birth at home, families should also be aware of the very real risk that emergency transport services could be unavailable due to the coronavirus response.” Alyson Sulaski Wyckoff, AAP Does Not Recommend Home Births, But Offers Guidance, AM. ACAD. PEDIATRICS NEWS (Apr. 20, 2020), https://www.aappublications.org/news/2020/04/20/homebirths042020 [https://perma.cc/4YSA-YCU].

11. Irin Carmon, When Your Zip Code Determines Whether You Live or Die, N.Y. MAG. (May 5, 2020), https://nymag.com/intelligencer/2020/05/when-your-zip-code-determines-whether-you-live-or-die.html [https://perma.cc/3BLT-PTVK] (quoting Amber Rose Isaac). Carmon notes: Isaac was worried about doctors’ replacing her in-person prenatal visits with video calls, a now-common practice to limit exposure during the pandemic, and begged her doctors to see her in person. When they finally did for the first time in roughly two months, doctors discovered her platelet levels were low. Within four days of her tweet, Isaac had given birth to a son at that Bronx hospital but lost her own life to a rare pregnancy complication. “She bled out,” said [her partner].

Id.

realities of Black maternal mortality and the pandemic’s disproportionate deadly
effects on Black communities?

This Article explores a temporal window—the rapid spread of COVID-19 in
the United States in the spring of 2020—when cultural ideas about risk,
pregnancy, institutionalized medicine, and race changed dramatically, most
visibly, I argue, around home birth, and where those cultural shifts collided with
the legal status of home birth and midwifery. By describing a dramatic cultural
shift in the conception of home birth, I refer to the ubiquitous, popular
representation of the birthing practice in mainstream media as a reasonable and
even responsible maternal response to COVID-19’s threat and to the association
of the hospital with threat and even death. In mapping the swift transformation
of home birth from a sign of risk to a symbol of parental responsibility, this
Article focuses on the complex racial politics that have swirled around home
birth. In particular, I bring a Black feminist lens to bear on home birth, probing
how reproductive justice advocates have long adopted a view of the hospital as
a site of death for Black women and their children and promoted home birth as
a viable and even life-saving practice for Black mothers. These advocates, such
as Demetra Seriki (the only Black home birth midwife in Colorado), emphasize
that “[e]very time you walk into a hospital as a black woman to give birth, you’re
rolling the dice.”

The last five years have been marked by sustained popular and political
attention to what Linda Villarosa termed the “life or death crisis” facing Black
mothers and children:

Black infants in America are now more than twice as likely to die as
white infants—11.3 per 1,000 black babies, compared with 4.9 per
1,000 white babies, according to the most recent government data—a
racial disparity that is actually wider than in 1850, 15 years before the
end of slavery, when most black women were considered chattel. In one
year, that racial gap adds up to more than 4,000 lost black babies.

This journalistic outpouring has had myriad results including new legislative
attention to Black maternal health (albeit with little change in Black maternal


health outcomes), the new visibility of Black birth-workers as life-saving bodyguards, and a new attention to the possibility of assisted home birth as a way of circumventing the deathly territory of the hospital. Yet the Black feminist advocacy of home birth that emerges from this perspective—one that sees the hospital as a death world for Black mothers and children and the home as a refuge from medical racism—has not shaped or informed popular, journalistic, or even public health conversations about the popularization of home birth during COVID-19.

In this Article, I explore the racialized, gendered, and classed caste system law and medicine have collaboratively established. The caste system that stratifies midwives—much like the caste system that marks other forms of birthwork—has made possible home birth’s new association with risk mitigation and good mothering during COVID-19. This same caste system has made it impossible for Black women to successfully argue for the necessity of home birth as they face the death world of the hospital in the years (and even decades) before COVID-19. I trace how the risk imagined inherent to home birth pre-COVID-19 is a risk imagined to attach to midwives, and how midwifery is governed by an intense legal classification system that champions and protects midwives who are most medicalized and most able to access formal credentials and leaves the Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services (MOMMIES) Act to extend Medicaid coverage—which was required to last sixty days following birth, though some states had longer periods of coverage—for postpartum women to a year after giving birth and explicitly supported “services that are proven to positively impact maternal health outcomes for black women” including doulas and midwives. See Press Release, Senator Cory Booker, Ahead of Mother’s Day, Booker, Pressley, Colleagues Introduce Bill to Improve Maternal Health Outcomes (May 8, 2019), https://www.booker.senate.gov/news/press-ahead-of-mother-and-squoos-day-booker-pressley-colleagues-introduce-bill-to-improve-maternal-health-outcomes [https://perma.cc/XFY2-SF35].

16. Despite the proliferation of popular attention and national, state, and local legislative interventions, the CDC’s May 2019 report on maternal mortality found that racial disparities in maternal mortality have not changed and might have even worsened. See Roni Caryn Rabin, Huge Racial Disparities Found in Deaths Linked to Pregnancy, N.Y. TIMES (May 7, 2019), https://www.nytimes.com/2019/05/07/health/pregnancy-deaths.html [https://perma.cc/B596-JRN].


19. For more on the idea of the “COVID hospital” in a global context, see Nandini Archer and Claire Provost, Top Doctors and Lawyers Condemn ‘Shocking’ Treatment of Women in Childbirth During COVID-19, OPENDEMOCRACY (July 16, 2020), https://www.opendemocracy.net/en/5050/doctors-lawyers-condemn-shocking-treatment-childbirth-covid [https://perma.cc/38VR-92TX] (“Since March, openDemocracy has identified cases of ‘traumatic’ experiences in at least 45 countries that contravene World Health Organization (WHO) guidance, and some national laws. In at least six countries, pregnant women have also died after COVID-19 restrictions reportedly prevented or delayed access to emergency services.”).
exposed and vulnerable (and deems risky) those most outside conventional medicine. My impulse here is not to advocate for home birthing as the solution to the problems of the present, but instead to think carefully about the racial logics that undergird the conditions of the present and to examine the challenges the present moment poses for feminist legal theory and practice. My analysis departs from scholarly work that emphasizes that the problem of the present can be solved through the licensure of non-nurse midwives or through increased legal regulation and recognition of the profession.20 Instead, I seek to show how even a form of birthing often hailed as feminist, as outside of the patriarchal strictures of the hospital, is marked by its own racial and class hierarchies entrenched by the law’s mandates of credentialization and certification. It was only when this seemingly outsider form of birthing could be harnessed to satisfy neoliberal mandates of individual commitment to risk mitigation that home birthing could be reimagined not as risky but as responsible, not as dangerous but as desirable.

This Article unfolds in three parts. First, I argue that the contemporary U.S. birth landscape has been rewritten by COVID-19, which has remade home birth into a responsible perinatal practice by making the task of “staying healthy” one that belongs to individual perinatal citizens rather than to the state. Second, I argue that this labor has happened through a fundamental resignification of the home as territory that is not domestic or private, but instead committed to risk mitigation. This vision of the home as office, school, and delivery room—as spaces where we “shelter in place” for our safety—hinges on the physical space and comfort of the home, on a vision of plentitude available only to certain citizens. Yet, I argue this presumption of home as the antithesis of death, as a place where we stay to avoid illness, has largely circulated as a result of COVID-19 and the uncertainty and precarity it has generated, rather than the long-standing Black feminist critiques of home as the opposite of the hospital, home as a refuge from obstetric violence and medical racism. Finally, I trace how the risk imagined inherent to home birth pre-COVID-19 has been a risk imagined to attach to midwives. Midwifery is governed by an intense legal classification system that champions and protects midwives who are most medicalized and most able to access formal credentials, and leaves exposed and vulnerable (and deems risky) those most outside conventional medicine, those most tethered to birthing in spaces outside of the hospital, often precisely because of their sense that the hospital is not safe. I trace how law has left wholly unprotected midwives who champion home birth as a practice of bodily integrity and safety, or even of racial justice.

I. RISK AND PERINATAL LIFE

COVID-19 has opened up a moment where the hospital is now widely viewed as a death world, despite a long period of intense Black feminist activism around the antiBlack outcomes of the hospital for Black mothers and children. How has home birth been able to move from reviled to responsible through white maternal bodies, despite

[A] segment of black people—midwives, reproductive rights activists, civilians—who are committed to offering home births as a safe option for their peers, particularly now, during crises that have laid bare the stark inequities in the medical system and the stress that comes with being black in this country?²¹

And what does it mean that home birth is described as a racially unmarked risk-mitigation strategy during COVID-19 when a recent study of pregnant women in Philadelphia finds that Black and Latina pregnant women are five times as likely as white pregnant women to have been exposed to COVID-19?²² On one hand, reproductive justice activists have sought to mitigate the deathly antiBlack obstetric violence that hospitals inflict on Black mothers and children by advocating home birth, and yet the discourse of home birthing in a time of COVID-19 has championed (white) mothers as responsible, flexible citizens responding to the conditions of the present by yielding to the full remaking of the home.

Indeed, since the beginning of the sustained national attention to COVID-19’s rapid spread in the United States, nearly every major newspaper in the country—The New York Times, The Los Angeles Times, The Star Tribune, The Washington Post, Chicago Tribune, and The Wall Street Journal—has reported on the particular threats faced by pregnant people contending with the material realities of illness and hospital rules ostensibly designed to protect patients but effectively limiting access to the delivery room by restricting partners and birth workers. These news outlets have represented home birth as an increasingly legitimate option for pregnant people facing the “Covid hospital” and frightening restrictions on birth partners and doulas. National Geographic and The Chicago Tribune both featured photo spreads of home births (a later National Geographic article focused on “giving birth in a time of death”).²³ The Wall Street Journal

²³ Amy Davis, Home Births During Coronavirus Pandemic: Photos, CHI. TRIB. (May 8, 2020),
described COVID-19 as presenting mothers with “tough choices.” And USA Today described hospitals as “transformed into coronavirus battle stations,” and interviewed mothers who were “grateful that [they] have this option [of home birth].” The Washington Post published a celebratory narrative of a mother who decided to home birth because she “feared my newborn and I might catch the virus from the hospital,” and continues, “To my surprise, my delivery was not lonely or alienating. Instead, it felt like the most communal experience of individual accomplishment I have ever pulled off.” The ubiquity of home birth’s appearance in national media suggests both the extent to which perinatal bodies became a kind of ground zero for conversations about COVID-19’s threat and the representation of home birth as a reasonable response to the threat of the hospital.

Perinatal life in the United States is marked by an elaborate taxonomy of risk, and there has long been debate about where birthing at home falls in that scheme. Some perinatal practices are hailed as virtuous, safe, and healthy. Others are denigrated as dangerous and even as producing future generations of unhealthy citizens. Good perinatal citizens are those who access ample prenatal care, seek hospital deliveries, and comply with the American Pediatrics Association’s (APA) recommendation of six months of exclusive breastfeeding. These are conceptions of perinatal life that, of course, privilege


27. Sociologist Miranda Waggoner argues that the idea of risk mitigation even extends to a time she calls “pre-pregnancy” or the “zero trimester” when “women are urged to prepare their bodies for a healthy pregnancy.” She writes, Pre-pregnancy care is a framework that emerged as the new panacea for ensuring healthy pregnancies and healthy infants in the United States in the twenty-first century. To have good pre-pregnancy health is to render pregnancy less risky, the thinking goes, and might improve the overall health of women, children, and society.


affluent parents whose economic plentitude allows them access to parental leave, to lactation consultants, and to baby friendly hospitals that routinely “bypass” Black communities. Because the notion of risk disproportionately attaches to Black women, Black mothers bear the particularly heavy weight of having any portion of their perinatal lives deemed dangerous, and even, as Dorothy Roberts reminds us, criminal. And, at the same time, their devastating maternal mortality rates have made birth—particularly hospital birth—a risky proposition, newly visible as risky in light of COVID-19 and shifts in popular conversations engendered by Black Lives Matter.

In the wake of COVID-19, home birthing has received considerable journalistic and popular attention as a birthing practice that should be seriously considered since the hospital is now marked as a site of illness and death for birthers, even as it has long been marked as such for Black women. Before COVID-19, home birthing was a relatively unpopular practice in the United States: approximately 35,000 births a year—or less than 1% of all births—unfolded at home. Government data suggests that the practice has grown modestly in popularity even before COVID-19. From 2004 to 2009, home births increased by 29%, perhaps because of the growing attention to the United States’ staggering high C-section rates. Home birth’s modest growth has been largely driven by the shifting interests and commitments of white women,

31. See Committee Opinion No. 697: Planned Home Birth, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Apr. 2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/planned-home-birth [https://perma.cc/D76Y-KG9E]; see also Bridget Richardson, The Regulation of Midwifery, 8 GEO. J.L. & PUB. POL’Y, 489, 489 (2010) (“For the first 100 years or so of our history, childbirth took place at home with the assistance of a midwife and/or female members of the pregnant woman’s family. But at the beginning of the 20th century, two major events occurred which dramatically changed the way women give birth in the United States. The first was a change in location of childbirth from the home to hospitals. The second was a change in the childbirth facilitator from midwives to physicians.”); U.S. DEP’T OF HEALTH & HUM. SERVS., DHHS PUBL’N NO. (PHS) 94-1918, MIDWIFE AND OUT-OF-HOSPITAL DELIVERIES, UNITED STATES (1984).
particularly affluent white women, who have turned to non-medicalized or quasi-medicalized birthing options to secure better health outcomes and increased birthing autonomy, and who have been largely able to do so free from the stigma of irresponsibility. Danielle Thompson writes (well before COVID-19), “White women are and probably will continue to be the primary movers of birth from the hospital back into the home and back into the hands of midwives.”

As a birthing practice, home birth remains shaped by race, class, and geography: 1.75% of white women in 2010 delivered outside of formal medicalized spaces, while only .48% Black women and .41% of Latinx women delivered outside of formal medicalized spaces. Home birth is also a geographically specific practice, practiced the most in the Northwest United States (Oregon, Montana, Idaho, Washington) and least in the Northeast (New Jersey, Rhode Island, Massachusetts, Delaware) and the Southeast (Texas, North Carolina). The geographical variation in home birthing reflects the tremendous state variation in birthing experiences, regulations, and outcomes in the United States more generally. We live in a country where the difference between delivering a baby in neighboring states can mean the difference between delivering a baby in a state that has a 22.7% C-section rate or a 33.8% C-section rate—as in Utah and Nevada, respectively.

Home birth’s relative unpopularity in the United States can be attributed to sustained collaborative efforts by law and medicine to mark the hospital as the safest place to deliver a baby. A host of organizations—ranging from the American Medical Association (AMA) to the American College of Obstetrics and Gynecologists (ACOG)—worked to limit access to home births in the United States and to limit the work of some midwives. Since the majority of home births are attended by midwives (in this Article, I do not discuss “unassisted births,” often colloquially described as “freebirth”), home births are marked not just by their anti-medical locations, but also by the participation of professionals who have complex relationships with medicalization. In 2008, ACOG affirmed its “long-standing opposition to home births” and emphasized that it “does not

34. Danielle Thompson, Midwives and Pregnant Women of Color: Why We Need to Understand Intersectional Changes in Midwifery to Reclaim Home Birth, 6 COLUM. J. RACE & L. 27, 44 (2016).
36. See MacDorman, Matthews & Declercq, supra note 35.
37. Cesarean Delivery Rate by State, supra note 33.
38. The CDC reports that “in 2009, 62% of home births were attended by midwives: 19% by certified nurse midwives and 43% by other midwives (such as certified professional midwives or direct-entry midwives).” MacDorman et al., Home Births in the United States, 1990-2009, supra note 35.
support programs that advocate for, or individuals who provide, home births.”

That same year, the AMA affirmed a similar policy, noting their support for “state legislation that helps ensure safe deliveries and healthy babies by acknowledging of the concept that the safest space for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG.”

In 2017, ACOG revised its assessment to note that “each woman has the right to make a medically informed decision about delivery,” but “hospitals and accredited birth centers are the safest settings for birth.” They emphasize that women interested in home birth should be aware of its potential risks, including the increased possibility of perinatal death. Thus, prior to COVID-19, home birth has been marked as a risky and undesirable birthing practice.

Despite a legal structure designed to promote hospital births and medicalized midwives, COVID-19 fundamentally rewrote—or continues to rewrite—the meaning of home birth. Now, as we transform our dining room tables into home schools, our bathrooms into therapist offices, and our living rooms into doctor offices to access “telemedicine,” it is deemed a responsible sign of a commitment to maternal and infant health, instead of a risky choice, to remake our bathrooms into birthing suites.


40. Rachel Walden, AMA’s Resolution on Homebirth, OUR BODIES OURSELVES (June 23, 2008), https://www.ourbodiesourselves.org/2008/06/amas-resolution-on-homebirth [https://perma.cc/849F-DQJP] (quoting the AMA resolution). However, the CDC reports that home birth is less risky than hospital birth: “The percentage of home births that were preterm was 6%, compared with 12% for hospital births. The percentage of home births that were low birthweight was 4%, compared with 8% for hospital births. Less than 1% of home births were multiple deliveries, compared with 3.5% of hospital births. The lower risk profile of home births suggests that home birth attendants are selecting low-risk women as candidates for home birth.” MacDorman et al., Home Births in the United States, 1990-2009, supra note 35. Several researchers from Canada and the United Kingdom have also suggested that home birth is not less risky. See Hutton et al., Perinatal or Neonatal Mortality Among Women Who Intend at the Onset of Labour to Give Birth at Home Compared to Women of Low Obstetrical Risk Who Intend to Give Birth in Hospital: A Systematic Review and Meta-Analyses, 14 ECLINICALMEDICINE 59, 59-70 (2019). Thus, the topic remains an area of scientific disagreement.

41. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, supra note 31.


II. THE SHIFTING MEANINGS OF HOME

In this section, I argue that the key to understanding home birth’s shifting cultural status during COVID-19 is understanding the complete and rapid refiguration of the meaning of home, a refiguration which interrupts the private/public binary around which so much of feminist legal theory has organized its interventions. For feminist legal scholars, home has long been fraught terrain, imagined both as the quintessential scene of patriarchal control and as the only potential site of women’s freedom. In her critique of United States v. Morrison, Catharine MacKinnon argued that the Supreme Court upheld a view that women should simply “keep . . . at home,” and that women are outside of commerce and thus quintessentially private. She continues:

One way to describe the process of change in women’s legal status from chattel to citizen is as a process of leaving home. The closer to home women’s injuries are addressed, the less power and fewer rights they seem to have; the further away from home the forum, the more power and rights women have gained—and with them freedom of action, resources, and access to a larger world. In experiential terms, women are least equal at home, in private; they have had the most equality in public, far from home. It is in the private, man’s sovereign castle, where most women remain for a lifetime, where women are most likely to be battered and sexually assaulted and where they have no recourse because the private, by definition, is inviolable and recourse means intervention.

In MacKinnon’s powerful formulation, home is the quintessential site of violence against women, and the private is precisely what must be deconstructed for women to secure some modicum of freedom and bodily integrity.

This conception of the private as the locus of injury was championed by U.S. feminist legal scholars—particularly in the 1980s and 1990s—seeking to expose the pervasiveness of intimate-partner violence and the inadequacy of state response to that violence. Efforts like mandatory arrest laws in the context of intimate-partner violence and a sustained attention to sexual assault (including the attempt to develop a federal civil remedy for gender-based violence in the Violence Against Women Act, which was struck down by Morrison) can be understood, at least in part, as concerted feminist efforts to compel a state response to gendered intimate injuries and to insist on the private as a space that should never be beyond public scrutiny or even surveillance. In her foundational work on domestic violence, Elizabeth M. Schneider writes,

45. 529 U.S. 598 (2000).
47. Id. at 174-75.
Concepts of privacy permit, encourage, and reinforce violence against women. The notion of marital privacy has been a source of oppression to battered women and has helped to perpetuate women’s subordination within the family. The idea of privacy continues to pose a challenge to theoretical and practical work on woman abuse.\(^{48}\)

Even as Schneider argues that the dichotomy between the private and the public is a legal and even discursive construction—with the family, the household, and the personal still well within the purview of the state—she argues that the “rhetoric of privacy . . . has isolated the female world from the legal order.”\(^{49}\) Anita Allen furthers this notion of privacy as problematically shielding women away from the protective arm of the state, arguing that women have had the “wrong kinds of privacy,” where privacy has meant “modesty, chastity, and domestic isolation” rather than autonomy, protection, safety, and choice.\(^{50}\) In this feminist conceptualization of privacy, the household is a space that renders women legally invisible and thus unprotected. Implicit in this conception of privacy is one of the benign labor of law, its capacity to redress harm and violence in the service of protecting citizens: if only the private could be subjected to law, women could experience freedom.\(^{51}\)

This conception of the private as the locus of violence has long been challenged by Black feminist scholars who, for a host of reasons, have valorized Black privacy and domesticity as a necessary respite from an antiBlack world, or argued for freedom from state intervention at home (and outside of the home) as being of paramount importance.\(^{52}\) Some have argued that privacy simply does not exist for various subjects, including Black women. Allen notes, “It is plain that in the United States domestic privacy is a virtual commodity purchased by the middle class and the well-to-do.”\(^{53}\) For these scholars, privacy is a racialized and gendered “commodity” that Black women can never access because of the persistence of violent state surveillance.\(^{54}\) Khiara M. Bridges reveals that the

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49. Id. at 89. Other feminist legal scholars have made similar arguments. See Catharine A. MacKinnon, Toward a Feminist Theory of the State 184-94 (1989) (arguing, similarly to Schneider, that privacy undergirds abortion); Martha Albertson Fineman, Intimacy Outside of the Natural Family: The Limits of Privacy, 23 Conn. L. Rev. 955 (1991); Catharine A. MacKinnon, Reflections on Sex Equality Under Law, 100 Yale L.J. 1281, 1311 (1991) (“[W]hile the private has been a refuge for some, it has been a hellhole for others . . . .”)
51. There are important critiques of this view, particularly in the work of Linda Mills, who argues that mandatory arrests “all too often reproduce the emotional abuse of the battering relationship.” Linda Mills, Killing Her Softly: Intimate Abuse and the Violence of State Intervention, 113 Harv. L. Rev. 550, 554-55 (1999). See also Miriam H. Ruttenberg, A Feminist Critique of Mandatory Arrest: An Analysis of Race and Gender in Domestic Violence Policy, 2 Am. U. J. Gender & L. 171 (1994) (arguing that advocacy of mandatory arrest often ignores white and Black women’s differing experiences of the criminal justice system).
54. See Nash, supra note 52, at 312.
absence of privacy is most acute for poor Black women—particularly poor Black mothers—who are fundamentally “deprived of privacy rights.”

Indeed, Bridges notes,

>Poor mothers are not given privacy rights because society, and thus the law, presumes that their enjoyment of privacy will realize no value or a negative value . . . . Accordingly, the privacy invasions demanded by Medicaid (and [Temporary Assistance for Needy Families] and [Women’s, Infants and Children] and public housing and the child protection system) do not violate the privacy rights of poor mothers because their socioeconomic status has already precluded their possession of any privacy rights that the state is obligated to protect.

For Bridges, poor Black mothers are stripped of privacy rights precisely because the state imagines these women as incapable of managing the freedom these rights would confer.

If some Black feminist scholarship has foregrounded privacy as something that Black women have simply never received—or have been constructed not to deserve—Black feminist scholarship often imagines the home as a kind of refuge. Dorothy Roberts argues, “The government’s pervasive involvement in Black women’s lives illustrates the inadequacy of the privacy critique presented by some white feminist scholars . . . . Women of color . . . often experience the family as the site of solace and resistance against racial oppression.”

COVID-19 has produced a particular Black feminist regard for home as a site of safety and for the “stay at home” order not as an imposition but as a welcome relief from ordinary, ubiquitous antiBlackness. Shoniqua Roach, for example, reflects on COVID-19 by noting how “[b]eing home feels a little like stolen pleasure and liberation, like a reclamation of black woman time.”

In a New York Times op-ed following the publicity surrounding Amy Cooper’s racist deployment of the police in Central Park, Ernest Owens noted, “I’m doing better these days because staying home alone and practicing social distancing has meant I’m avoiding many of the racist encounters that used to plague my daily life.” In these accounts, “staying home” allows a necessary “social distancing from racism,” with home cast as a sanctuary.

“Staying home” has also been described by Black-feminist reproductive justice advocates as a life-saving practice for Black women. Describing her work

56. Id. at 12.
60. Id.
with home birthing clients in Colorado, Seriki notes, “When I committed to this work, I knew that white families were gifted the ability and the right to choice, whereas Black families were not . . . . A home birth is a privilege. I wanted to afford my community the same opportunity.”\textsuperscript{61} Indeed, some reproductive justice advocates have argued that Black mothers’ interest in home birth has had less to do with COVID-19 and more to do with the influx of media describing and highlighting racial disparities in perinatal care.\textsuperscript{62} This work has made the Black perinatal body synonymous with risk—the risk of death in the hospital, medical neglect, and obstetric violence. In this case, “staying home” is about a freedom—whether real or imagined—from the threat of violence and a sense that home offers safety, autonomy, and freedom that the hospital might not afford.

For some Black feminist scholars, then, home is positioned not as a site of violence, but as a kind of refuge from the antiBlack misogyny of the “outside” world, as a space that can be carefully crafted to affirm the self. While MacKinnon imagines state intervention on behalf of women’s autonomy as a form of freedom, Black feminist scholarship and activism has sought to imagine forms of relationality and even redress that deprivitize the state—precisely because the state has been a key actor in antiBlack violence and persistently impervious to calls for substantive change. We might then understand the calls to “Defund the Police” and for abolitionism that have been amplified long before the present moment, but that have circulated with greater speed now, as evidence of a political desire to reconfigure conceptions of safety, privacy, autonomy, and collective responsibility, to find modes of accountability that bypass the state entirely. Work by Black feminist historians like Sarah Haley on the state’s long history of intrusion into Black homes generally,\textsuperscript{63} and Black women’s homes

\textsuperscript{61} Jones, supra note 13 (quoting Seriki).

\textsuperscript{62} Alison Cutler, Mothers, Midwives and Mortality: Why Some Black Women Seek a Holistic Approach, CRONKITE NEWS (Oct. 1, 2020) https://cronkitenews.azpbs.org/2020/10/01/black-mothers-seek-midwives/ [https://perma.cc/5BSH-TSSZ]; Anna North, America is Failing Black Moms During the Pandemic, VOX (Aug. 10, 2020) https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality [https://perma.cc/5QK6-JWDS] (noting that “[l]ong before the pandemic hit, Black pregnant and birthing people around the country were reporting that doctors disregarded their concerns, ignored their wishes, and put them at risk. Out of 10 similarly wealthy countries, the US had the highest number of maternal deaths per capita in 2018. Black women are disproportionately impacted, dying in childbirth at three to four times the rate of white women. Now, birthing people and their advocates say the Covid-19 crisis is only exacerbating the discrimination that Black patients and other patients of color already face from providers — one of the main drivers behind their higher rates of maternal mortality”); Becca Andre, Everything About the Coronavirus-Fueled Home Birth Trend Ignores the Realities for Black Women, MOTHER JONES (June 15, 2020) https://www.motherjones.com/politics/2020/06/race-coronavirus-black-women-pregnancy-home-births-trend/ [https://perma.cc/KQ3N-2FDR].

\textsuperscript{63} See, e.g., Intrusion: Domestic State Violence & Carceral Los Angeles: Sarah Haley, CTR. FOR RACE & GENDER, U.C., BERKELEY, https://www.crg.berkeley.edu/events/save-the-date-sarah-haley [https://perma.cc/YLSH-7ABU]. Haley’s new work focuses on police invasions of Black homes in Los Angeles in the 1970s through the 1990s. This work explores the role of mundane and ostentatious forms of police violence and harassment executed in Black homes from the 1970s through the 1990s. In it, she analyzes the relationship between Black domesticity, carceral gendering, and carceral state expansion as well as the affective work of life making that Black women performed in the face of ubiquitous police violence.” Id.
particularly, along with the ongoing inattention to the 2020 murder of Breonna Taylor in her home, reveals that Black homes themselves have rarely been regarded by the state as worthy of protection or privacy. Thus, efforts to protect Black homes, to safeguard Black privacy, are imagined as crucial acts of freedom seeking.

Here, we have two competing feminist conceptions of the space of the home—either as “man’s castle” shoring up intimate violence with little legal redress or as a necessary sanctuary from antiBlack violence. In the context of reproductive justice activism, a political project spearheaded by Black feminists and Black feminist organizations including SisterSong, Loretta Ross, and Julia Oparah, home has taken on a slightly different meaning: it is a space of care, one that refuses and upends the non-care that the hospital provides. Indeed, this conception of home recognizes the house as a space that is diametrically opposed to the hospital and its prevailing mode of engaging with laboring women: obstetric violence. As a term, obstetric violence describes and aggregates the “phenomenon of mistreatment during childbirth” from “less dramatic forms of subtle humiliation to coercion, unconsented clinical care, and more extreme instances of verbal and physical abuse.”  

Elizabeth Kukura suggests that obstetric violence is sufficiently capacious to describe and contest forms of physical, mental, and spiritual abuse; discrimination; practices of coercion; and experiences of disrespect. Importantly, the feminist deployment of obstetric violence highlights violence as the condition of the ordinary where, as Emily Varnam notes,

You pretty much one percent of the time see women getting the care that is appropriate for them. Whether that’s from lack of evidence-based care or lack of compassion, or lack of respect for the human race, you pretty much just never see care that feels appropriate. Either it’s how they’re spoken to, or nonconsensual vaginal exams. It’s nonconsensual episiotomy or coercion, or bullying, or scare tactics. 

65. Id. at 730.
66. Sarah Yahr Tucker, There Is a Hidden Epidemic of Doctors Abusing Women in Labor, Doulas Say, BROADLY (May 8, 2018, 12:08 PM), https://broadly.vice.com/en_us/article/evqew7/obstetric-violence-doula-abuse-giving-birth [https://perma.cc/EP2V-K77B] (quoting Emily Varnam); see Julia Belluz, A Shocking Number of Women Are Harassed, Ignored, or Mistreated During Childbirth, Vox (June 20, 2019, 12:28 PM EDT), https://www.vox.com/2019/6/10/18628073/maternal-mistreatment-women-of-color [https://perma.cc/P4N8-X8SR]; Saraswathi Vedam et al., The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States, 16 REPRODUCTIVE HEALTH, no. 77, 2019, at 2 (“Of the 2700 women who filled out the survey, one in six (17.3%) reported mistreatment. Among all participants, being shouted at or scolded by a health care provider was the most commonly reported type of mistreatment (8.5%), followed by ‘health care providers ignoring women, refusing their request for help, or failing to respond to requests for help in a reasonable amount of time’ (7.8%). Some women reported violations of physical privacy (5.5%), and health care providers threatening to withhold treatment or forcing them to accept treatment they did not want (4.5%). Women of colour, women who gave birth in hospitals, and those who face social, economic, or health challenges reported higher rates of mistreatment.”).
While the term “obstetric violence” currently circulates in U.S. feminist birthing circles, and among women-of-color birth workers to describe the trauma Black women’s bodies bear in the delivery room, it has a particular juridical history outside of the United States. In 2004, Argentina granted women the right to a “humanized” birthing experience and offered a legal guarantee of the right to be treated “respectfully” throughout pregnancy and childbirth.67 Three years later, Venezuela recognized obstetric violence as a form of violence that law could redress.68 The “Organic Law on the Right of Women to a Life Free of Violence” defined “obstetric violence” as

The appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.69

The law criminalizes nonconsensual C-sections and inductions performed without informed, voluntary consent and roots itself not in tort law but in human-rights law, thus casting injuries as forms of gender-based violence. This juridical conception of obstetric violence, which offers both recognition of harm and a form of redress, has been expanded by activist groups. In Spain, for example, the Left group La Revolución de las Rosas defines obstetric violence broadly to include “the act of disregarding the spontaneity, the positions, the rhythms and the time labor requires in order to progress normally when there is no need for intervention.”70 Even as the term obstetric violence has provided a framework for activists to describe normalized violence, and for the state to, at the very least, offer a gesture toward remedying that violence, the term has also become a site of anxiety for physicians in Latin America. For example, the Federal Council of Medicine in Brazil described the term as “an assault on the medicine and specialty of gynecology and obstetrics, contrary to established scientific


70. Id. at 849.
knowledge, reducing the safety and efficiency of good care and ethical practice.”

In recent years, obstetric violence has become a rhetorical and political touchstone for reproductive justice activists who use it to describe the field in which they seek to intervene, one where obstetric medicine, as practiced, is itself constitutive of the field of violence. Obstetric violence describes a set of birthing practices that are marked by unsafety, institutionalized medicine, and non-home-birthing locales. Dána-Ain Davis coined the term “obstetric racism”—a fusion of obstetric violence and medical racism. “Obstetric racism,” she argues, constitutes “a form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated because they are obstetric patients... Obstetric violence includes dehumanizing treatment and medical abuse such as birth rape, or violations experienced during childbearing.”

Racial disparities in birthing experiences, outcomes, mortality, and postpartum health suggest that Black women’s perinatal experiences are the quintessential case of obstetric violence, most deeply and explicitly indicative of the violence of birth. In other words, obstetric violence is imagined to be a form of violence constitutive of institutionalized medicine and inflicted in the space of the hospital. Home is a different kind of space—one that is imagined as fundamentally nonviolent, marked by care, patience with the timeline of laboring bodies, and responding to pain with nonmedical interventions like massage, rebozos, and deep breathing.

But COVID-19 has ushered in a new conception of home that existing feminist debates about the meaning of home have not yet thought through. Home birth is deemed desirable not because it unfolds in private, but because it is imagined to mitigate risk—the risk thought to attach to the physical space of the hospital in the long, uncertain time of the pandemic. Here, home has come to mean something other than “private,” “domestic,” or the antithesis of the public,

71. Murillo Dias & Valeria Eunice Mori Machado, Obstetric Violence in Brazil: An Integrated Multiple Case Study, 8 HUMAN. & SOC. SCI. REV. 117, 118 (2018) (quoting the Federal Council of Medicine); see also Vanessa Barbara, Latin America Claims to Love Its Mothers. Why Does It Abuse Them?, N.Y. TIMES (Mar. 11, 2019), https://www.nytimes.com/2019/03/11/opinion/latin-america-obstetric-violence.html [https://perma.cc/S3LT-H9TC] (Emphasizing the ubiquity of obstetric violence in Latin America, and the urgency of legislation. She writes, “[t]he majority of these laws came not a moment too soon. In Latin America, reports of obstetric violence have been extensively documented. They’ve even come to be expected, as if this is the price women have to pay for having any sexuality. The most common kinds of mistreatment are non-consensual procedures (including sterilization), non-evidence-based interventions like routine episiotomies, and physical, verbal and sexual abuse. We can only wonder why obstetric abuse is so ubiquitous in Latin America, a place where motherhood is often sanctified.”).

72. Indeed, popular feminist forums have been marked by a call that obstetrics needs its own #MeToo movement. See, e.g., Kathi Valei, Birth Needs a #MeToo Reckoning, DAME (June 18, 2018), https://www.damemagazine.com/2018/06/18/birth-needs-a-metoo-reckoning [https://perma.cc/6LQQ-G9EE]


74. I discuss these techniques in my forthcoming book, JENNIFER C. NASH, BIRTHING BLACK MOTHERS (forthcoming 2021).
even as we were urged to “shelter at home,” to quarantine, to build our pantries and prepare to simply stay put—at least those of us who are not deemed “essential workers,” disproportionately Black and brown people who keep the hospitals, medical offices, pharmacies, grocery stores, and gig economy running at dire cost to their health. Indeed, in the course of a few weeks, homes were transformed; we are instructed on how to participate in this remaking of home as we hold Zoom calls from our dining room tables, conduct therapy from our bathrooms, make “telemedicine” appointments with our doctors, and learn how to dress for meetings that are held from our living rooms. This expansive conception of home as private and public at once, we were told, was taken on in the service of the collective, but it came at the cost of the dramatic remaking of home, a cost born disproportionately by women who described juggling the incessant demands of work and family, and by Black and brown people who juggled their status as “essential workers” and the demands of the household alongside the heightened threat of illness and death. It is in this refigured home—

75. See Gottlieb, supra note 43.
one that is private and public for the sake of personal and collective well-being—that home birth comes to be refigured not as risky, but as the preferred birthing practice for risk-mitigating citizens who are presumed to have houses with sufficient resources, space, privacy, and comfort to conduct a home birth. To birth at home is to embrace the notion of the public-private house that can be remade at any moment to accommodate the call for all citizens to become fully risk-mitigating, to avoid the threat of a “second wave” of COVID-19.\(^78\) This vision of home is one where we work, live, labor, and even birth in one contained, continuous space. Yet this vision of home that has made home birth culturally palatable and even celebrated has wholly ignored Black women’s longstanding struggle with the hospital as a death world and their struggle with COVID-19 as the latest iteration of the hospital as a deathly site for Black mothers.

III. THE MEANING OF MIDWIVES

While home birth has enjoyed a revival in the cultural imaginary thanks to the crisis of COVID-19, those who make home birth possible—midwives—have not enjoyed the same reimagination. The “panic shopping”\(^79\) for midwives that COVID-19 engendered as perinatal bodies sought nonhospital births was due, at least in part, to a hierarchy created by law and medicine that celebrates, credentializes, and renders most accessible the midwives who operate in medicalized spaces—precisely the spaces that reproductive justice advocates argue are death worlds for Black women.

Home birth—a practice of laboring and delivering at home, with the support of a midwife, instead of at the hospital—occupies complex legal terrain.\(^80\) The law governing midwives is a patchwork, a “wild terrain,” that varies dramatically state by state, reflecting a profound national ambivalence about midwifery.\(^81\) While the term “midwife” presumes a singularity to the profession, midwifery is

78. As of the writing of this, Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, tells us we are still “knee-deep” in the first wave of the virus as a result of states prematurely reopening. Oliver Laughland, Fauci: US is ‘Still Knee-Deep in First Wave’ of Pandemic as It Passes 130,000 Deaths, GUARDIAN (July 7, 2020), https://www.theguardian.com/world/2020/jul/07/fauci-first-wave-coronavirus-us-nears-130000-deaths [https://perma.cc/3F8E-98PW].

79. Allers, supra note 8.


actually multiple professions that have vastly different legal statuses. The certified nurse midwife (CNM, sometimes called nurse-midwife) is an advanced-practice registered nurse who specializes in women’s health, including, but not limited to, pregnancy and childbirth. CNMs graduate from midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME) and pass a national exam; they also hold a state license that is usually administered by a state nursing board. CNMs practice in collaboration with—or, often, in subordination to—doctors, and they usually practice in hospitals or birthing centers. Thus, they are often thought to be able to operate within a traditional medical framework if necessary. Suzanne Hope Suarez argues,

In physician-chosen settings, nurse-midwives must work under “doctor’s orders.” Outside the hospital, nurse-midwife services are constrained by requirements for supervision by physicians. . . . In hospitals and physician-controlled birth centers the physician defines what is normal and what is abnormal. Physicians control the training of midwives and the services they can produce. As such, hospital-based nurse-midwifery is thus no real threat to medical control.

Because CNMs work within conventional medical structures, Indra Lusero asserts that,

The role of CNMs, while still contested within the hierarchical framework of medicine, is more secure within the health care industry than non-nurse midwives. . . .

. . . . These direct-entry midwives work exclusively outside of hospitals in homes and freestanding birth centers. They are experts in non-medicalized, physiologic childbirth.

CNMs are legally recognized to practice everywhere in the United States, even as their regulation and certification varies by state.

82. For a history of midwifery in the United States, see Judy Barrett Litoff, American Midwives: 1860 to the Present (1978) and Suzanne Hope Suarez, Midwifery Is Not the Practice of Medicine, 5 Yale J.L. & Feminism 315 (1993).

83. CNMs are also often trained as Women’s Health Nurse Practitioners (WHNPs) or Family Nurse Practitioners (FNPs).

84. Hope Suarez, supra note 82, at 324.


86. See Legal Recognition, Am. C. of Nurse-Midwives, https://www.midwife.org/The-Credential-CNMAND-CM [https://perma.cc/H8R4-CJC7]. The American College of Nurse-Midwives offers a tool to help midwives understand the states that are most hospitable to their practice. These include investigating questions including: “[w]hich states require physician supervision or collaboration? What do state laws and regulations say about hospital privileges or participation on medical staff? Which states license direct entry midwives? Which states license or regulate birth centers?” and “[u]sing Medicaid and commercial payment rates, how much revenue might a CNM/CM generate who attends 70 vaginal births in a year? How does that revenue compare to average annual wages?” Understanding State Practice Environments, Am. C. of Nurse-Midwives, https://www.midwife.org/Understanding-State-Practice-Environments [https://perma.cc/92QE-NG79].
Midwives who are not CNMs are often called “direct-entry midwives” (or pejoratively “lay midwives”), and their legal status, licensing requirements, and professional licensing board varies by state. The Certified Midwife (CM)—a classification created in 1994 by the American Midwifery Certification Board—is a healthcare worker who has earned a master’s degree and who has trained in midwifery. CMs pass an exam, but, unlike CNMs, they do not have a nursing background. As of 2016, only a few states recognize and license them.87 The certified professional midwife (CPM) is a credential available only through the North American Registry of Midwives (NARM). A CPM must show knowledge and experience in midwifery services both inside and outside of hospital settings. CPMs tend to work in homes and birthing centers, and they must complete a portfolio evaluation or graduate from a midwifery program (but need only hold a high school degree or equivalent).88

CPMs have produced the most legal ambivalence. As of 2020, according to the National Association of Certified Professional Midwives, thirty-four states and the District of Columbia offer CPMs a path to licensure.89 In other states, it is de facto illegal to have a midwife attend a home birth. Since the midwives most likely to attend a homebirth would be CPMs, those who do not work in traditionally medicalized spaces, CPMs’ practices can be severely limited by the threat of criminal charges. Pregnant people who seek home births must, as Noah Berlatsky notes, “find a midwife willing to risk operating illegally—or they have to deliver their babies without professional help.”90 Indeed, practicing direct-entry midwifery in these states is treated, as Christopher Rausch notes, “the same as practicing medicine without a license.”91 Highly publicized cases of midwives who have been punished—including Karen Carr, Elizabeth Catlin, Judith Wilson, and the highly sensationalized case of Angela Hock—reveal how states mobilize their criminal justice apparatus to penalize midwives who practice home birth. This confusing and punitive legal patchwork reflects an intense state


91. Rausch, supra note 81, at 233.
effort to champion midwifery that is practiced in hospital settings, and that most closely resembles conventional medical care.

The legal preference for CNMs has severe consequences for both midwives (particularly CPMs) and birthers. As Lusero argues, “[p]eople cannot choose home birth or hospital birth like they choose between Pepsi and Coke. In fact, the system necessitates certain choices and eliminates others.”92 For midwives, laboring as a CPM can pose particular challenges, including a lack of a regular stream of work, or laboring without health benefits and insurance. One interlocutor succinctly described CPM work as motivated by an intense desire to serve a particular community, and as performed by “some of the most vulnerable groups in order to serve the most vulnerable.”93 Yet law leaves CPMs the most vulnerable because they are consistently constructed as lacking the expertise and training of CNMs since hospital births are imagined as constituting “work experience” in ways that home births are not. The restrictions on CPMs essentially funnel pregnant people into hospital births, which are represented as appropriately risk-mitigating and responsible, even as they are most risky for Black women.94

While the journalistic coverage of home birth has described pregnant people’s “panic shopping” for midwives95 and has represented midwives and birthing centers as “in demand” because of COVID-19,96 there has been little attention to how the lack of midwives to meet the demands of the present is the result of the law’s varied midwifery certification requirements, and a legal and medical preference for midwives whose work most closely resembles obstetricians’ labor. Indeed, while certification and credentialization are often described as tools for ensuring medically equal outcomes, the two often work together to ensure that women of color do not have access to certain professions. In fact, much of the conversation about home birth in the context of COVID-19 has unfolded as if midwives are readily available for home birthing, with little analysis of the deeply racialized history of state regulation of midwives that has led to the conditions where a surge in demand for home birthing is met by an insufficient number of available midwives. The marking of CNMs as experts, and non-CNMs as lacking expertise, has produced a landscape of intense racial stratification within midwifery where, as the Department of Education found in 2015, 76.6% of CNM degrees went to white women and 6.4% were earned by

92. Lusero, supra note 85, at 406.
93. Telephone Interview with Julie Morel, Researcher (July 15, 2020). At the time of this writing, Jennie Joseph’s Commonsense Childbirth had just become the first Black-owned and operated accredited CPM school in the country.
94. See Lusero, supra note 85, at 406-34; see also Waggoner, supra note 27.
95. Allers, supra note 8.
96. de Freytas-Tamura, supra note 6; see supra notes 7-8 and accompanying text.
Black women.\footnote{Julie Morel writes that, “Racha Tahani Lawler, a Black CPM who has been practicing for 16 years, estimates that the US has fewer than 100 Black CPMs.”\textsuperscript{98}} In other words, a profession imagined to be shaped by feminist ethics and praxis has interfaced with a legal and medical regime of classification and credentialing schemes that have bolstered and intensified racial hierarchies in the profession, allowing midwives who can access advanced degrees legal shelter and greater access to regular income, benefits, and health insurance.

If before COVID-19, home birth was culturally and legally marked as an undesirable birthing practice, the midwives who perform it have been similarly marked. They have been figured as medically adjacent para-professionals, and the less they conform to conventional medical standards of certification and expertise, the more they are deemed irresponsible, as “lay” practitioners. While the relegation of non-CNMs to the category of risk has a long history, the consequences of this taxonomy and stratification are hyperapparent during COVID-19 as demand for midwives who can practice home birth well exceed the numbers of midwives who can perform this critical service.

Feminist scholarship on midwifery has often celebrated the profession as a kind of direct challenge to patriarchy, particularly medical models of control over women’s bodies. The resurgence of midwifery in the 1970s, a direct result of feminist activism challenging patriarchal control of medicine, was largely “embraced by middle-class white women who wanted more of a voice in their maternity care, including the possibility of delivering at home.”\footnote{Sandi Doughton describes midwives as “mavericks, standing in opposition to the traditional American way of birth, which is the world’s costliest but often leaves women and their families feeling powerless.”\textsuperscript{100}} In Doughton’s conceptualization of midwives, their status as “mavericks” is what makes their work transformative and deeply unsettling to the prevailing medical order.\footnote{Dianne Martin reads midwifery as about “relationships between law, patriarchy, and medicine in the control of women’s reproductive powers.”\textsuperscript{102}} She notes,
Doctors are trained to think in terms of pathology, to find something wrong and then to do something about it. This is even more the case with surgeons, who are trained to cut... The obstetrician is thus half-surgeon, and he controls the procedures and protocols surrounding pregnancy and birth.103

The midwife relinquishes the notion that pregnancy is a time of unwellness best responded to with medical intervention and instead centers “community-based care, close relationships between providers and patients, prenatal and postpartum wellness, and avoiding unnecessary interventions that can spiral into dangerous complications.”104 It is this willingness to be patient with laboring bodies, coupled with a commitment to relationship building as a practice of care, that has led to the conclusions that midwives are generally less likely to care for patients whose deliveries result in C-sections.105

Despite these positive outcomes, law and medicine have collaborated to shrink the scope of the midwife’s practice and to shore up hierarchies of midwives. This collaboration has effectively produced the relative accessibility of CNMs—who labor in medicalized spaces like hospitals and birth centers, and who have secured the most rigorous academic credentials—and the relative legal inaccessibility of other forms of midwives and of home birthing practices. For example, in 2008, the AMA debated Resolution 204, which sought to completely ban so-called lay midwifery and to require midwives to practice in hospitals. They also considered a resolution to outlaw home birth—including an effort to publicly censure Ricki Lake for her endorsement of home birth in the 2008 documentary The Business of Being Born.106 Finally, the AMA also sought to entirely eliminate the CPM designation, noting that they are “often self-taught and in an unregulated apprenticeship model,” revealing the extent of their
commitment to the notion of the CNM as the best-trained, most-effective midwife. The AMA ultimately passed a resolution stating

[We] support state legislation that helps ensure safe deliveries and healthy babies by acknowledging [] the concept that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers.

The AMA’s statement sought to champion the CNM practice, and to tether non-CNMs to risk, irresponsibility, and even death. The collaboration between law and medicine to curtail the scope of non-CNM practice, at times, takes the form of legal murkiness that leaves direct-entry midwives—and birthers—unsure of whether their desired home births are legally compliant. In Pennsylvania, for instance, Linda Levinson argues,

[T]here is currently confusion regarding the legality of a non-nurse midwife’s practice . . . . This confusion helps neither advocates nor opponents of non-nurse midwifery practice. Non-nurse midwives in Pennsylvania and their clients live in a state of uncertainty, never knowing when the state may decide to enforce the Midwife Regulation Law.

Relegating non-CNMs to legal precarity is yet another way the law operates to bolster medicalized midwifery practice.

This legal effort mirrors longer historical efforts to limit the scope of practice for midwives, which were often explicitly marked by a desire to shut Black women out of the profession through calls for heightened credentialization, expertise, and training. Michele Goodwin writes, “Successful racist and misogynistic smear campaigns, cleverly designed for political persuasion and to achieve legal reform, described black midwives as unhygienic, barbarous, ineffective, non-scientific, dangerous, and unprofessional.” Indeed, as Danielle Thompson’s research reveals, the language of expertise has often been mobilized both to shore up medical control of labor and delivery, and to denigrate practicing midwives’ experience, wisdom, and skill. Thompson’s historical work shows that at the turn of the century, so-called lay midwives—many of whom were women of color—delivered the majority of babies, but anti-

108. Walden, supra note 40 (quoting the AMA resolution).
109. Levinson, supra note 20, at 155-56.
midwifery campaigns grew in state-specific ways to solidify the control of obstetricians." She argues that the consolidation of obstetrics was built around shuttering midwives out of the birthing business, painting midwives as lacking the expertise of medicine, which was coded as both white and male. Often these efforts toward regulation were explicitly racialized, as Thompson reveals in her analysis of a 1924 meeting of the Southern Medical Association when “a physician stated that they must not attempt to make competent obstetricians out of the great army of ignorant women now practicing midwifery in this country.”

Similarly, Thompson notes that in the “1920s, the Director of the Mississippi Bureau of Child Hygiene, a White male, asked, ‘What could be a more pitable picture than that of a prospective mother . . . and [midwife], filthy and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism?’” The proliferation of licensing requirements couched in terms of public health and collective safety “quickly replaced the Black and immigrant midwives with White nurse-midwives and physicians.”

Stacey A. Tovino offers a similar analysis rooted in a close engagement with the history of midwifery in Alabama, a state which was marked by the prominence of Black midwives through the 1970s, when efforts at standardization, licensure, and examination seeking to curb competition between midwifery and obstetricians culminated in the passage of a 1976 act that ended lay midwifery and criminalized nonhospital midwifery. The 1976 law, some argue, coincided with the rise of Medicaid in the state, which covered hospital birth and contributed to the boom in obstetricians’ business. Katherine Webb-Hehn writes that this moment meant that

[T]he Black, rural women who’d relied on midwives for generations were suddenly being shuffled into an institution they were once banned from entering. And the Black midwives who had built a profession for themselves were now without work, deemed dirty and illegitimate by the white leaders of the state.

The effects of this intensely racialized regulation continue to reverberate in the present moment. Alabama, which has the country’s highest infant mortality rate, persists with midwifery restrictions that, as Sheila Lopez, one of thirteen CNMs licensed in state notes, are an effort to severely constrain the

111. Thompson, supra note 34, at 28-29.
112. Id. at 31.
113. Id.
114. Id. at 32.
117. Id.
profession. Alabama’s lack of midwifery education programs and requirement that CNMs to have a “collaborative physician” who oversees their practice have left many who seek to become midwives to practice in other states. Lopez further notes, “Here they associate us with granny midwives—someone with absolutely no medical background.” This denigration of midwifery generally, and of lay midwifery specifically, leaves pregnant people in precarious positions.

As one journalist reported,

Each year expecting mothers jump the border into Tennessee, Mississippi or Georgia, where midwifery is either legal or at least exists in some kind of gray area. Whether the journey is 10 minutes or two and a half hours, these women often make the drive while already in labor and pray they aren’t forced to have the baby in a parking lot or by the side of the road. They give birth in makeshift spaces, often in secret—Airbnbs, cheap hotel rooms, campers, a network of birthing cottages nestled anonymously throughout the hills of small, southern Tennessee towns, the western part of Georgia or along the Mississippi line.

In May 2016, the state decriminalized CPM practice, and in January 2019, Alabama’s State Board of Midwifery began issuing homebirth midwife licenses. As of January 2020, it had licensed 15 home birth midwives who had completed nearly 100 home births, offering a respite for some, though not all—midwives.

This racialized history of midwifery, one that unfolds in distinct ways in different states, is integral to understanding present conditions. When COVID-19 produced a dramatic and rapid cultural shift in the conception of home birth, which came to mean safety, risk-reduction, and personal responsibility in the face of the pandemic, the midwife had already been constructed in a particular way: as performing her work in the space of the hospital or birthing center, as medically adjacent, even as embedded in the “Covid hospital.” This meant that the torrent of demand for different birthing locales could not be met by adequate

118. Martin, supra note 99.
120. Id.
support precisely because law had tethered midwives to institutional medicine, to credentialization, and to imagined safety by fundamentally excluding home birth, and the women-of-color midwives who often perform those births, from protection. Thompson urges an intersectional approach to midwifery’s history; this approach reveals both the history of midwifery’s elaborate state-based caste system and the marking of home birth as risky (precisely because it was often performed by women who were themselves marked as risky actors). This “stratified reproduction” describes the intersections of multiple forms of stratification: a racial caste system of midwives produced by law and with criminal consequences, a racial caste system dictating the availability of birthing options, and the pre-COVID synonymousness of home birth with midwives whose practices were deemed problematic.

IV. COVID-19’S POSSIBILITIES AND PERILS

This Article has traced a moment when home birth, a practice that has long been legally and medically marked as dangerous, has been reimagined not as risky but as responsible. In this formulation, home is where the birth is—or where it should be—to avoid the danger of the “Covid hospital.” While reproductive justice activists have long called attention to the systemic non-care the hospital provides Black women and children, a sustained critique of institutionalized medicine only became culturally audible in the face of the pandemic, when the risk of COVID-19 was described as affecting everyone, even as it disproportionately left its deathly mark on Black and brown bodies. This plea became audible not as a way of describing the hospital as a site of cruelly disparate health outcomes, but as a way of celebrating a new form of responsible parenting—a willingness to home birth. Of course, home birth, like every other aspect of perinatal life in the United States, is unequally distributed; it requires not only the capacity to compensate a midwife, but also space in one’s home to labor for a time of unknown duration. So even as access to home birth

124. See CRAVEN, supra note 80, at 3.
is celebrated as a way of circumventing the potentially deadly outcomes of the
hospital and the potential threat of birthing alone, home birth too continues to be
steeped in inequities, including the racialized logics that have made home birth
relatively inaccessible in the United States.

As I argue here, home birth’s longstanding precarious status in the United
States stems from a collaboration between medicine and law designed to
safeguard the authority of doctors and hospitals, as well as intense racial logics
that have sought to leave unprotected and legally vulnerable midwives who are
least likely to have access to expensive, time-consuming, and traditional forms
of education, most often women of color. This is not without consequence.
Lusero argues,

In a climate where potential consumers have the impression that medical
professionals deride midwifery, consumer confidence will be
diminished. Consumers will respond to how valued and valid the
profession is, in terms of public and medical opinion. This is impacted
by the information and experience that people have, but it is also
impacted by structural factors like how integrated the profession is into
other systems, like insurance.\textsuperscript{127}

Lusero’s intervention reveals that the legal taxonomy of midwives produces a
set of conditions that can make midwives—particularly non-CNMs—seem like
irresponsible choices for birth companions.

Ultimately, this Article is not a call to romanticize home birth or midwives,
but instead to think about the conditions that allowed a form of birth—long
advocated for by Black women to escape the death world of the hospital—to
become reimagined as a practice that enables all parents to perform their
responsible citizenship or to manage the seemingly endless risks that COVID-19
poses. Indeed, it is crucial to note that the hospital only became more broadly
visible as a death world during COVID-19, despite sustained attention to racial
maternal health inequities and the particularly profound role of institutionalized
medicine in \emph{producing} those inequities. As home birth becomes increasingly
visible and even celebrated through the language of “consumer choice,”\textsuperscript{128}
feminists might harness this moment to continue to probe how feminist spaces—
like midwifery—become structured by logics of credentialization, licensure, and
education that are described as promoting safety but that actually fundamentally
shape access—both access to midwives and midwives’ access to practicing
midwifery. We must then continue to interrogate credentials for feminist birth
workers, not with an eye toward compromising safety, but with attention to
dismantling hierarchies and stratifications that work to the disadvantage of
women-of-color midwives and to women-of-color birthers. These women’s
bodies, needs, and wishes have largely been shut out of COVID-19 conversations

\textsuperscript{127} Lusero, \textit{supra} note 85, at 421.

\textsuperscript{128} \textit{See} Craven, \textit{supra} note 80, at 7.
about home birth, despite the conditions of their ordinary lives, which were structured by the bleak realities of Black maternal and infant mortality long before COVID-19.