

Home Birth and the Maternity Outcomes Emergency: Attending to Race and Gender in Childbirth

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Abstract: Childbirth in the United States is in crisis. This is especially true for Black and brown mothers. This childbirth emergency constitutes a failure of the social contract: because society has failed to provide minimally decent care for all birthing mothers, but especially for Black and brown mothers, it is necessary to allow mothers to choose home birth. I amplify the voices of Black and brown scholars and midwives to defend home birth, and I argue that home birth is safe and empowering and that it is rational for those who desire it to choose it.

Keywords: antiracism, ethics, mothers

1. Introduction

Childbirth in the United States is experiencing a long-standing public health crisis. According to the CIA World Factbook ([Index Mundi 2019](#)), the United States ranks fifty-fourth in the world in its rate of maternal mortality, with the same number of maternal deaths per 100,000 live births, as Romania, Oman, Latvia, Moldova, and Ukraine. Whereas in most countries around the world, maternal mortality rates are on the decline, in the United States, they are on the rise.¹ Significant racial outcome disparities also exist in the United States: According to the CDC (2019), the pregnancy related mortality ratio is 12.7 deaths per 100,000 births for white mothers,² whereas it is more than three times higher (40.8 deaths per 100,000 births) for Black mothers. For Black mothers, the United States ranks eightieth in the world in maternal mortality, comparable to Malaysia, Cape Verde, Turkmenistan, Mongolia, and Brazil ([CIA 2020](#)). It is no exaggeration to say that there is a public health emergency in the United States for Black mothers and that birthing for all U.S. mothers has been in a crisis for several decades.

At this same time, increasing numbers of mothers are giving birth at home. In the past, most of these mothers have been white, cisgendered, and often very privileged. But sociologist Julia Chinyere [Oparah \(2016\)](#) argues that although the

alternative birth movement (a movement to date predominantly by and for white women, defending natural birth and midwifery care) has been plagued by racism and an implicit commitment to white supremacy and white solipsism, still the aims of that movement—to promote birthing justice, midwifery care, natural and home birth—are in line with the aims of Black and brown mothers and mothers of color “to challenge medical violence and coercion during pregnancy and childbirth, to reclaim midwifery traditions in communities of color, and to raise awareness among women of color about strategies to overcome birth inequities” (7).

My twofold aim in this paper is to highlight the emergency in U.S. maternity care and to amplify the voices of those who see home birth as an important alternative to hospital birth. To do this, I first argue that home birth is safe. Despite the fact that recent data show that twice as many infants die when born at home than die in the hospital, I nevertheless argue that home birth meets or exceeds standards of safety that society holds in other areas of everyday life. Having established home birth as a safe, rational (if not risk-free) option, I then argue that it is important to avoid undermining the autonomy of those who make rational choices, including those choosing home birth: Undermining the autonomous choice of a person who desires home birth constitutes coercion and, in the extreme, is a form of medicalized violence in the same way that a forced cesarean is a form of medicalized violence.³ Moreover, I argue that home birth can be empowering for those who choose it. Finally, I argue that the childbirth emergency in the United States constitutes a failure of the social contract: Because medical systems and providers have failed to provide minimally decent care for all birthing mothers, but especially for Black and brown birthing mothers, it is necessary to allow mothers to choose home birth. For all these reasons, I conclude that home birth is a necessary component of maternity care in the United States.

2. Home birth: Background and increasing in popularity

A small but committed number of mothers give birth at home in the United States and abroad (Levinson 2017) every year. In the United States in 2011, there were about 25,000 births in the home, where 75 percent of these were planned home births—the remaining 25 percent are births that were planned to occur in hospitals or birth centers, but due to the unexpected onset and rapidity of labor, occurred at home. According to the Centers for Disease Control and Prevention (2012), the percentage of people giving birth at home increased three-fold between 2004 and 2012 (from 0.56 percent of all births in 2004 to 0.72 percent of all births in 2009 and 1.4 percent of all births in 2012). In 2012 alone, 50,000 people had a planned birth at home. From 2004 to 2017, home births in the United States increased by 77 percent, with more than 62,000 people giving birth at home in 2017. This represents 1 out of every 62 births, or 1.61 percent of all births (MacDorman 2019). When these numbers are broken down by race, home births are increasing at the fastest rate among non-Hispanic Black mothers: In 2004, 1.2 percent of non-Hispanic Black mothers gave birth at home, and in 2017, 2.43 percent of non-Hispanic Black mothers gave birth at home, a more than 100 percent increase.

Although the overwhelming majority of births occur in hospitals, giving birth in a hospital is not without problems. Compared to home births, hospital births have higher rates of morbidity (Wax 2010) for birthing mothers. According to an analysis by George Molina et al. (2015) in the *Journal of the American Medical Association*, the ideal cesarean section rate appears to be 19 percent: above that rate, morbidity and mortality increases, for both birthing mothers and neonates. The United States Department of Health and Human Services has set a cesarean section birth target of 23.9 percent by 2020 (Rosenberg 2016); however, the current rate of cesarean births in the United States is substantially higher, at 32 percent (CDC 2020a).

Much of the medical and philosophical literature on home birth has focused on the safety of giving birth outside of a hospital.⁴ Determining the safety of home birth is partly an empirical matter that can be elucidated by data on birth outcomes in homes and hospitals. But a judgment about safety is also a philosophical matter that depends on attitudes toward risk and on views about the value of the experience in question.

To date, there have been no large-scale randomized clinical trials of planned home birth. This is not surprising. Most people have clear preferences about where to give birth, and it could be difficult to persuade people to enter a clinical trial and be randomly assigned a place of birth. Thus, I assume the validity of the best data we currently have on home birth.

Given the best data currently available, researchers agree that mothers who give birth at home have better maternal outcomes than mothers who give birth in the hospital (Wax 2010). Hospital births involve more medical interventions (including unnecessary ones) during labor (including epidurals, electronic fetal monitoring, episiotomy, operative vaginal deliveries, and cesarean deliveries); people giving birth in hospitals have a modestly increased incidence of most morbidities (greater than third-degree laceration, infection, cord prolapse, retained placenta)—people giving birth at home have a greater incidence of perineal laceration and a similar incidence of postpartum hemorrhage (Wax 2010). The rates of maternal deaths are identical in both birth settings: In the meta-analysis by Wax et al. (2010), no maternal deaths occurred in either the home birth or the hospital birth group. Although newborns have similar or lower incidence of morbidity when born in a planned home birth, newborns born at home have a higher incidence of mortality: in the meta-analysis by Wax and colleagues (2010), there were thirty-two deaths in 16,500 births at home, whereas there were the same number of deaths (thirty-two) in more than twice as many hospital births (33,302). There appears to be a risk of death twice as high for newborns born at home as compared to those born in the hospital.

For Black and brown mothers, the situation is more dire. Because the rates of maternal mortality are so high (as we have seen, more than forty deaths per 100,000 births among non-Hispanic Black mothers as compared with twelve deaths per 100,000 births for white mothers in the United States, and compared to eight deaths per 100,000 births for mothers in France (Roder 2019)), the

dangers of giving birth in the hospital are even higher than they are for the general population. My argument is not that home birth will decrease maternal deaths for Black and brown mothers, though with an attentive midwife, it may; rather, given these poor outcomes and a failed social contract, I argue Black and brown mothers, as well as all mothers giving birth, ought to have the freedom to give birth in a place of their choosing.

3. Safety first?

Before turning to the advantages of home birth, including respecting the autonomy and promoting the empowerment of those who desire it, and promoting reproductive justice, we must consider an objection to home birth. We have seen that an infant born at a planned home birth appears to have a twice-greater risk of perinatal death. Some argue that this fact alone should lead birthing mothers and childbirth care providers to avoid home birth as long as this outcome disparity persists. To consider whether this argument is correct, we must begin outside of the highly contested domain of pregnancy and childbirth, as our views about pregnancy and childbirth often seem inconsistent with views we hold in other domains of life; inconsistency here suggests that childbirth is policed to a greater extent, perhaps due to the gender of those who give birth. Consider, then, the following examples.

According to the CDC (2012, 2020c), between 2005 and 2009, approximately 700 children younger than fourteen died *every year* from non-boating related drownings. Most of these drownings occurred in home swimming pools. Drowning is the second leading cause of death in children aged 1–4 (after congenital anomalies).

Or again: In 2013, there were eight fatalities among high school students while playing organized football. From 2000–13, there were a total of forty-seven deaths of high school students while playing football. These deaths are due to overheating, undiagnosed heart conditions, and traumatic brain injuries (Marois 2014). Considering both high school and college football players, there were an average of 12.2 football fatalities each year between 1990 and 2010 (Boden 2013) and in 2015 alone there were eighteen football fatalities among high school and college players (Willingham 2018).

In 2003, there were more than 2,100 traffic fatalities in children younger than fourteen. Nearly 80 percent of these children died in non-alcohol related crashes. Moreover, roughly 45 percent of these children were properly restrained with seat belts and child safety seats (NHTSA 2003, 2014). This means that nearly 1,000 children are killed *every year* in U.S. traffic fatalities where those accidents are neither the result of improper seat restraint nor of someone operating under the influence.

In 2003, there were 390 pedestrian fatalities in the United States in children aged younger than fourteen, and 130 bicycle fatalities in the same population of children. Approximately 15 percent of those fatalities (nineteen children) were children who were properly wearing bicycle helmets (NHTSA 2003).

A non-insignificant proportion of these traffic deaths were due to an increase in the legal speed limit: In 1987, Congress allowed the rural speed limit to increase beyond 55 miles per hour; then, in 1995, Congress repealed the federal speed limit of 55 miles per hour. As a result, many states increased their highway speed limit to 65 mph, others to 70 mph, and still others to 75 mph. In 1987, the year immediately following the increase of the rural speed limit, there were 15 percent more deaths on rural highways than during the preceding five years (Baum 1989). During the period from 1995–2005, following the repeal of the federal speed limit, highway fatalities increased by more than 12,500 deaths, and this despite significant improvements in automobile safety, including better seatbelts, front and side air bags, and also better trauma care to improve the survivability of car crashes (Beitsch 2009; Nagourney 2009). If we assume that the number of children killed in car crashes after the speed limit increased was proportional to the number of people killed in car crashes after the speed limit increase, then approximately 130 of the 1,000 children who die in car crashes every year are killed because of these increases in speed limit.

But these deaths are not inevitable. Consider the public policy initiative in Stockholm, Sweden, known as Vision Zero. This is a series of initiatives in Stockholm to reduce to zero traffic-related fatalities (including car crashes, car vs. bicycle crashes, and car vs. pedestrian crashes). The initiatives include lower speed limits, more physical barriers, and automated enforcement; together they have cut traffic fatalities in Stockholm in half since their enactment in 1997. The current traffic fatality rate in Stockholm is 1.1 deaths per 100,000, less than one-third the rate of comparably-sized New York City. And despite the improvements in trauma care that have increased car crash survivability, states and cities in the United States that have adopted Vision-Zero type programs have seen traffic fatalities drop at disproportionately higher rates (Flegenheimer 2014). Writing in the *New York Times*, Flegenheimer reports that “fatality rates in American states with Vision Zero policies, including Minnesota and Utah, fell at a pace more than 25 percent quicker than the national rate.”

What I take these examples to show is that, as a society, we believe it is sometimes rational to prioritize some other value over safety. In the case of swimming pools, for instance, those who have swimming pools in their backyards are trading the safety of their and others’ children for a kind of experience. We could, at a fairly low social cost, eliminate nearly all of those 700 deaths per year, if we required the removal of home swimming pools.

The same is true of driving. The United States could, as Stockholm has done, adopt social policies that significantly reduce or even possibly eliminate all traffic fatalities (including deaths in cars, on bicycles, and for pedestrians). But we currently value efficiency and the freedom to drive faster more than we value these individuals’ lives. Indeed, valuing efficiency in this context could be quantified: Even if more people die as a result of driving faster, the total benefit to society of permitting faster driving could be greater due to the increased

productivity and efficiency of those who stay alive. Some people find this exchange of safety for efficiency to be rational and justified.

Something similar can be said of the deaths of the football players: as a society, we are willing to trade those twelve or eighteen lives every year, for the pleasure and value of many thousands of other children playing and enjoying football and the enjoyment experienced by their families, friends, and fans watching the games. And while it is true that society has begun to question the safety of football, it is also true that many families still sign their children up to play football every summer.

My first point, derived from these many examples, is that in many domains of life, we are willing to trade our children's safety for other goods, including freedom, efficiency, and pleasure. Sometimes we exchange safety for goods experienced by the children themselves (playing football, swimming in at-home swimming pools); other times we exchange our children's safety for goods that accrue to the adults (or siblings or friends) in the lives of those children. In the first case, we are willing to risk the small chance that our child will die playing football (or skiing, doing gymnastics, or riding a bicycle) for the greater chance that our child will play and enjoy that activity. In the second case, we are willing to risk the small chance that our child will die in a car crash or in a home swimming pool, for the greater chance that *others* will enjoy the freedom and efficiency of driving faster or the pleasure of the swimming pool.

Someone who chooses a home birth is doing something very similar to people who have home swimming pools, allow their children to play football, or drive 65 mph when that is the speed limit: They are rejecting an absolute commitment to safety, prioritizing some other value over it. Those choosing home birth are choosing some other good in the recognition of a very small, but increased, chance of death for their child.

For Black and brown mothers, we must remember that they face a risk of death in childbirth almost four times higher than white U.S. mothers and seven times higher than mothers in Finland. It is no exaggeration to say that for this population of mothers, it simply is not safe to give birth in the hospital (WHO 2015). There have been several high-profile stories of Black and brown mothers who have nearly died during and after childbirth, including Serena Williams and Beyoncé. And there have been less well-known examples of Black and brown people who have in fact died during or just after giving birth. One example is Shalon Irving, an epidemiologist at the U.S. CDC. In the days after giving birth, Irving was experiencing symptoms whose severity was unrecognized by her physician and from which Irving died (Roder 2019). These examples typify the risks faced by Black and brown mothers. Both Irving's family and Williams herself emphasize that their symptoms were not taken seriously by their medical providers (Salam 2018). Although these stories reveal pervasive injustice, they are not surprising: it has been widely reported that doctors often do not listen well to women-identified people (Fetters 2018; Kiesel 2017; Pagan 2018), particularly during childbirth, and most especially to Black and brown mothers (Kritz 2018).

Mothers, as a group, fare better when they give birth at home, although infants fare a bit worse. Is it morally acceptable for a mother to prioritize their own well-being over that of their neonate? We have seen that in other domains of life (e.g., driving, swimming, playing football) it is rational to prioritize other values more highly than safety. Why would childbirth be any different? Indeed, one might think that respecting the wishes and protecting autonomy in the highly intimate, deeply personal setting of childbirth is more important than it is to allow a child to play football, or a person to have a home swimming pool, or to drive a little bit faster. On this view, there would seem to be more reason to respect the choices of the birthing mother, even if this puts the newborn at slightly higher risk, than to respect the choices of the parent-driver or pool-user, or child-football-player. Because home birth is being singled out, it suggests that gender is a factor. Critics are policing childbirth to an extent that they do not police other areas of life.

4. Home birth and gender

It is important to contextualize home birth by looking at the gender-neutral examples of driving a vehicle, having a home swimming pool, and playing football. In these other domains, society seems to be very comfortable allowing parents to assume some risks on behalf of their children. We do not require parents to prioritize safety above all else. Indeed, if we did, we would not allow parents to drive, ever. We allow parents the freedom to autonomously make tradeoffs for their children's safety: We allow parents to drive the speed limit of 65 or 75 miles per hour, even knowing as we do that this will increase the number of children who die in car crashes each year. Those, say, 130 lives each year are traded for the freedom to drive 10mph faster. Mothers who give birth at home are exchanging some risk to their newborn for the greater likelihood of giving birth without unnecessary medical interventions and experiencing the intimate and personal domain of childbirth in a non-medical setting. The only difference between home birth and these other examples is that requiring all parents to limit their freedom (driving slower, etc.) would constrain fathers as well as mothers. There seems no other difference between these two kinds of constraints. Someone who singles out home birth but allows all these other choices, polices women-identified-people more than they police all parents. It is hard to see what else might explain the difference.

Now, some people will react to the examples I have given (of football, swimming pools and driving safety) and argue that we should, as Sweden has, adopt Vision Zero-type policies all around: We should reduce speed limits, ban home swimming pools, prevent young children (or all people) from playing football. In short, we should value safety, even if not absolutely, much more highly than we currently do. Just as the loss of one at-home-swimmer, one child football player, one pedestrian or one bicyclist, or one motorist is too many, in the same way, the loss of even one neonate is too many. So we ought to do everything we can to prevent neonatal deaths, and that includes opposition to home birth.

It may be rational to hold this view. But notice that it does not unproblematically point us to the view that home birth is unethical, “unprofessional,”

or should not be allowed under any circumstances. Rather, it suggests that we should make it safer to give birth at home. In Canada and in many European countries, home birth and midwife-provided care are integrated into their health systems, allowing for more coordination between home birth and hospital birth providers, more regulation of who is an appropriate candidate for home birth, and easier transfers from home to hospital in case of complications.⁵ The reticence of some to do something similar in the United States again suggests that opposition to home birth outstrips concerns about its safety: Those who single out home birth are holding birthing mothers to a standard of safety that they do not require of parents and other people in other domains of life, where those other choices have far greater harmful effects on children.

One final objection as concerns safety: Perhaps the objection to home birth concerns not what risks we should tolerate as a society to protect freedom, efficiency, or another good, but rather what we should expect parents to undertake to save the lives of their children. This is an important point. But I would caution that accepting this view with respect to home birth will have far-reaching consequences. If we require people to give birth in hospitals against their wishes (make home birth illegal and prosecute midwives who attend births at home or even prosecute families who intentionally give birth at home, for instance), we must also legally require parents to drive more slowly (55 mph for parents?), make it illegal to have backyard swimming pools, and make it illegal for children to play football, ride bikes, etc. Indeed, we will also need to shift our policies and require that parents donate their blood, their extra kidneys, and the lobes of their livers to save the lives of their children. We do not currently require any of these things—either legally or morally—perhaps because we believe that parents are not required to do these things. But we should not single out home birth, with only a handful of preventable deaths per year, when there are so many other preventable childhood deaths and so many other ways for parents to act to save the lives of their children.

5. Four arguments for home birth

Having now argued that home birth meets (or exceeds) standards of safety society holds in other areas of everyday life, I argue that there are four reasons to maintain and expand the availability of home birth as an option for birthing mothers who desire it.

First, [Oparah \(2016\)](#) has argued that the alternative birth movement is crucial for promoting reproductive justice. Reproductive justice is a term “coined by women of color as a radical, inclusive, and intersectional political analysis and praxis that challenged the narrow focus of the mainstream reproductive rights movement” (5). Arguing for reproductive justice, [Stephanie Etienne \(2016\)](#) argues that midwives earn the trust of their clients, “honor [their] wisdom and experience [so that] the countless structural divisions that exist between provider and patient start to crumble” (122). Etienne works as a midwife in a nonprofit hospital serving the South and Central Bronx. But this praxis can be extended to

home birth. Thus, midwives in home birth settings may also be able to dismantle these structural divisions between midwife and patient. Midwives in both settings build trust by listening carefully to mothers and developing relationships with them over time.

By contrast, some physicians do not listen well to Black and brown mothers, especially when they are giving birth (Kritz 2018). The earlier examples of Serena Williams and Shalon Irving are a testament to this. Black and brown mothers are also far less likely than their white counterparts to know their birth attendant during a hospital birth: The 2006 survey “Listening to Mothers II: Report of the Second National U.S. Survey of Women’s Childbirth Experiences” (Declercq et al. 2007) found that out of 1,573 mothers interviewed, Black, non-Hispanic mothers were least likely to have met their birth attendant prior to being in labor. But in a home birth, the attendant is chosen by the mother and develops a close relationship with the birthing mother over many months. It is possible that having a close relationship with a trusted midwife will improve outcomes: Had someone really listened to Williams or to Irving, their outcomes might have been very different. In addition, having a close relationship with a trusted birth attendant is also valuable. Home birth promotes this close relationship.

Finally, a mother giving birth at home has far more control over who will attend the birth than were they giving birth in a hospital. In a hospital, many people will cycle through the birthing room (several labor and delivery nurses, a pediatrician, a midwife or obstetrician, perhaps medical or nursing students, residents, phlebotomists, and so on). By contrast, at home, all attendants are chosen by the mother. For all these reasons, home birth may promote reproductive justice.

The second reason why home birth is an important option is that those who choose it believe that it can be empowering (England 1998; Leavitt 1986; Lake 2009). Giving birth, especially in a nonmedicalized setting, requires agency within passivity. Childbirth is a largely passive process, much of the time spent waiting and in pain. It requires achieving an outcome (giving birth) through a process that involves some risk and is uncertain. Being an agent within such a passive, uncertain process promotes empowerment. By contrast, a person who gives birth in a medicalized setting is acted upon by others. Someone will place an intravenous line and fetal monitor leads. This makes the laboring mother more passive, docile even, because they are less able to walk or move around. It also means nurses and other hospital staff will be paying attention to the monitors (instead of, or in addition to, the laboring mother). Laboring mothers in the hospital will be subject to many hospital regulations in limiting visitors, limiting when the mother can eat or drink, and so on. These limits are needed for some laboring people, but all are subject to them, whether they are needed or not. All of this encourages passivity and a feeling that others are in control. Even the language used to describe the act of giving birth varies, and significantly so. At home, a midwife is said to “catch” a baby, an essentially passive act that honors the laboring mother as the actor. In the hospital, the doctor is said to “deliver” the baby, suggesting that the doctor is the actor effecting the separation of these

two individuals. Without a doubt, giving birth in a hospital is sometimes necessary. But that it is sometimes best or necessary does not mean it is always best, or that mothers who desire a home birth should not have one.

Moreover, as a philosophical matter, there is value in learning to cope with uncertainty. As Iris Murdoch (1970) puts it, “the world is aimless, chancy, and huge . . . [and g]oodness is connected with the acceptance of real death and real chance and real transience” (100). Murdoch acknowledges that life is risky and that we lose the ability to cope with this when we attempt to purify all our experiences of risk. Attempting to purify birth of uncertainty (for instance by using the cesarean birth in most births) produces worse medical outcomes and habituates people to be less able to embrace and respond to the inherent riskiness of life itself. Home birth, on the other hand, provides an opportunity to be an agent of a partially passive, somewhat risky process, whose outcome is neither certain nor guaranteed. Not all people desire to give birth at home. But for those who do, this can be an important, empowering experience.

The third argument in favor of home birth is that it is important to respect the autonomy of those who make rational choices. I’ve shown, I think, that the choice for home birth is can be a rational one. To undermine the autonomy of a person making a rational choice does them a wrong, and in the extreme, is a form of medicalized violence. By way of analogy, consider forced cesareans. Nancy Rhoden (1987) argues that there is neither a legal nor a moral justification for requiring a pregnant person to undergo a cesarean delivery against their wishes. Indeed, Rhoden argues that a forced cesarean is analogous to requiring a parent or relative or even a stranger to donate blood, or tissue, or an organ to someone. In a court case on this point, *McFall v. Shimp*, a man dying of aplastic anemia asked “the court to mandate that his cousin donate bone marrow to save him” (120). The court held that the law cannot “sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member” and that this “is revolting to our hard-wrought concepts of jurisprudence” (122). Rhoden argues that performing a nonconsensual cesarean on someone requires that the individual be restrained and that their autonomy be violated and is, thus, similarly wrong. In the same way, I argue that to require that a person give birth in the hospital, against their autonomous, rational decision, necessitates that the person be restrained and subjected to the myriad potential maternal harms that exist for hospital births. And when one of those harms obtains, and the laboring mother is subjected to an operative vaginal delivery (forceps), or to an episiotomy, or to a cesarean delivery, these constitute violations of the body and of the autonomy of the laboring mother.

Sonya Charles (2011) argues that obstetricians engage in practices that are relevantly similar to those employed by abusive partners in intimate partner violence. Intimate partners use coercion, manipulation, and violence to maintain control of their partners. Obstetricians, Charles argues, believe they know what is best for their patients and similarly “use manipulation, intimidation and violence to control [pregnant persons’] bodies” (52). Charles concludes that forced cesareans and other nonconsensual invasive procedures are “direct assaults on

[pregnant people's] bodies" (54). This conclusion can be extended to cover the prohibition on home births: The requirement that people give birth in the hospital aims to control what pregnant people can choose and do with their bodies, leaving them subject to forced or pressured surgeries and other invasive procedures. Home birth, because it is a rational choice, and because it is a choice that is autonomously made with proper information, must be available. Its unavailability constitutes coercion of, and violence against, pregnant people.

Finally, I argue that for all mothers who give birth in the United States, but especially for Black and brown mothers, society has failed in upholding its end of the social contract. We have seen the alarming rates of maternal mortality in the United States. We have also seen the high rates of adverse outcomes for hospital births in the United States. And we have seen that the rate of cesarean delivery is far higher than what is recommended by experts. The rate of neonatal mortality (death of a neonate within twenty-eight days of birth) is far higher in the United States than it is in many of our counterpart countries (Kamal et al. 2019). In 2017, the United States had a rate of 5.8 neonatal deaths per 1,000 live births, whereas Japan (whose rate is the lowest in the world) had a rate of 2.0 per 1000 births, followed by Sweden at 2.4 deaths per 1000 births, and many nations at a rate of two to three deaths per 1,000 live births, including France, whose rate is 3.9 per 1000 births. Within the United States, the neonatal mortality rate among Black non-Hispanic neonates is more than twice as high (10.8 out of 1000 infants) as it is for white neonates and three times higher than it is for Asian neonates (CDC 2020b). Given that many world health systems have outcomes far better than the United States has in general, and that white and Asian mothers and infants fare far better in the United States than do Black and brown mothers and infants, it is necessary to allow pregnant mothers to make the rational, autonomous choice to give birth at home, even if there are some risks in giving birth at home.

6. Objections

Before closing, I consider two objections to my view. We have seen that Oparah (2016) holds that the alternative birthing movement can promote reproductive justice. Home birth falls clearly within the alternative birthing movement and thus may be a component of promoting reproductive justice in childbirth. One objection to this view, however, is that systemic racism is a problem of enormous magnitude. Birthing mothers in the United States, especially in Black and brown communities, are dying. Allowing all birthing mothers who desire home birth to choose it will make but a tiny contribution to promoting racial justice in childbirth.

I grant the objection. The problem of systemic racism is enormous and we have much work to do in the United States to overcome systemic and institutionalized racism in childbirth and in other domains of life. But still, home birth can play a small, but important, role in this crucial work: Enabling birthing mothers to choose the place of their births promotes autonomy and empowerment. These are good in their own right. But in addition, home birth can give those who face

institutionalized oppressions another tool to address institutionalized racism or other forms of oppression in their lives. Home birth enables birthing mothers to change the context in which they give birth, and choose a context with an attentive, supportive midwife, in the comfortable environment of the home.

Another concern about home birth is that some mothers will be unable to access home birth. There may be many reasons for this: Perhaps they are experiencing homelessness or domestic abuse or they do not have health insurance. Society must address all these obstacles to reproductive justice, obstacles to the lives and health of so many families, including ensuring that all families have a safe place to live and have access to affordable, high-quality health care.

Some mothers may also be unable to access home birth because they are considered to be in a high risk group for pregnancy complications, and home birth is typically considered to be an option only for those in lower risk groups. Here, I'd suggest that it is important to uncover the reasons why some mothers are at high risk for childbirth complications. The reasons may be different for mothers in different demographic groups. For Black and brown mothers who are in a higher risk group, institutionalized racism may be the most plausible reason. One aspect of institutionalized racism is a phenomenon known as "weathering," a term coined by Arlene Geronimus several decades ago. The idea behind weathering is that individuals who experience systemic, institutionalized racism or other forms of oppression during their whole lives are worn down by these oppressions. This can result in diseases such as hypertension, type 2 diabetes, and depression, which can in turn put mothers at higher risk for complications in childbirth. [Geronimus \(1996\)](#) found, in particular, that white mothers are more likely to have a healthy baby when they delay childbirth until their twenties; however, Black mothers are *less* likely to do so: Black mothers are more likely to give birth to a healthy baby in their teens, and healthy outcomes for Black mothers diminish the older they grow. David R. Williams ([Shariff-Marco et al. 2011](#)) has cited Geronimus's work in his Everyday Racism Scale, which helps explain how racism and pervasive racist policies and other forms of social oppression affect health. What these findings point to is that everyday racism (racist policies, systemic and institutionalized racism) undermine health and contribute to poorer outcomes for Black and brown mothers in childbirth.

Because there is strong evidence that certain diseases (which can cause childbirth complications) are rooted in racist policies, institutionalized racism, and other forms of oppression, it makes sense to hold that society is obligated to provide, and increase access to, childbirth strategies that have a chance of obviating some of this oppression. Birthing mothers, especially in the context of failures of the social contract, ought to be free to choose how to respond to those social contract failures. Because home birth is safe, it is unjust to foreclose this option to birthing mothers who desire to give birth at home.

Home birth enables birthing mothers, one at a time, to potentially have a more empowering birth and to autonomously choose where to give birth. And while it is essential for individuals to have this agency over their lives, it

is important to acknowledge that a just society cannot be achieved simply by changing childbirth practices and it cannot be achieved through individual action alone. Dismantling systemic and institutionalized racism, racist policies, and all forms of oppression requires the widespread changing of laws and policies, changing corporate rules, changing cultures, changing distributions of power and wealth, overcoming implicit biases, and so on; and these changes require widespread, coordinated collective action. But while we do this work, still it is valuable for individuals to have as many resources at their disposal to help them cope with this unjust reality. Home birth is one such important resource in one important domain of life.

7. Conclusion

I have offered two main arguments in support of home birth. First, I have argued that home birth is safe. Allowing parents the freedom to choose the place of their birth is analogous to other freedoms we allow to parents. Society allows some parents (especially privileged ones—though we should, *of course*, allow these freedoms to all parents) the parental autonomy to make decisions about competing goods for their child. Parents ought to have the freedom to balance the competing goods of safety, efficiency, pleasant experiences, and so on. So even if a choice is somewhat less safe (driving the speed limit of 65 mph, rather than driving 55; having a home swimming pool, rather than not; allowing a child to play football, rather than learning to knit), society currently gives parents the freedom to make that somewhat-less-safe choice. All parents should have these freedoms, and in the same way, all parents should have the freedom to choose home birth.

Second, I have argued that home birth promotes several important goods: It can promote reproductive justice, it can be empowering, and it can promote autonomy. Home birth may promote reproductive justice because a mother giving birth at home has the freedom to choose who will be present at the birth and can choose a midwife committed to reproductive justice. A midwife also typically attends to the birthing mother in a way that builds trust. Both promote reproductive justice.

Home birth can be also be empowering: When individuals are agents of a risky, chancy process, able to embody agency within passivity and accomplish the birth of the infant, this can be a powerful, life altering experience. I have argued that home birth is typically regarded as an empowering experience for the birthing mother and that this good either cannot be as well promoted by hospital birth, or has not typically been promoted by hospital birth. Recognizing this, we should acknowledge that it is reasonable to allow birthing families the freedom to choose home birth. At the same time, society should work to make home birth as safe as possible, by developing clearer credentialing for home birth midwives, transfer protocols, and ensuring strong collaborative relationships between obstetricians and home birth midwives. We should also work to make hospital birth as safe as possible, eliminating racist policies in hospitals and bringing the rates of maternal and infant morbidity and mortality in line

with our global peers. Doing all this empowers people who give birth. Home birth can help parents begin or continue their journey as parents with the foundation of an empowering birth. And even if doing so is a small fraction less safe, this is a tradeoff that is common in other domains, and rational to make in the domain of childbirth as well.

Finally, having a home birth, for those who want one, can promote autonomy. It is a substantial wrong when society forecloses rational options that are autonomously chosen. Doing so is coercive, violates respect for the body and choices of the individual, and, in the extreme, can be a form of violence. As we have seen, society permits parents to decline to donate their organs and their blood to their children even when these are needed to save the children's lives; in the same way, individual autonomy should protect a parent's freedom to choose home birth, even if this choice creates risks for their child to a small degree.

In closing, home birth is needed, especially in the context of current outcomes for mothers and infants in childbirth in the United States. The United States has failed in its social contract by allowing exorbitantly high rates of maternal and neonatal mortality. These rates are a true emergency for Black and brown mothers and babies in the United States and are a crisis for all U.S. mothers and babies. Because of this failure, society has an even stronger obligation to respect a birthing mother's choice for home birth, a choice I have shown to be autonomous, empowering, and rational.

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NOTES

1. See also [Martin \(2017\)](#).
2. To be as inclusive of people of many gender identities, I will use the terms "birthing mother" rather than "birthing woman." I follow Sara [Ruddick \(1989\)](#) in holding that mothers can be humans of any gender.
3. See also [Rhoden \(1987\)](#); [Charles \(2011\)](#); and [Scott \(2000\)](#).
4. See also [Chervenak, et al. \(2013\)](#); [Declercq \(2013\)](#); [Minkoff \(2013\)](#); [Regan \(2013\)](#).
5. See also [Eschner \(2017\)](#) and [Van der Kooy et al. \(2017\)](#).

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